Health Financia	al Syst	ems	MARGARET MARY COMMUNI	TY HOSPITAL			In Lieu	u of Form	CMS-255	52-10
This report is	requi i	red by Law (42 USC 1395	g; 42 CFR 413.20(b)). Failu	re to report can	resul	t in all i	nterim	FORM APP	ROVED	
payments made	since '	the beginning of the co	st reporting period being d	leemed overpayment	ts (42	USC 1395g	J).	OMB NO.	0938-005	50
HOSPITAL AND H	OSPI TAI	L HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provi der CCN: 15	1329	Peri od:		Workshee		
AND SETTLEMENT	SUMMAI	RY				From 01/0				
						To 12/3	31/2015	Date/Tim		
								5/26/201	0 11:50	aiii
PART I - COST	REPORT	STATUS								
Provi der	1. [ X	] Electronically filed	cost report			Date:	5/26/20	16 Tir	me: 11:5	0 am
use only	2. [	] Manually submitted co	st report							
			I report enter the number of		der re	submitted	this co	ost repor	t	
	4. [ F	] Medicare Utilization.	Enter "F" for full or "L"	for low.						
Contractor	5. ſ 1	1Cost Report Status	6. Date Received:		10. N	PR Date:				
use only	(1)	As Submitted	7. Contractor No.			ontractor'				4
)	(2)	Settled without Audit	8. [ N ] Initial Report for	this Provider CCI	N 12. [	0]Iflin	ie 5, co	lumn 1 is	4: Ent	er
		Settled with Audit	9. [ N ] Final Report for the	nis Provider CCN				es reoper		
	(4)	Reopened								

## PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARGARET MARY COMMUNITY HOSPITAL (151329) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	
	Officer or Administrator of Provider(s)
	` '
T' 11	
Title	
Date	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	659, 071	-595, 319	395, 678	138, 721	1.00
2.00	Subprovi der - I PF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		74, 058		0	10.00
200.00	Total	0	659, 071	-521, 260	395, 678	138, 721	200. 00

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

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

Health Financial Systems In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151329 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/26/2016 11:49 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 321 MITCHELL 1.00 PO Box: 1.00 2.00 City: BATESVILLE State: IN Zi p Code: 47006-County: RIPLEY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 MARGARET MARY COMMUNITY 151329 99915 01/07/1966 Ν 0 0 3.00 HOSPI TAI Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA MARGARET MARY COMMUNITY 157143 99915 03/01/1985 N Ρ Ν 12.00 HOSPI TAL 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce MARGARET MARY COMMUNITY 99915 14 00 151551 12/31/2003 14 00 HOSPI TAL 15.00 Hospital-Based Health Clinic - RHC MARGARET MARY COMMUNITY 158511 99915 09/03/2013 N 0 Ν 15.00 HOSPI TAL 16, 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2015 12/31/2015 20.00 Type of Control (see instructions) 21.00 21.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this cost reporting Ν 22.01 Ν period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care payments to be N Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22. 03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν 22.03 Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" for yes or "N" fo<u>r no</u> In-State In-State Out-of Out-of Medi cai d Other Medi cai d Medi cai d State State HMO days Medi cai d Medi cai d paid days el i gi bl e Medi cai d days unpai d paid days el i gi bl e unpai d days 1.00 2.00 3. 00 4.00 5.00 6.00 24.00 | If this provider is an IPPS hospital, enter the 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

	ee Prepared: 6 11: 49 am eer cai d ys  25. 00  26. 00  27. 00  35. 00
In-State   In-State   Medicaid	6 11: 49 am er cai d ys  00  25. 00  27. 00  35. 00  36. 00  37. 00
Medicaid paid days   Medicaid paid days   Medicaid unpaid   Medicaid paid days   Medicaid unpaid   Medicaid paid days   Medicaid paid paid days   Medicaid paid paid days   Medicaid paid paid paid paid paid paid paid p	26. 00 27. 00 35. 00 37. 00
25.00   If this provider is an IRF, enter the in-state	25. 00 26. 00 27. 00 35. 00 36. 00 37. 00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid Medicaid eligible unpaid days in column 5.    Urban/Rural S Date of Calcolor	25. 00 26. 00 27. 00 35. 00 36. 00 37. 00
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.  27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.  35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.  Beginning: Ending 1.00 2.00  36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.  37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.  38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	26. 00 27. 00 35. 00 36. 00 37. 00
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.  27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.  35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.  Beginning: Ending 1.00 2.00  36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.  37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.  38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	26. 00 27. 00 35. 00 36. 00 37. 00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.  35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.  Beginning: Ending 1.00 2.00  36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.  37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.  38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	35. 00 36. 00 37. 00
effect in the cost reporting period.  Beginning: Ending: 1.00 2.00  36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.  37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.  38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	36. 00 37. 00
Beginning: Ending 1.00 2.00  36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.  37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.  38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	36. 00 37. 00
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.  37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status of is in effect in the cost reporting period.  38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	36. 00 37. 00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.  38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	20 00
	36.00
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume N N	39.00
hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or N	40. 00
"N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	XI X
Prospective Payment System (PPS)-Capital	3. 00
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N with 42 CFR Section §412.320? (see instructions)	N 45.00
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances N N pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N 46.00
47.00 Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.  N N N STEACH TO SENTING THE S	N 47.00 N 48.00
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes N or "N" for no.	56. 00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved  GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	57. 00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.  N Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	59. 00 60. 00
Y/N IME Direct GME IME Direct	GME
1.00 2.00 3.00 4.00 5.00	
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)	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 instructions)	61. 01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)	

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der (		eriod: rom 01/01/2015 o 12/31/2015	Worksheet S-2 Part I Date/Time Pre 5/26/2016 11:4	pared
	Y/N	I ME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3. 00	4.00	5.00	
Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0. 00	0.00			61. C
Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).		0. 00	0.00			61. 0
Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0. 00	0.00			61. 0
.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0. 00	0.00			61.0
	Pro	ogram Name			Direct GME FTE Count	
.10 Of the FTEs in line 61.05, specify each new program		1.00	2. 00	3.00	4.00	61. 1
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.  1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0. 00		61. 2
					1.00	
ACA Provisions Affecting the Health Resources and Ser						
2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instructions)		d in this cost	reporting peri	od for which	0.00	62.0
2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	Teachi ram. (s	<u>see instruction</u>		your hospital	0.00	62.0
Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this co	instructions)	,	N	63. (
			Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te 1. 00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No						

				1.00	2.00	3.00	
	Section 5504 of the ACA Base Yea	ır FTE Residents in No	onprovider Settings	This base year	is your cost r	eporting	
	period that begins on or after .	luly 1, 2009 and befor	re June 30, 2010.				
64.00	Enter in column 1, if line 63 is	yes, or your facilit	y trained residents	0.00	0. 00	0. 000000	64.0
	in the base year period, the num						
	resident FTEs attributable to ro	all nonprovider					
	settings. Enter in column 2 the number of unweighted non-primary care						
	resident FTEs that trained in yo	ur hospital. Enter ir	column 3 the ratio				
	of (column 1 divided by (column	1 + column 2)). (see	instructions)				
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				FTEs	FTEs in	(col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
				Si te			
		1. 00	2.00	3. 00	4. 00	5.00	

0.000000 64.00

Health Financial Systems	MARGARET MA	ARY COMMUNITY HOSPITA	AL .	In Li€	eu of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider			eriod: com 01/01/2015 ) 12/31/2015		pared:	
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	47 4111
(F.00   F.1   1   1   1   1   1   1   1   1   1	1.00	2. 00	3. 00	4. 00	5.00	/F 00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column			0.00	0. 00	0. 000000	65.00
4)). (see instructions)			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
Section 5504 of the ACA Current	Vaar FTF Dasidants in	Nonnrovider Setting	1.00	2.00	3.00	
beginning on or after July 1, 20	010		,	·		
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	occurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. Ty care resident B the ratio of	0.00	0.00	0. 000000	66.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
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)	1.00	2.00	3.00	4.00	5.00	67. 00
				1.0	0 2.00 3.00	
Inpatient Psychiatric Facility F		DE)				70.05
70.00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no		PF), or does it cont	aın an IPF subp	rovider? N		70. 00
71.00 If line 70 yes: Column 1: Did the recent cost report filed on or but 42 CFR 412.424(d)(1)(iii)(c)) Comprogram in accordance with 42 CFC Column 3: If column 2 is Y, indicate instructions)  Inpatient Rehabilitation Facilit	ne facility have an apefore November 15, 20 Jumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	004? Enter "Y" for y lity train residents (D)? Enter "Y" for y	res or "N" for n s in a new teach res or "N" for n	o. (see i ng o.	0	71. 00
75.00 Is this facility an Inpatient Re	habilitation Facility	(IRF), or does it c	contain an IRF	N		75. 00
subprovider? Enter "Y" for yes 76.00 If line 75 yes: Column 1: Did th recent cost reporting period enc no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ling on or before Nove train residents in a er "Y" for yes or "N"	ember 15, 2004? Enter new teaching program for no. Column 3: If	"Y" for yes or in accordance column 2 is Y,	"N" for	0	76. 00

	Health Financial Systems MARGARET MARY COMM HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		L CCN: 151329	In Lie	u of Form CMS Worksheet S-	
Dog Trim Give Hospital (109)				From 01/01/2015	Part I Date/Time Pr	epared:
Book   See   This is a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.   N   80		<b>'</b>				
80.00   St this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.   N   80.	Long Term Care Hospital PPS				1. 00	
BETRA Providers	80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part of			g period? Enter		80. 00 81. 00
Bo. 00   Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section   \$413.40(r)(1)(1)? Enter "Y" for yes and "N" for no.   \$1.00   \$2.00   \$1.00   \$1.00   \$2.00   \$1.00   \$1.00   \$1.00   \$2.00   \$1	TEFRA Provi ders					
15. this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(8)(iv)(II)? Enter "Y"   N   S7.	86.00 Did this facility establish a new Other subprovider (exclude		,		N	85. 00 86. 00
11   10   2   10   10   10   10   10	87.00 Is this hospital a "subclause (II)" LTCH classified under se	ection 1886(d)	(1) (B) (i v) (I I	)? Enter "Y"	N	87. 00
Title V and XIX Services	1.01 300 0. 1. 10. 110.					
90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for N y 90. yes or "N" for no in the applicable colum. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in N Y 91. Full or in part? Enter "Y" for yes or "N" for no in the applicable colum. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see Instructions) Enter "Y" for yes or "N" for no in the applicable colum. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter N N 93. "Y for yes or "N" for no in the applicable colum. 94.00 polical to volum. 95.00 polication of the column of the	Title V and VIV Services			1. 00	2. 00	
yes or "N" for no in the applicable column.  91.00   st his hospital reliabursed for title V and/or XIX through the cost report either in N		al services? E	nter "Y" for	N	Υ	90.00
Full or In part? Enter "Y" for yes or "N" for no in the applicable column.	yes or "N" for no in the applicable column.			N	Y	91. 00
Instructions  Enter "Y" for yes or "N" for no in the applicable column.	full or in part? Enter "Y" for yes or "N" for no in the appl	icable column			N	92. 00
"\" for yes or "\" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "\" for yes, and "\" for no in the applicable column. 95.00   F    ine 94 is "\", enter the reduction percentage in the applicable column. 96.00 Does title V or XIX reduce operating cost? Enter "\" for yes or "\" for no in the applicable column. 97.00   F    ine 94 is "\", enter the reduction percentage in the applicable column. 98.00 Does title V or XIX reduce operating cost? Enter "\" for yes or "\" for no in the applicable column. 99.00   F    ine 96 is "\", enter the reduction percentage in the applicable column. 99.00   F    ine 96 is "\", enter the reduction percentage in the applicable column. 99.00   F    ine 96 is "\", enter the reduction percentage in the applicable column. 99.00   F    ine 96 is "\", enter the reduction percentage in the applicable column. 99.00   F    ine 96 is "\", enter the reduction percentage in the applicable column. 99.00   F    ine 96 is "\", enter the reduction percentage in the applicable column. 99.00   F    ine 96 is "\", enter the reduction percentage in the applicable column. 99.00   F    ine 96 is "\", enter the reduction percentage in the applicable column. 99.00   F    ine 96 is "\", enter the reduction percentage in the applicable column. 99.00   F    ine 96 is "\", enter the reduction percentage in the applicable column. 99.00   F    ine 96 is "\", enter the reduction percentage in the applicable column. 99.00   F    ine 96 is "\", enter the reduction percentage in the applicable column. 99.00   F    ine 96 is "\", enter the reduction percentage in the applicable column. 99.00   F    ine 96 is "\", enter the reduction percentage in the such access position of the cRNA fee schedule? See 42    info percentage in the such access percentage in the such access position of the cRNA fee schedule? See 42    info percentage in the such access position of the cRNA fee schedule? See 42    info percentage in the such access position of the such access position of the such a	instructions) Enter "Y" for yes or "N" for no in the applica	able column.	, ,	N		93. 00
applicable column.  9.00   Filine 94 is "Y", enter the reduction percentage in the applicable column.  9.00   Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the N N N 96.  8policable column.  9.00   O.00   O.0	"Y" for yes or "N" for no in the applicable column.					94. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.  9.00 If line 96 is "Y", enter the reduction percentage in the applicable column.  9.00 0.00 0.00 0.00 97.  Rural Providers  105.00 Does this hospital qualify as a critical access hospital (CAH)?  106.00 lef this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)  107.00 lef this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R not training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wist B. Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wist. 0-2, Pt. II.  108.00 lis this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 Nounce CER Section \$412.113(c). Enter "Y" for yes or "N" for no.    Physical Occupational Speech Respiratory	applicable column.					
97.00   Î Î Î Î Î Î Î Î Î 9 6 Î S "Y", enter the reduction percentage in the applicable column.   0.00   0.00   97.	96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			1		96. 00
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1.00 2.00 3.00		ıcy? Enter 1				118. 00
			Premi ums	Losses	Insurance	
			1, 00	2,00	3.00	
	118.01 List amounts of malpractice premiums and paid losses:		7.00			0118.01

ealth Financial Systems HOSPITAL AND HOSPITAL HEALTH	CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151329	Peri od: From 01/01/2015	u of Form CN Worksheet S Part I	S-2
			To 12/31/2015	Date/Time I 5/26/2016	
			1. 00	2.00	
	ums and paid losses reported in a cost o		N		118. 0
and amounts contained	neral? If yes, submit supporting schedu therein.	le listing cost centers			
19.00 DO NOT USE THIS LINE					119. 0
	that qualifies for the Outpatient Hold amendments? (see instructions) Enter in		N	N	120. 0
"N" for no. Is this a	rural hospital with < 100 beds that qua	alifies for the Outpatient			
	on in ACA §3121 and applicable amendment " for yes or "N" for no.	s? (see instructions)			
	ur and report costs for high cost implar	ntable devices charged to	Υ		121. 0
patients? Enter "Y" fo					
Transplant Center Info 25.00 Does this facility ope	ormation erate a transplant center? Enter "Y" for	yes and "N" for no. If	N		125. 0
yes, enter certificati	ion date(s) (mm/dd/yyyy) below.				
	certified kidney transplant center, ent nation date, if applicable, in column 2.				126. 0
27.00 If this is a Medicare	certified heart transplant center, enter	er the certification date			127. 0
	nation date, if applicable, in column 2. certified liver transplant center, ente				128. 0
in column 1 and termin	nation date, if applicable, in column 2.				
	certified lung transplant center, enter ion date, if applicable, in column 2.	the certification date i	n		129. 0
	certified pancreas transplant center, e	enter the certification			130. 0
	termination date, if applicable, in colu				121 0
	certified intestinal transplant center, termination date, if applicable, in colu				131. 0
32.00 If this is a Medicare	certified islet transplant center, enter	er the certification date			132. 0
	nation date, if applicable, in column 2. certified other transplant center, ente				133. 0
in column 1 and termin	nation date, if applicable, in column 2.				
	rocurement organization (OPO), enter the if applicable, in column 2.	e OPO number in column 1			134. 0
					1
All Providers					
40.00 Are there any related	organization or home office costs as de		N		140. 0
40.00 Are there any related chapter 10? Enter "Y" are claimed, enter in	organization or home office costs as defor yes or "N" for no in column 1. If y column 2 the home office chain number.	yes, and home office costs (see instructions)			140. 0
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40.00 Are there any related chapter 10? Enter "Y" are claimed, enter in 1.00  If this facility is pa home office and enter  41.00 Name: 42.00 Street: 43.00 City:  44.00 Are provider based phy  45.00 If costs for renal ser inpatient services onl no, does the dialysis period? Enter "Y" for 46.00 Has the cost allocatic Enter "Y" for yes or "yes, enter the approva  47.00 Was there a change in 48.00 Was there a change in	organization or home office costs as defor yes or "N" for no in column 1. If y column 2 the home office chain number.  art of a chain organization, enter on lithe home office contractor name and composition contractor's Name:  PO Box:  State:  ysicians' costs included in Worksheet Affice  rvices are claimed on Wkst. A, line 74,  ly? Enter "Y" for yes or "N" for no in claim 1, facility include Medicare utilization for yes or "N" for no in column 2.  on methodology changed from the previous "N" for no in column 1. (See CMS Pub. 15 and date (mm/dd/yyyy) in column 2.  the statistical basis? Enter "Y" for yet the order of allocation? Enter "Y" for	res, and home office costs (see instructions)  nes 141 through 143 the restriction number.  Contraction  Zip Code  are the costs for column 1. If column 1 is for this cost reporting  Sly filed cost report?  S-2, chapter 40, §4020) If the ses or "N" for no.  yes or "N" for no.	3.00 ame and address or's Number:  1.00  N	1. 00 Y 2. 00	141. ( 142. ( 143. ( 144. ( 145. ( 146. ( 147. ( 148. (
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40.00 Are there any related chapter 10? Enter "Y" are claimed, enter in 1.00 If this facility is payone office and enter 41.00 Name: 42.00 Street: 43.00 City: 44.00 Are provider based phy 45.00 If costs for renal ser inpatient services onlino, does the dialysis period? Enter "Y" for 46.00 Has the cost allocatic Enter "Y" for yes or "yes, enter the approva 47.00 Was there a change in 49.00 Was there a change to	organization or home office costs as defor yes or "N" for no in column 1. If you column 2 the home office chain number.  2.00 art of a chain organization, enter on lithe home office contractor name and column 2. State:  PO Box: State:  Possible are claimed on Wkst. A, line 74, ly? Enter "Y" for yes or "N" for no in column 2. On methodology changed from the previous "N" for no in column 1. (See CMS Pub. 15 all date (mm/dd/yyyy) in column 2.  The statistical basis? Enter "Y" for yes the order of allocation? Enter "Y" for yes implified cost finding method? Enter "Y" for the simplified cost finding method? Enter "Y" for yes implified cost finding method? Enter "Y" for yes implication? Enter "Y" for yes implified cost finding method? Enter "Y" for yes implified cost finding method? Enter "Y" for yes implication? Enter "Y" for yes implication? Enter "Y" for yes implified cost finding method? Enter "Y" for yes implication? Enter "Y" for yes implication	res, and home office costs (see instructions)  nes 141 through 143 the restriction number.  Contraction contraction is contracted are the costs for column 1. If column 1 is contracted in the cost reporting is ly filed cost reporting is ly filed cost reporting is contracted in the cost report of th	3.00 ame and address or's Number:  1.00 N N N Title V 3.00	1.00 Y 2.00 1.00 N N N Title XI)	141. 0 142. 0 143. 0 144. 0 145. 0 146. 0 147. 0 148. 0 149. 0
40.00 Are there any related chapter 10? Enter "Y" are claimed, enter in 1.00 If this facility is pa home office and enter 41.00 Name: 42.00 Street: 43.00 City:  44.00 Are provider based phy 45.00 If costs for renal ser inpatient services onl no, does the dialysis period? Enter "Y" for 46.00 Has the cost allocatic Enter "Y" for yes or "yes, enter the approva 47.00 Was there a change in 49.00 Was there a change in 49.00 Was there a change to Does this facility cor or charges? Enter "Y"	organization or home office costs as defor yes or "N" for no in column 1. If y column 2 the home office chain number.  art of a chain organization, enter on lithe home office contractor name and composition contractor's Name:  PO Box:  State:  ysicians' costs included in Worksheet Affice  rvices are claimed on Wkst. A, line 74,  ly? Enter "Y" for yes or "N" for no in claim 1, facility include Medicare utilization for yes or "N" for no in column 2.  on methodology changed from the previous "N" for no in column 1. (See CMS Pub. 15 and date (mm/dd/yyyy) in column 2.  the statistical basis? Enter "Y" for yet the order of allocation? Enter "Y" for	res, and home office costs (see instructions)  nes 141 through 143 the restriction number.  Contraction in the costs for column 1. If column 1 is for this cost reporting is given in the cost of the cost of the cost of the cost reporting is given in the cost of the cost	3.00 ame and address or's Number:  1.00  N  N  N  N  Itile V  3.00 tion of the lowe (See 42 CFR §413	1.00 Y 2.00 1.00 N N Title XI) 4.00 er of costs	141. 0 142. 0 143. 0 144. 0 145. 0 146. 0 147. 0 148. 0 149. 0
40.00 Are there any related chapter 10? Enter "Y" are claimed, enter in 1.00  If this facility is pa home office and enter  41.00 Name: 42.00 Street: 43.00 City:  44.00 Are provider based phy  45.00 If costs for renal ser inpatient services onl no, does the dialysis period? Enter "Y" for 46.00 Has the cost allocatic Enter "Y" for yes or "yes, enter the approva  47.00 Was there a change in 48.00 Was there a change in 49.00 Was there a change to 0.00 Was there a change to 0.00 Hospital	organization or home office costs as defor yes or "N" for no in column 1. If yellow the home office chain number.  2.00  art of a chain organization, enter on list the home office contractor name and contractor's Name:  PO Box:  State:  ysicians' costs included in Worksheet Afortives are claimed on Wkst. A, line 74, ly? Enter "Y" for yes or "N" for no in column 2.  on methodology changed from the previous "N" for no in column 1. (See CMS Pub. 15 all date (mm/dd/yyyy) in column 2.  the statistical basis? Enter "Y" for yes the order of allocation? Enter "Y" for the simplified cost finding method? Enter intain a provider that qualifies for an enter interval in the statistical provider that qualifies for an entertal interval in the statistical cost finding method? Enterval interval interv	res, and home office costs (see instructions)  nes 141 through 143 the restriction number.  Contraction contraction in the costs for column 1. If column 1 is for this cost reporting for this cost reporting for this cost report?  Soly filed cost report and for no.  Soly filed cost report no.  Soly filed cost report no.  Soly filed cost report no.  Soly filed cost report?  Soly filed cost report?  Soly filed cost report no.  Soly filed cost no.  Soly filed cost report no.  Soly filed cost no.  Soly filed cost no.  Soly filed cost n	3.00 ame and address or's Number:  1.00  N  N  N  N  Title V  3.00 tion of the lowe (See 42 CFR \$413) N	1.00 Y 2.00 1.00 N N Title XI) 4.00 er of costs	141. C 142. C 143. C 144. C 145. C 146. C 147. C 148. C 149. C
40.00 Are there any related chapter 10? Enter "Y" are claimed, enter in 1.00  If this facility is pa home office and enter  41.00 Name: 42.00 Street: 43.00 City:  44.00 Are provider based phy  45.00 If costs for renal ser inpatient services onl no, does the dialysis period? Enter "Y" for 46.00 Has the cost allocatic Enter "Y" for yes or "yes, enter the approva  47.00 Was there a change in 48.00 Was there a change in 49.00 Was there a change to  Does this facility cor or charges? Enter "Y"  55.00 Hospital  56.00 Subprovider - IPF	organization or home office costs as defor yes or "N" for no in column 1. If yellow the home office chain number.  2.00  art of a chain organization, enter on list the home office contractor name and contractor's Name:  PO Box:  State:  ysicians' costs included in Worksheet Afortives are claimed on Wkst. A, line 74, ly? Enter "Y" for yes or "N" for no in column 2.  on methodology changed from the previous "N" for no in column 1. (See CMS Pub. 15 all date (mm/dd/yyyy) in column 2.  the statistical basis? Enter "Y" for yes the order of allocation? Enter "Y" for the simplified cost finding method? Enter intain a provider that qualifies for an enter interval in the statistical provider that qualifies for an entertal interval in the statistical cost finding method? Enterval interval interv	res, and home office costs (see instructions)  nes 141 through 143 the restriction number.  Contraction in the costs for column 1. If column 1 is for this cost reporting is given in the cost of the cost of the cost of the cost reporting is given in the cost of the cost	3.00 ame and address or's Number:  1.00  N  N  N  N  Itile V  3.00 tion of the lowe (See 42 CFR §413	1.00 Y 2.00 1.00 N N Title XI) 4.00 er of costs	141. 0 142. 0 143. 0 144. 0 145. 0 146. 0 149. 0 (
40.00 Are there any related chapter 10? Enter "Y" are claimed, enter in 1.00  If this facility is pay home office and enter 41.00 Name: 42.00 Street: 43.00 City:  44.00 Are provider based phy  45.00 If costs for renal ser inpatient services onlino, does the dialysis period? Enter "Y" for 46.00 Has the cost allocation Enter "Y" for yes or "yes, enter the approvation of the provider a change in 49.00 Was there a change in 49.00 Was there a change to 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER	organization or home office costs as defor yes or "N" for no in column 1. If yellow the home office chain number.  2.00  art of a chain organization, enter on list the home office contractor name and contractor's Name:  PO Box:  State:  ysicians' costs included in Worksheet Afortives are claimed on Wkst. A, line 74, ly? Enter "Y" for yes or "N" for no in column 2.  on methodology changed from the previous "N" for no in column 1. (See CMS Pub. 15 all date (mm/dd/yyyy) in column 2.  the statistical basis? Enter "Y" for yes the order of allocation? Enter "Y" for the simplified cost finding method? Enter intain a provider that qualifies for an enter interval in the statistical provider that qualifies for an entertal interval in the statistical cost finding method? Enterval interval interv	res, and home office costs (see instructions)  nes 141 through 143 the restriction number.  Contraction in the cost of column 1. If column 1 is for this cost reporting is filled cost report in the cost of	3.00 ame and address or's Number:  1.00  N  N  N  N  Itle V  3.00 tion of the lowe (See 42 CFR §413) N N N	1.00 Y 2.00 1.00 N N N Title XI) 4.00 er of costs 1.13)	155. 0 156. 0 157. 0 158. 0
Are there any related chapter 10? Enter "Y" are claimed, enter in 1.00  If this facility is pa home office and enter  41.00 Name: 42.00 Street: 43.00 City:  144.00 Are provider based phy  145.00 If costs for renal ser inpatient services onl no, does the dialysis period? Enter "Y" for yes or "yes, enter the approva enter the approva enter the approva the services on the services of the services o	organization or home office costs as defor yes or "N" for no in column 1. If yellow the home office chain number.  2.00  art of a chain organization, enter on list the home office contractor name and contractor's Name:  PO Box:  State:  ysicians' costs included in Worksheet Afortives are claimed on Wkst. A, line 74, ly? Enter "Y" for yes or "N" for no in column 2.  on methodology changed from the previous "N" for no in column 1. (See CMS Pub. 15 all date (mm/dd/yyyy) in column 2.  the statistical basis? Enter "Y" for yes the order of allocation? Enter "Y" for the simplified cost finding method? Enter intain a provider that qualifies for an enter interval in the statistical provider that qualifies for an entertal interval in the statistical cost finding method? Enterval interval interv	are the costs for column 1 is for this cost reporting SI y filed cost reporting SI y filed cost report? Co.2, chapter 40, §4020) If the cost of the cost reporting SI y filed cost reporting SI	3.00 ame and address or's Number:  1.00  N  N  N  N  Title V  3.00 tion of the lowe (See 42 CFR §413) N	1.00 Y 2.00 1.00 N N N Title XI) 4.00 or of costs	141. 0 142. 0 143. 0 144. 0 145. 0 146. 0 149. 0 (

Health Financial Systems	MARGARET MAR	V COMMUNIT	V HOCDLEAL			1 - 1 :	eu of Form CMS	2552 10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  Provider CCN: 151329   Period: From 01/01/2015   To 12/31/2015								-2
							1.00	_
Multicampus							1.00	
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs?  Enter "Y" for yes or "N" for no.							N	165. 00
	Name		unty	State	Zip Co		FTE/Campus	
	0	1	. 00	2. 00	3.00	4.00	5. 00	
166.00 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)							0.0	00 166. 00
							1.00	-
Health Information Technology (HI	T) incentive in the A	merican Re	covery and	Rei nves	tment Ad	ct		
167.00 Is this provider a meaningful user							Y	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the	05 is "Y") and is a mo	eani ngful				nter the	548, 2	79168.00
168.01 If this provider is a CAH and is reception under §413.70(a)(6)(ii)						nardshi p		168. 01
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y")					, enter the	0.	00169.00
						Begi nni ng	Endi ng	
						1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR begins period respectively (mm/dd/yyyy)	peginning date and end	ding date	for the rep	orti ng		01/01/2015	12/31/2015	170. 00
							1.00	
171.00 ffline 167 is "Y", does this prov Medicare cost plans reported on Wh (see instructions)							N	171. 00

	Financial Systems MAR AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	RGARET MARY COMMUNITY STIONNAIRE F		L CCN: 151329	Period: From 01/01/2015 To 12/31/2015		2 epared:
					Y/N	Date	
	General Instruction: Enter Y for all YES resp	onees Enter N for a	II NO re	snonses Ent	1.00	2.00	
	mm/dd/yyyy format.	Jonses. Effect N For a	11 110 10	эропэсэ. Епт			
	COMPLETED BY ALL HOSPITALS						
1.00	Provider Organization and Operation  Has the provider changed ownership immediatel	y prior to the begin	ning of	the cost	N		1.00
	reporting period? If yes, enter the date of t			instructions			
				Y/N 1.00	2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in			N	2. 00	0.00	2. 00
	yes, enter in column 2 the date of termination voluntary or "I" for involuntary.	on and in column 3, "	V" for				
3.00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related	, chain home offices	, drug	N			3.00
	officers, medical staff, management personnel of directors through ownership, control, or frelationships? (see instructions)	, or members of the	board				
				Y/N	Туре	Date	
	Financial Data and Reports			1.00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prep	pared by a Certified	Public	Y	A		4.00
	Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	Audited, "C" for Comenter date available	pi I ed,				
5. 00	Are the cost report total expenses and total those on the filed financial statements? If y			N			5. 00
	those on the fired financial statements: If y	yes, subilifit reconciti	<u>ati 011.</u>		Y/N	Legal Oper.	
	Annual Educational Activities				1. 00	2. 00	
6. 00	Approved Educational Activities  Column 1: Are costs claimed for nursing scho	ool? Column 2: If ve	s. is th	ne provider i	s N		6.00
	the Legal operator of the program?	,					
7. 00 8. 00	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog	? If "Y" see instruct grams approved and/or	ions.	l during the	N N		7. 00 8. 00
0.00	cost reporting period? If yes, see instruction		renewed	r durring the	14		0.00
9. 00	Are costs claimed for Interns and Residents i program in the current cost report? If yes, s		te medic	al education	N		9. 00
10.00	Was an approved Intern and Resident GME progr		wed in t	he current	N		10.00
11. 00	cost reporting period? If yes, see instruction Are GME cost directly assigned to cost center		n on Ann	uray ta d	N		11. 00
11.00	Teaching Program on Worksheet A? If yes, see		п ап Арр	or oved	IN		11.00
						Y/N 1.00	
	Bad Debts					1.00	
	Is the provider seeking reimbursement for bac					Y	12.00
13. 00	If line 12 is yes, did the provider's bad deb period? If yes, submit copy.	ot collection policy	change d	luring this c	ost reporting	N	13.00
14. 00	If line 12 is yes, were patient deductibles a	and/or co-payments wa	ived? If	yes, see in:	structi ons.	N	14. 00
15. 00	Bed Complement Did total beds available change from the price	or cost roporting por	ind2 lf	vos soo ins	tructions	l N	15. 00
13.00	bru total beus avairable change from the price	cost reporting per	rou: II		art A	Part B	13.00
		Description 0		Y/N	Date	Y/N	
	PS&R Data	0		1.00	2. 00	3. 00	
16. 00	Was the cost report prepared using the PS&R			Y	02/03/2016	Y	16. 00
	Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see						
47.00	instructions)						47.00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns			N		N	17. 00
	2 and 4. (see instructions)						
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not			N		N	18.00
19. 00	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			N		N	19. 00
	made to PS&R Report data for corrections of other PS&R Report information? If yes, see						
	i nstructi ons.						

Health Financial Systems	MARGARET MARY COMMUNI	TY HOSPITA	AL		In Lieu of Form CMS-2552-10
HOODE TALL AND HOODE TALL HEALTH OADE D	THE PROPERTY OF THE PROPERTY O	T	00N 4E4000	T	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Worksheet S-2 Provider CCN: 151329 Peri od: From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 5/26/2016 11:49 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see 25.00 25.00 Ν instructions. 26.00 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 copy Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. Ν 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions Provi der-Based Physi ci ans Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based Υ 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 N 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position KYLF SMI TH 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel v. BLUE & CO., LLC 42.00 Enter the employer/company name of the cost report 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317-713-7957 KCSMI TH@BLUEANDCO. COM 43.00 report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 151329 Peri od: Worksheet S-2 From 01/01/2015 To 12/31/2015 Part II Date/Time Prepared: 5/26/2016 11:49 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 02/03/2016 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position SENIOR MANAGER 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00

report preparer in columns 1 and 2, respectively.

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Health Financial Systems MARGARET MARGA Provi der CCN: 151329

						То	12/31/2015	Date/Time Pre	
								5/26/2016 11: 	
								Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days		CAH Hours	Title V	
	Component	Li ne Number	INO.	or beus	Avai I abl e		CAIT HOULS	TI LIE V	
		1.00		2. 00	3. 00	_	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		18			104, 808. 00	0.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	30.00		10	0, 37	٩	104, 000. 00	0	1.00
	Hospice days) (see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)								2.00
3.00	HMO IPF Subprovider								3.00
4. 00	HMO IRF Subprovider								4.00
5.00	Hospital Adults & Peds. Swing Bed SNF							0	
6. 00	Hospital Adults & Peds. Swing Bed SNI							0	
7. 00	Total Adults and Peds. (exclude observation			10	6, 57		104 909 00	0	
7.00	beds) (see instructions)			18	0, 37	U	104, 808. 00	U	7.00
8. 00	INTENSIVE CARE UNIT	31. 00		7	2, 55	5	8, 640. 00	0	8.00
9. 00	CORONARY CARE UNIT	31.00		,	2,55	5	8, 040. 00	U	9.00
10.00									10.00
	BURN INTENSIVE CARE UNIT								
11.00	SURGICAL INTENSIVE CARE UNIT								11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	42.00						0	12.00
13.00	NURSERY	43. 00		٥٦		_	110 440 00	0	
14. 00	Total (see instructions)			25	9, 12	5	113, 448. 00	0	
15. 00	CAH visits							0	
16.00	SUBPROVIDER - I PF								16.00
17. 00	SUBPROVI DER - I RF								17.00
18.00	SUBPROVI DER								18.00
19. 00	SKILLED NURSING FACILITY								19. 00
20. 00	NURSING FACILITY								20.00
21. 00	OTHER LONG TERM CARE							_	21.00
22. 00	HOME HEALTH AGENCY	101. 00						0	
23. 00	AMBULATORY SURGICAL CENTER (D. P. )								23. 00
24. 00	HOSPI CE	116. 00		0	)	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00							24. 10
25. 00	CMHC - CMHC								25. 00
26. 00	RURAL HEALTH CLINIC	88. 00						0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER								26. 25
27. 00	Total (sum of lines 14-26)			25					27. 00
28. 00	Observation Bed Days							0	28. 00
29. 00	Ambul ance Tri ps								29. 00
30.00	Employee discount days (see instruction)								30.00
31. 00	Employee discount days - IRF								31.00
32.00	Labor & delivery days (see instructions)			0		0			32. 00
32. 01	Total ancillary labor & delivery room								32. 01
	outpatient days (see instructions)								
33.00	LTCH non-covered days								33. 00

Provi der CCN: 151329

					0 12/31/2013	5/26/2016 11:	
		I/P Days	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	33p3.13.112			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 914	139	4, 367			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	378	595				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	1 014	0	0			6. 00 7. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 914	139	4, 367			7.00
8. 00	INTENSIVE CARE UNIT	205	3	360			8.00
9. 00	CORONARY CARE UNIT	203	3	300			9.00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		0	928			13. 00
14. 00	Total (see instructions)	2, 119	142	5, 655		448. 75	
15. 00	CAH visits	ol	0	0			15. 00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	5, 380	812	9, 013	0.00	18. 53	
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE	0	0	0	0.00	12. 03	1
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC	4 077	4 050				25. 00
26. 00	RURAL HEALTH CLINIC	1, 277	1, 058	4, 109	0.00	5. 94	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER				0.00	405.05	26. 25
27. 00	Total (sum of lines 14-26)		11	942	0.00	485. 25	27. 00 28. 00
28. 00 29. 00	Observation Bed Days Ambulance Trips	0	11	942			28.00
30.00	Employee discount days (see instruction)	٩		0			30.00
31. 00	Employee discount days (see l'istruction)			0			31.00
32. 00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 00	Total ancillary labor & delivery room		٩	0			32. 00
JZ. UI	outpatient days (see instructions)			U			32.01
33. 00	LTCH non-covered days	o					33. 00
	1	-1	1		'	'	

Health Financial Systems MARGARET MARGA Provi der CCN: 151329 

					12/31/2013	5/26/2016 11:4	
	·	Full Time		Di sch	arges		
		Equi val ents			•		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	661	51	1, 661	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			119	257		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	661	51	1, 661	14. 00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

		RGARET MARY COM				eu of Form CMS-	
HOME H	IEALTH AGENCY STATISTICAL DATA		Provi der	CCN: 151329	Peri od: From 01/01/2015	Worksheet S-4	
			Componen	t CCN: 157143	To 12/31/2015	Date/Time Pre 5/26/2016 11:	
					Home Health	PPS	
					Agency I		
	T.	-			1.	00	
0. 00	County	Title V	Title XVIII	Title XIX	Other	Total	0. 00
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA  Home Health Aide Hours	0	(	nl	0 0	Ι ο	1.00
2. 00	Unduplicated Census Count (see instructions)	0. 00	307. 00	1			
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the numb	or of bours in	Staff	Contract	Total	
		your normal		Starr	Contract	Total	
	HOME HEALTH ACENOV NUMBER OF FURLOWERS	(	)	1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40.00	0.0	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		.5. 00	0.0	0. 00	0.00	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			6.2		1	1
7. 00	Nursing Supervisor			0.0			1
8.00	Physical Therapy Service			3.5			
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service	•		0.0			1
11. 00	Occupational Therapy Supervisor			0.0	0. 00	0.00	11. 00
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0.0			12. 00 13. 00
14. 00	Medical Social Service			0.2			14. 00
15. 00	Medical Social Service Supervisor			0.0			15. 00
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			1. 2			•
18. 00	Other (specify)			0. (			1
19. 00	HOME HEALTH AGENCY CBSA CODES  Enter in column 1 the number of CBSAs where				6	I	19. 00
17.00	you provided services during the cost						1 7. 00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			17140			20. 00
20.00	during this cost reporting period (line 20			17710			20.00
20. 01	contains the first code).			50031			20. 01
20. 01				50031			20. 01
20. 03				50035			20. 03
20. 04 20. 05				50042 99915			20. 04 20. 05
		Full Ep			555.01		
		Without Outliers	With Outliers	LUPA Epi sode	PEP Only Epi sodes	Total (cols. 1-4)	
	T	1.00	2.00	3.00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	2,744	28	3	94 49	2, 915	21. 00
22. 00	Skilled Nursing Visit Charges	459, 984	4, 704	1	20 8, 232	488, 040	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	1, 646 332, 492	7, 414	1	16 22 32 4, 444	1, 691 341, 582	1
25. 00	Occupational Therapy Visits	332, 492	7, 414	3, 2.	1 10		
26. 00	Occupational Therapy Visit Charges	71, 064	1, 512	2	16 2, 160		
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	32 6, 976	(	4:	2 12 36 2, 616	46 10, 028	
29. 00	Medical Social Service Visits	13	C		0 0	13	29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	4, 160 353	) 15	1	0 0	4, 160 368	•
32. 00	Home Health Aide Visit Charges	34, 947	1, 485	1	0 0	36, 432	1
33. 00	Total visits (sum of lines 21, 23, 25, 27,	5, 117	57	' 1 ·	13 93	5, 380	33. 00
34. 00	29, and 31) Other Charges	0	C		0 0	0	34. 00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	909, 623	9, 115	1			
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	333			43 6	382	36. 00
	outlier)						
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	74, 145	2, 204	19	0 32 6		37. 00 38. 00
55.00	1.5ta. Non Routi no mourear Suppry Gridinges	,4,145	2, 204	.1	J- <sub>1</sub> 0	1 ,0,537	1 55.00

	n Financial Systems MAR TAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	RGARET MARY COM LED HEALTH CEN		CCN: 151329	Peri od:	worksheet S-		
TATIS	STICAL DATA		Componer	nt CCN: 158511	From 01/01/2015 To 12/31/2015			
					Rural Health Clinic (RHC) I	Cost		
					1.	00		
	Clinic Address and Identification							
00	Street				112 N. BUCKEYE		1.	
				ity	State	ZIP Code		
			_	. 00	2. 00	3. 00		
.00	City, State, ZIP Code, County		OSG00D		I N	47037	2.	
						1.00		
00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for u	rban				0 3.	
	1				Grant Award	Date		
					1. 00	2. 00		
	Source of Federal Funds					<u> </u>		
00	Community Health Center (Section 330(d), PHS	Act)			0		4.	
00	Migrant Health Center (Section 329(d), PHS Ac	et)			0		5.	
00	Health Services for the Homeless (Section 340				0		6.	
. 00	Appal achi an Regi onal Commi ssi on				0		7.	
00	Look-Al i kes				0		8.	
00	OTHER (SPECIFY)				0		9	
					1. 00	2. 00		
0. 00	Does this facility operate as other than an F	HC or FQHC? Er	nter "Y" for y	es or "N" for	N		0 10.	
	no in column 1. If yes, indicate number of ot							
	subscripts of line 11 the type of other opera							
			nday		londay	Tuesday		
		from	to	from	to	from		
		1. 00	2. 00	3.00	4. 00	5. 00		
1 00	Facility hours of operations (1)		T	00.00	17, 20	00.00	- 11	
1.00	Clinic			08: 00	16: 30	08: 00	11.	
					1. 00	2.00		
2. 00	Have you received an approval for an exception	n to the produ	uctivity stand	lard?	N N	2.00	12.	
3. 00	1				N		0 13.	
	30. 8? Enter "Y" for yes or "N" for no in colu						1	
	number of providers included in this report.							
	numbers below.		·					
				Prov	ider name	CCN number		
					1. 00	2. 00		
4. 00	Provider name, CCN number	V/ /N/		\ \ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	N/LV/	<del>-</del>	14.	
		Y/N	V	XVIII	XIX	Total Visits		
		1. 00	2.00	3.00	4. 00	5. 00	4.5	
							15.	
5. 00	GME cost? Enter "Y" for yes or "N" for no in							
5. 00								
5. 00	column 1. If yes, enter in columns 2, 3 and							
5. 00	4 the number of program visits performed by							
5. 00	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and							
5. 00	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the							
5. 00	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.							
5. 00	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the		Co	unty				
5. 00	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.			ounty				
	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			ounty 00			2	
	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Tuesday	4	. 00	Thur	Sdav	2.	
5. 00	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Tuesday to	4 Wedi	nesday		sday to	2.	
	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	to	4 Wedi	nesday to	from	to	2.	
	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		4 Wedi	nesday			2.	

Health Financial Systems MA	RGARET MARY	COMMUNI	TY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	FIED HEALTH C	ENTER	Provi der	CCN: 151329	Peri od:	Worksheet S-8	
STATISTICAL DATA			Component	t CCN: 158511	From 01/01/2015 To 12/31/2015	Date/Time Pre 5/26/2016 11:	
					Rural Health	Cost	
					Clinic (RHC) I		
	F	ri day		Sa	turday		
	from		to	from	to		
	11. 00		12.00	13. 00	14. 00		
Facility hours of operations (1)							
11. 00 Clinic	08: 00	12: 00	)				11. 00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL IDENTIFICATION DATA	Provi der CCN: 151329 Component CCN: 151551	Peri od: From 01/01/2015 To 12/31/2015 Worksheet S-9 Parts I & II Date/Time Prepared: 5/26/2016 11: 49 am
-		Hospi ce I

						Hospi ce I		
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	10, 943	84	5, 507	0	797	11, 824	2. 00
3.00	Inpatient Respite Care	0	0	0	0	0	0	3. 00
4.00	General Inpatient Care	6	0	0	0	2	8	4.00
5.00	Total Hospice Days	10, 949	84	5, 507	0	799	11, 832	5. 00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	116	7	87	0	107	230	6.00
	Hospi ce Care							ĺ
7.00	Total Number of Unduplicated	0. 00		0.00				7. 00
	Continuous Care Hours Billable							l
	to Medicare							l
8.00	Average Length of Stay (line	94. 39	12. 00	63. 30	0.00	7. 47	51. 44	8. 00
	5/line 6)							1
9.00	Unduplicated Census Count	190	7	85	0	22	219	9. 00

HOSPI 1	FINANCIAL Systems MARGARET MARY COMMUNITY FAL UNCOMPENSATED AND INDIGENT CARE DATA P		CN: 151329	Peri od:	u of Form CMS-2 Worksheet S-10			
11031 1	THE GROOM ENGRIED AND THUTGENT GARE DATA	TOVI GCT C	ON. 131327	From 01/01/2015				
				To 12/31/2015	Date/Time Pre			
					5/26/2016 11:	49 am		
					1. 00			
	Uncompensated and indigent care cost computation					1		
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	ed by line	e 202 column	8)	0. 373224	1.0		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid				2, 103, 027	2.0		
3.00	Did you receive DSH or supplemental payments from Medicaid?			0	N	3.0		
4. 00 5. 00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Mo		rom wedicald	?	0	4. 0 5. 0		
5. 00 6. 00	Medicaid charges 7,809,678							
7. 00	Medicaid cost (line 1 times line 6)				2, 914, 759			
7. 00 3. 00	Difference between net revenue and costs for Medicaid program (lin	ne 7 minu	e sum of lin	os 2 and 5: if	811, 732			
3. 00	<pre>&lt; zero then enter zero)</pre>	11C 7 III 11G	3 3411 01 111	C3 Z dild 3, 11	011, 732	0.0		
	State Children's Health Insurance Program (SCHIP) (see instruction	ns for eac	ch line)			İ		
9. 00	Net revenue from stand-alone SCHIP				0	9.0		
10. 00	Stand-allone SCHIP charges				0	10.0		
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0	11.0		
12. 00	Difference between net revenue and costs for stand-alone SCHIP (li	ine 11 mi	nus line 9;	if < zero then	0	12.0		
	enter zero)							
	Other state or local government indigent care program (see instruc				_			
13.00	Net revenue from state or local indigent care program (Not include			,	0			
14. 00	Charges for patients covered under state or local indigent care pr	rogram (N	ot included	in lines 6 or	0	14. C		
15. 00	10)   State or local indigent care program cost (line 1 times line 14)				0	15. 0		
16. 00		ent care	orogram (Lin	a 15 minus lina	0			
10.00	13; if < zero then enter zero)	ent care i	program (TTT	e is illinus iine	0	10.0		
	Uncompensated care (see instructions for each line)					1		
17. 00	Private grants, donations, or endowment income restricted to fundi	ing chari	ty care		0	17. 0		
18. 00	Government grants, appropriations or transfers for support of hosp	pital ope	rati ons		0	18. 0		
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local i	indigent (	care program	s (sum of lines	811, 732	19. 0		
	8, 12 and 16)							
			Uni nsured	Insured	Total (col. 1			
		-	patients 1.00	pati ents 2, 00	+ col . 2) 3.00			
20. 00	Total initial obligation of patients approved for charity care (a	t full	2, 311, 41		2, 311, 419	20. 0		
20. 00	charges excluding non-reimbursable cost centers) for the entire fa		2, 311, 41	9	2, 311, 417	20.0		
21. 00	Cost of initial obligation of patients approved for charity care		862, 67	7 0	862, 677	21.0		
	times line 20)	`	,		,			
22. 00	Partial payment by patients approved for charity care	İ		0 0	0	22. 0		
23. 00	Cost of charity care (line 21 minus line 22)		862, 67	7 0	862, 677	23. 0		
24. 00	Doos the amount in Line 20 column 2 include charges for national	ave bayon	d a Langth a	f ctov limit	1. 00 N	24.0		
24. 00	Does the amount in line 20 column 2 include charges for patient daimposed on patients covered by Medicaid or other indigent care pro		u a rength d	r Stay IImit	IN	24. 0		
25. 00			aram's Lenat	h of stav limit	0	25. 0		
26. 00			g. am 3 1 51191	or stay rimit	7, 083, 404			
27. 00					7, 003, 404	1		
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line		line 27)		6, 381, 365			
	,		,	28)	2, 381, 679	1		
29. 00								
29. 00 30. 00					3, 244, 356	30.0		

COST CENTER   COST CENTERS   COST	Health Financial Systems MAF	RGARET MARY COMMU	JNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
To   12/31/2015   Detarting Propared   Cost Center Description   Salaries   Other   Total (col. 2)   Description   Cost Center Description   Cost	RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der			Worksheet A	
ENERAL SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00							
STRUBBL_SERVICE COST CHIFES   1.00   2.00   3.00   4.00   5.00   1.00   1.01	Cost Center Description	Sal ari es	Other				
GINERAL SERVICE COST CENTERS				+ col . 2)	ons (See A-6)		
SINEMAL SERVICE COST CENTERS							
1.00		1.00	2. 00	3.00	4. 00		
1.01   0.010   INEW CAR PRIL COSTS-OFFSITE BLIGG   5.99, 837   4.078, 222   -158, 573   3.99, 647   2.00   2.01   0.000   0.	GENERAL SERVICE COST CENTERS						
2.00   00200   INT VAR PEL COSTS-MYBLE FOULP 0 F5ST   4,078, 222   -158, 573   3,919, 649   2.00   00200   INT VAR PEL COSTS-MYBLE FOULP 0 F5ST   177, 343   11,934, 377   12,111,720   0   12,111,720   4.00   0.							
2.01   00201   NEW CAP REL COSTS-MMELE EQUIP OFFSIT							
0.000   0.0000   DIPLOYER BENEFITS DEPARTMENT   177, 343   11, 934, 377   12, 111, 720   0   12, 111, 720   4.0   7.0   0.000   0.0000   DIPLOYER BENEFITS DEPARTMENT   1, 130, 678   7.0   0.00700   OPERATI ON OF PLANT   1, 300, 598   7.0   0.00700   OPERATI ON OF PLANT   1, 300, 598   7.0   0.00700   OPERATI ON OF PLANT   1, 300, 598   7.0   0.00700   OPERATI ON OF PLANT   1, 300, 598   7.0   0.00700   OPERATI ON OF PLANT   1, 500, 598   7.0   0.00700   OPERATI ON OF PLANT   1, 500, 598   7.0   0.00700   OPERATI ON OF PLANT   1, 500, 598   7.0   0.00700   OPERATI ON OF PLANT   1, 500, 598   7.0   0.00700   OPERATI ON OF PLANT   1, 500, 598   7.0   0.00700   OPERATI ON OF PLANT   1, 500, 598   7.0   0.00700   OPERATI ON OF PLANT   1, 500, 598   7.0   0.00700   OPERATI ON OF PLANT   1, 500, 598   7.0   0.00700   OPERATION OF PLANT   1, 500, 590   0.00700			4, 078, 222				
5.00   00500   ADMINISTRATIVE & GENERAL   4.883, 185   6.241, 050   11, 124, 235   222, 847   11, 347, 082   5.00		177 343	11 934 377			-	
7.00         007000 DEPEATION OF PLANT OFFSITE         0         1,300,769         1,000         498,703         0         498,703         7,02         0         498,703         7,02         0         498,703         0         498,703         7,02         0         0         0,000         0							
7. 02         007020   DERRATION OF PLANT - HOSPITAL & OFFS         489, 625         9, 078         498, 703         −2, 710         132, 814         8.00           9. 00         00000   HOUSEKEEPING         640, 496         259, 637         900, 133         0         900. 133         0         900. 133         9, 00           11. 00         00000   HOUSEKEEPING         640, 496         259, 637         900, 30         -1, 133, 448         17, 2872         10, 00           11. 00         01100   CAFETERIA         0         0         0         1, 098, 301         1, 098, 301         11, 00           14. 00         01400   CENTRAL SERVICES & SUPPLY         0         425, 932         425, 932         425, 932         425, 932         -1, 133, 448         17, 218         17, 00, 602         11, 00           16. 00         01600   PHARIMACY         866, 420         2, 335, 499         2, 911, 919         -1, 227         2, 00, 602         1, 60           16. 00         1000   MEDICAL RECORDS & LIBRARY         888, 657         154, 289         1, 042, 946         -1, 709         1, 041, 237         16, 00         300, 70         30, 00         300, 00         300, 00         300, 00         300, 00         300, 00         300, 00         300, 00         300, 00         <							
8.00   00000   LANIDRY & LINEN SERVICE   82, 256   63, 268   145, 524   -12, 710   132, 814   8.00   000   00000   MOUSEKEEPIN   785, 023   521, 297   1, 306, 320   1, 133, 448   172, 872   10.00   1.000   11000   0   1 ETRAY   785, 023   521, 297   1, 306, 320   1, 133, 448   172, 872   10.00   130   0   10000   0   1 ETRAY   -2   712, 845   13.00   130   0   0   10000   0   1, 098, 301   1, 098, 301   11.00   11000   11000   0   1   1000   10000   0	7.01   00701   OPERATION OF PLANT -OFFSITE	0	107, 129	107, 129	0	107, 129	7. 01
9,00   000900   00USKEKEPING							
10.00   01000   015ARY   785,023   551,297   1, 306,320   -1, 133,448   172,872   10.00   10.00   1100   CAFETERIA   0   0   1,098,301   11.098,301   11.00   13.00   01300   NURSING ADMINISTRATION   698,209   14,638   712,845   73.00   15.00   01500   PHARMACY   566,420   2,335,499   2,901,919   -1,227   2,900,692   15.00   15.00   01500   PHARMACY   888,657   154,299   1,042,946   -1,709   1,041,237   10.00   10.00   10.00   MEDICAL RECORDS & LI BRARY   888,657   154,299   1,042,946   -1,207   2,900,692   15.00   10.0							
11.00   01100   CAFETERIA   0   0   0   1,098,301   1,098,301   11.00   13.0							
13. 00   01300   OLISBING ADMINISTRATION   698, 209   14, 638   712, 847   .2   712, 845   31. 00     14. 00   01400   CENTRAL SERVICES & SUPPLY   .0   .425, 932   .425, 932   .425, 932   .10   .10     15. 00   01500   PERMANCY   .888, 657   .154, 289   .2, 901, 919   .1, 227   .2, 900, 692   .15, 00     16. 00   1600   OLIDICAL RECORDS & LI BRARY   .888, 657   .154, 289   .2, 901, 919   .1, 227   .2, 900, 692   .15, 00     16. 00   1000   MEDI CAL RECORDS & LI BRARY   .888, 657   .154, 289   .1, 743, 853   .434, 104   .2, 177, 957   .30, 00     17. 00   03100   ADULTS & PEDI ATRIC S   .3, 1598, 604   .145, 249   .1, 743, 853   .434, 104   .2, 177, 957   .30, 00     18. 00   03000   ADULTS & PEDI ATRIC S   .3, 174, 426   .30, 278   .377, 852   .8, 909   .369, 762   .31, 00     18. 00   03000   ADULTS & PEDI ATRIC S   .3, 174, 426   .30, 278   .377, 852   .8, 909   .369, 762   .31, 00     18. 00   03000   ADULTS & PEDI ATRIC S   .3, 174, 426   .30, 248   .566, 189   .666, 189   .669, 765   .30, 248   .669, 762   .31, 00     18. 00   03000   OLIS PEDI ATRIC S   .3, 174, 436   .4, 500, 616   .2, 873, 669   .6, 69, 765   .30, 00     18. 00   03000   OLIS PEDI ATRIC S   .3, 174, 436   .4, 500, 616   .2, 873, 669   .6, 69, 765   .30, 00     18. 00   03000   OLIS PEDI ATRIC S   .3, 174, 436   .4, 500, 616   .2, 873, 669   .6, 294, 75   .00     18. 00   03000   OLIS PEDI ATRIC S   .3, 174, 436   .4, 500, 616   .2, 873, 669   .6, 294, 75   .00     18. 00   03000   OLIS PEDI ATRIC S   .3, 174, 436   .4, 500, 616   .2, 873, 669   .4, 500, 765   .4, 500   .00     18. 00   03000   OLIS PEDI ATRIC S   .3, 174, 436   .4, 500, 616   .2, 873, 669   .4, 500, 765   .4, 500		785, 023	521, 297 0	1, 300, 320			
14. 00		698 209	14 638	712 847			
15. 00   01500   PHARMACY   8.86, 627   2, 335, 499   2, 901, 919   1, 227   2, 900, 692   15. 00   10. 00		1					
IMPATIENT ROUTINE SERVICE COST CENTERS   1,598,604   145,249   1,743,853   434,104   2,177,957   30,00   30,00   0300   ADULTS & PEDIATRIC CS   1,598,604   145,249   1,743,853   434,104   2,177,957   30,00   31,00   03100   INTERNI VE CARE UNIT   362,382   15,470   377,852   -8,090   369,762   31,00   343,00   348,00   369,762   31,00   369,70   369,	15. 00 01500 PHARMACY	566, 420				2, 900, 692	15. 00
30.0   03000  ADULTS & PEDIATRICS   1,598,604   145,249   1,743,853   434,104   2,177,973   30.0     43.00   04300   NURSERY   0   103,248   103,248   566,187   669,435   43.0     43.00   04300   NURSERY   0   103,248   103,248   566,187   669,435   43.0     50.00   05000   DERATING ROOM   1,329,180   3,171,436   4,500,616   -2,873,669   1,626,947   50.0     50.00   05000   DERATING ROOM   1,066,775   213,263   1,280,038   -1,172,989   107,049   52.0     50.00   05000   DERATING ROOM   1,066,775   213,263   1,280,038   -1,172,989   107,049   52.0     60.00   05000   RICHORY   1,229,700   1,980,097   3,209,797   -40,527   3,169,270   60.00     60.01   05001   BLODO LABORATORY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		888, 657	154, 289	1, 042, 946	-1, 709	1, 041, 237	16. 00
31.00   03100   INTENSIVE CARE UNIT   362, 382   15, 470   377, 852   -8, 090   369, 762   31.00							
A32.00							
ANCILLARY SERVICE COST CENTERS							
50.00   050000   050000   050000   050000   050000   050000   0500000   05000000   0500000000		<u> </u>	103, 246	103, 240	500, 167	007, 433	43.00
1,066,775   213,263   1,280,038   -1,172,989   107,049   52.00		1, 329, 180	3, 171, 436	4, 500, 616	-2, 873, 669	1, 626, 947	50. 00
60. 00   06000   LABORATORY   1, 229, 700   1, 980, 097   3, 209, 797   -40, 527   3, 169, 270   60. 00   06001   BLOOD LABORATORY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52.00 05200 DELIVERY ROOM & LABOR ROOM						52. 00
60.01   06001   BLOOD LABORATORY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		2, 650, 194	5, 607, 665	8, 257, 859	-188, 912		54.00
65. 00   06500   RESPIRATORY THERAPY   439,596   98,471   538,067   -12,182   525,885   65.00   66. 00   06600   O6500   CHARGED TO PATIENT   333,664   21,139   354,803   -10,915   343,886   67.00   68. 00   06800   SPECH PATHOLOGY   187,220   1,485   188,705   -10,552   178,153   68.00   69. 00   06900   ELECTROCARDIOLOGY   532,650   336,324   868,974   -14,418   854,556   69.00   69. 00   06900   ELECTROCARDIOLOGY   532,650   336,324   868,974   -14,418   854,556   69.00   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   72. 00   07200   IMPL   DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   74. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   75. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   75. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   75. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   75. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   75. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   75. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   75. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   75. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   0   0   75. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   0   0   75. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   0   0   76. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   0   0   77. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   0   0   77. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   0   0   77. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   0   0   77. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   0   0   77. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   0   77. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   0   77. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   0   77. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   77. 00   07500   DRUGS CHARGED TO PATIENTS   0   0   77. 00   07500		1, 229, 700		1			
66. 00   06600   PHYSICAL THERAPY   967, 266   78, 354   1, 045, 620   -14, 907   1, 030, 713   66. 00   67. 00   06700   0cCUPATI ONAL THERAPY   333, 664   21, 139   354, 803   -10, 915   343, 888   67. 00   68. 00   06800   SPEECH PATHOLOGY   187, 220   1, 485   188, 705   -10, 552   178, 153   68. 00   06900   ELECTROCARDI OLOGY   532, 650   336, 324   868, 974   -14, 418   854, 556   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0 0 0 0 0 2, 619, 735   2, 619, 735   71. 00   73. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0 0 0 0 0   1, 650, 682   1, 650, 682   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0 0 0 0 0   0   0   0   0   0   0		420 504	-		-		
67.00   06700   OCCUPATIONAL THERAPY   333, 664   21, 139   354, 803   -10, 915   343, 888   67. 00   68.00   O6800   SPEECH PATHOLOGY   187, 220   1, 485   188, 705   -10, 552   178, 153   68. 00   69.00   O6900   ELECTROCARDI OLOGY   532, 650   336, 324   868, 974   -14, 418   845, 556   69. 00   71. 00   O7100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   2, 619, 735   2, 619, 735   71. 00   72. 00   O7200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   73. 00   O7300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   74. 00   O7300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   75. 00   O7300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   76. 00   O9000   CLIN C   1, 428, 581   294, 160   1, 722, 741   -197, 794   1, 524, 947   90. 00   79. 01   O9001   WOUND CLINC   225, 595   159, 619   385, 214   -150, 824   234, 390   90. 01   79. 00   O9000   EMERGENCY   1, 554, 112   2, 221, 805   3, 775, 917   -102, 501   3, 673, 416   91. 00   79. 00   O9000   DIME REALTH AGENCY   1, 262, 287   183, 596   1, 445, 883   0   1, 445, 883   101. 00   718. 00   O11600   HORE   HEALTH AGENCY   1, 262, 287   183, 596   1, 445, 883   0   1, 445, 883   101. 00   719. 00   O11600   HORE   HEALTH AGENCY   1, 262, 287   183, 596   1, 445, 883   0   986, 289   0   986, 289   116. 00   719. 00   O19200   PHYSICAL SUM OF LINES 1-117)   25, 516, 917   46, 190, 803   71, 707, 720   218, 484   71, 926, 204   118. 00   719. 00   O19200   PHYSICAL SUM OF LINES 1-117)   25, 516, 917   46, 190, 803   71, 707, 720   218, 484   71, 926, 204   118. 00   192. 01   192.						-	
68.00   06800   SPEECH PATHOLOGY   187, 220   1, 485   188, 705   -10,552   178, 153   68.00   69.00   06900   ELECTROCARDI OLOGY   532, 650   336, 324   868, 974   -14, 418   854, 556   69.00   710.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0 0 0   0   2, 619, 735   71.00   72.00   07200   IMPL DEV. CHARGED TO PATI ENT   0 0 0   0   0   1, 650, 682   1, 650, 682   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0017PATI ENT SERVI CE COST CENTERS  88.00   08800   RURAL HEALTH CLINIC   503, 716   76, 240   579, 956   0   579, 956   88.00   90.00   09000   CLINIC   1, 428, 581   294, 160   1, 722, 741   -197, 794   1, 524, 947   90.00   90.01   09001   WOUND CLINC   225, 595   159, 619   385, 214   -150, 824   234, 390   90.01   91.00   09100   EMERGENCY   1, 554, 112   2, 221, 805   3, 775, 917   -102, 501   3, 673, 416   91.00   92.00   09SERVATI ON BEDS (NON-DISTINCT PART)   07HER REIMBURSABLE COST CENTERS  113.00   11300   INTEREST EXPENSE   0   0   0   9.0   113.00   116.00   11300   INTEREST EXPENSE   0   0   9.0   9.0   9.0   118.00   11300   INTEREST EXPENSE   0   0   0   9.0   9.0   119.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   7, 533, 468   1, 555, 837   9, 089, 305   0   9, 089, 305   192.00   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   7, 533, 468   1, 555, 837   9, 089, 305   0   9, 089, 305   192.00   194.00   07950   COMMUNITY RELATIONS   194, 843   499, 102   693, 945   -228, 078   465, 850   194.00   194.01   07951   COMMUNITY RELATIONS   194, 843   499, 102   693, 945   -228, 078   465, 850   194.00   194.01   07952   COHMUNITY RELATIONS   194, 843   499, 102   693, 945   -228, 078   465, 850   194.00   194.02   07952   COHMUNITY RELATIONS   194, 843   499, 102   693, 945   -228, 078   465, 850   194.00   194.01   07952   COHMUNITY RELATIONS   194, 843   499, 102   693, 945   -228, 078   465, 850   194.00   194.02   07952   COHMUNITY RELATIONS   194, 843   499, 102   693, 945   -228, 078   465, 850   194.00   194.03   07952   COHMUNITY RELATION							
69. 00   06900   ELECTROCARDI OLOGY   532,650   336,324   868,974   -14,418   854,556   69. 00   710. 00   710. 00   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   2,619,735   2,619,735   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATI ENT   0   0   0   0   0   1,650,682   1,650,682   72. 00   0   0   0   0   0   0   0   0   0							
72. 00 07200   IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 1,650,682 1,650,682 72. 00 73. 00 07300   DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 00 0 0 73. 00 00 0 0 0 73. 00 00 0 0 0 0 73. 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	2, 619, 735	2, 619, 735	71. 00
88. 00   08800   RURAL HEALTH CLINIC   503,716   76,240   579,956   0   579,956   88. 00		1	0	·			
88. 00   08800   RURAL HEALTH CLINIC   503,716   76,240   579,956   0   579,956   88. 00   90. 00   90000   CLINIC   1,428,581   294,160   1,722,741   -197,794   1,524,947   90. 00   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 00	73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
90. 00		503 716	76 240	570 054	J	570 056	88 00
90. 01						-	
91. 00							
OTHER REIMBURSABLE COST CENTERS   1, 262, 287   183, 596   1, 445, 883   0   1, 445, 883   101. 00	91. 00 09100 EMERGENCY	1, 554, 112					91. 00
101. 00   10100   HOME   HEALTH   AGENCY   1, 262, 287   183, 596   1, 445, 883   0   1, 445, 883   101. 00   SPECI   AL PURPOSE COST CENTERS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							92. 00
SPECIAL PURPOSE COST CENTERS							
113. 00		1, 262, 287	183, 596	1, 445, 883	8  0	1, 445, 883	101. 00
116. 00			0			0	113 00
118. 00   SUBTOTALS (SUM OF LINES 1-117)   25, 516, 917   46, 190, 803   71, 707, 720   218, 484   71, 926, 204   118. 00		634 181	352 108	986 289			
NONRE   MBURSABLE COST CENTERS   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   7, 533, 468   1, 555, 837   9, 089, 305   0   9, 089, 305   192. 00     192. 01   19201   PRI VATE DUTY   0   0   0   0   0   0     192. 01   194. 00   07950   COMMUNI TY RELATI ONS   194, 843   499, 102   693, 945   -228, 078   465, 867   194. 00     194. 01   07951   COMMUNI TY BENEFI TS   336, 424   115, 426   451, 850   0   451, 850   194. 01     194. 02   07952   OTHER NONREI MBURSABLE COST CENTERS   0   0   0   9, 594   9, 594   194. 02     194. 03   07953   EMS   13, 361   43, 130   56, 491   0   56, 491   194. 03							
192. 01 19201 PRI VATE DUTY  0 0 0 0 0 0 0 192. 01 194. 00 194. 00 07950 COMMUNI TY RELATI ONS 194. 01 07951 COMMUNI TY BENEFI TS 136, 424 115, 426 451, 850 0 451, 850 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 13, 361 43, 130 56, 491 0 56, 491 194. 03							
194. 00 07950 COMMUNITY RELATIONS 194. 843 499, 102 693, 945 -228, 078 465, 867 194. 00 194. 01 07951 COMMUNITY BENEFITS 336, 424 115, 426 451, 850 0 451, 850 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 9, 594 9, 594 194. 02 194. 03 07953 EMS 13, 361 43, 130 56, 491 0 56, 491 194. 03		7, 533, 468	1, 555, 837	9, 089, 305	0		
194. 01 07951 COMMUNITY BENEFITS 336, 424 115, 426 451, 850 0 451, 850 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 9, 594 9, 594 194. 02 194. 03 07953 EMS 13, 361 43, 130 56, 491 0 56, 491 194. 03			0	1	-		
194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 9, 594 9, 594 194. 02 194. 03 07953 EMS 13, 361 43, 130 56, 491 0 56, 491 194. 03							
194. 03 07953 EMS 13, 361 43, 130 56, 491 0 56, 491 194. 03		336, 424	115, 426			451, 850	194.07
		13 361	43 130				
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 Health Financial
 Systems
 MARGARET MARY

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151329 | Period: From 01/01/201

Peri od: Worksheet A From 01/01/2015 Date/Ti me Prepared: 5/26/2016 11: 49 am

				5/26/2016 11	<u>:49 am</u>
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
	DENERAL OFFICE OF SERVICE	6.00	7. 00		
1 00	GENERAL SERVICE COST CENTERS	0.47,000	2 127 070		1 1 00
1. 00 1. 01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-OFFSITE BLDG	-947, 083	2, 127, 979 610, 827		1. 00 1. 01
2.00	00200 NEW CAP REL COSTS-MYBLE EQUIP	-302, 918	3, 616, 731		2. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	-302, 418	158, 573		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	12, 111, 720		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-1, 659, 517	9, 687, 565		5. 00
7.00	00700 OPERATION OF PLANT	-5, 620	1, 294, 978		7. 00
7. 01	00701 OPERATION OF PLANT -OFFSITE	0,020	107, 129		7. 01
7. 02	00702 OPERATION OF PLANT - HOSPITAL & OFFS	0	498, 703		7. 02
8.00	00800 LAUNDRY & LINEN SERVICE	-555	132, 259		8. 00
9.00	00900 HOUSEKEEPI NG	0	900, 133		9. 00
10.00	01000 DI ETARY	-21, 273	151, 599		10.00
11.00	01100 CAFETERI A	-303, 217	795, 084		11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	712, 845		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	107		14. 00
15.00	01500 PHARMACY	0	2, 900, 692		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-5, 361	1, 035, 876		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	-146, 811	2, 031, 146		30. 00
31.00	03100   NTENSI VE CARE UNIT	0	369, 762		31.00
43.00	04300 NURSERY	-102, 337	567, 098		43. 00
	ANCI LLARY SERVI CE COST CENTERS				
50.00	05000 OPERATING ROOM	0	1, 626, 947		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	107, 049		52. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	-822, 324	7, 246, 623		54.00
60.00	06000 LABORATORY	0	3, 169, 270		60.00
60. 01 65. 00	06001 BL00D LABORATORY 06500 RESPI RATORY THERAPY	0	0 525, 885		60. 01 65. 00
66.00	06600 PHYSI CAL THERAPY	-14, 699	1, 016, 014		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	-14, 699	343, 888		67. 00
68. 00	06800 SPEECH PATHOLOGY		178, 153		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-179, 245	675, 311		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	177, 243	2, 619, 735		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	l o	1, 650, 682		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
	OUTPATIENT SERVICE COST CENTERS	-	-		1
88. 00	08800 RURAL HEALTH CLINIC	0	579, 956		88. 00
90.00	09000 CLI NI C	-462, 399	1, 062, 548		90.00
90. 01	09001 WOUND CLINC	0	234, 390		90. 01
91.00	09100 EMERGENCY	-1, 687, 161	1, 986, 255		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
	OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY	0	1, 445, 883		101. 00
	SPECIAL PURPOSE COST CENTERS				
	11300 INTEREST EXPENSE	0	0		113. 00
	11600 H0SPI CE	0	986, 289		116. 00
118.00		-6, 660, 520	65, 265, 684		118. 00
	NONREI MBURSABLE COST CENTERS	,			4
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	9, 089, 305		192. 00
	19201 PRI VATE DUTY	0	0		192. 01
	07950 COMMUNITY RELATIONS	0	465, 867		194. 00
	07951 COMMUNITY BENEFITS	0	451, 850		194. 01
	07952 OTHER NONREIMBURSABLE COST CENTERS	0	9, 594		194. 02
	3 07953  EMS	0	56, 491		194. 03
200.00	TOTAL (SUM OF LINES 118-199)	-6, 660, 520	75, 338, 791		200. 00

| Peri od: | Worksheet A-6 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 151329

					5/26/201	6 11: 49 am
		Increases		·		
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	A - CAFETERIA					
1.00	CAFETERI A	11.00	66 <u>0, 0</u> 18	43 <u>8, 2</u> 83		1. 00
	0		660, 018	438, 283		
	B - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	468, 255	58, 455		1. 00
2.00	NURSERY	43.00	50 <u>3, 3</u> 51	6 <u>2, 8</u> 36		2. 00
	0		971, 606	121, 291		
	C - COMMUNITY RELATIONS					
1. 00	ADMINISTRATIVE & GENERAL		6 <u>8, 1</u> 95	15 <u>9, 8</u> 83		1. 00
	0		68, 195	159, 883		
	D - OFFSITE BUILDING DEPR REC					
1.00	NEW CAP REL COSTS-OFFSITE	1. 01	0	10, 990		1. 00
	BLDG					
2.00	NEW CAP REL COSTS-MVBLE	2. 01	0	158, 573		2. 00
	EQUIP OFFSIT		+			
	O E LANDI ANTARI E CURRILLEG REGI	100	0	169, 563		
1 00	E - IMPLANTABLE SUPPLIES RECL		ما	1 (50 (00		1.00
1. 00	IMPL. DEV. CHARGED TO	72.00	0	1, 650, 682		1. 00
	PAT I ENT	+		1, 650, 682		
	F - SPEECH RECLASS		U	1, 000, 082		
1.00	OTHER NONREI MBURSABLE COST	194. 02	9, 567	27		1.00
1.00	CENTERS	174.02	9, 507	27		1.00
	<u> </u>	+	9, 567	<sub>27</sub>		
	I - CENTRAL SUPPLY RECLASS		7,007	27		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	2, 619, 735		1.00
	PATIENTS			_, _, , , , , ,		
2.00		0.00	o	0		2. 00
3.00		0.00	o	0		3. 00
4.00		0.00	o	0		4. 00
5.00		0.00	o	0		5. 00
6.00		0.00	o	0		6. 00
7.00		0.00	o	0		7. 00
8.00		0.00	o	0		8. 00
9.00		0.00	o	0		9. 00
10.00		0.00	O	0		10.00
11.00		0.00	o	0		11. 00
12.00		0.00	o	0		12. 00
13. 00		0.00	o	0		13. 00
14. 00		0.00	o	0		14. 00
15. 00		0.00	ol	Ö		15. 00
16. 00		0.00	Ö	Ö		16. 00
17. 00		0.00	ol	Ö		17. 00
18. 00		0.00	o	Ö		18. 00
19. 00		0.00	o	Ö		19. 00
20. 00		0.00	o	ő		20. 00
21. 00		0.00	o	Ö		21. 00
22. 00		0.00	ol	Ö		22. 00
	TOTALS	<del>                                     </del>		2, 619, 735		
500.00	Grand Total: Increases		1, 709, 386	5, 159, 464		500.00
	•					•

Health Financial Systems RECLASSIFICATIONS MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 | Peri od: | Worksheet A-6 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 151329

Decreases Cost Center Line # Salary Other Wkst. A-7 Ref.	
6.00 7.00 8.00 9.00 10.00	
A - CAFETERIA	
1. 00 DI ETARY 10. 00 660, 018 438, 283 0	1. 00
0 660, 018 438, 283	
B - OB RECLASS	
1. 00 DELI VERY ROOM & LABOR ROOM 52. 00 971, 606 121, 291 0	1. 00
2.00 0.00 0 0	2. 00
0 971, 606 121, 291	
C - COMMUNITY RELATIONS	
1. 00 COMMUNITY RELATIONS 194. 00 68, 195 159, 883 0	1. 00
0 68, 195 159, 883	
D - OFFSITE BUILDING DEPR RECLASS	
1.00 NEW CAP REL COSTS-BLDG & 1.00 0 10,990 9	1. 00
FI XT	
2.00   NEW CAP REL COSTS-MVBLE   2.00   0   158,573   9	2. 00
EQUI P	
0 0 169, 563	
E - IMPLANTABLE SUPPLIES RECLASS	
1. 00 <u>OPERATI NG_ROOM</u>	1. 00
0 0 1,650,682	
F - SPEECH RECLASS	
1. 00   SPEECH_PATHOLOGY   68. 00   9, 567   27   0	1. 00
0 9, 567 27	
I - CENTRAL SUPPLY RECLASS	
1.00   ADMINISTRATIVE & GENERAL   5.00   0   5,231   0	1. 00
2.00   OPERATION OF PLANT   7.00   0   171   0	2. 00
3.00   LAUNDRY & LINEN SERVICE   8.00   0   12,710   0	3. 00
4. 00   DI ETARY   10. 00   0   35, 147   0	4. 00
5.00   NURSING ADMINISTRATION   13.00   0   2   0	5. 00
6. 00   CENTRAL SERVICES & SUPPLY   14. 00   0   425, 825   0	6. 00
7. 00   PHARMACY   15. 00   0   1, 227   0	7. 00
8. 00   MEDI CAL RECORDS & LI BRARY   16. 00   0   1, 709   0	8. 00
9.00   ADULTS & PEDIATRICS   30.00   0   92,606   0	9. 00
10.00   INTENSIVE CARE UNIT   31.00   0   8,090   0	10. 00
11.00   OPERATING ROOM   50.00   0   1,222,987   0	11. 00
12.00   DELIVERY ROOM & LABOR ROOM   52.00   0   80,092   0	12. 00
13. 00   RADI OLOGY-DI AGNOSTI C   54. 00   0   188, 912   0	13. 00
14. 00   LABORATORY   60. 00   0   40, 527   0	14. 00
15. 00   RESPI RATORY THERAPY   65. 00   0   12, 182   0	15. 00
16. 00 PHYSI CAL THERAPY   66. 00   0   14, 907   0	16. 00
17. 00   OCCUPATI ONAL THERAPY   67. 00   0   10, 915   0	17. 00
18.00   SPEECH PATHOLOGY   68.00   0   958   0	18. 00
19. 00   ELECTROCARDI OLOGY   69. 00   0   14, 418   0	19. 00
20. 00 CLINIC 90. 00 0 197, 794 0	20. 00
21. 00 WOUND CLINC 90. 01 0 150, 824 0	21. 00
22. 00 EMERGENCY	22. 00
TOTALS 0 2, 619, 735	
500.00 Grand Total: Decreases 1,709,386 5,159,464	500.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 151329 Peri od: Worksheet A-7 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/26/2016 11:49 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2, 371, 158 0 1.00 0 25, 591 2.00 Land Improvements 398, 310 25, 591 0 2.00 0 3.00 68, 968, 816 855, 062 855, 062 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 6, 341, 285 0 5.00 0 6.00 Movable Equipment 41, 727, 166 7, 785, 342 7, 785, 342 2, 229, 542 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 119, 806, 735 8, 665, 995 8, 665, 995 2, 229, 542 8.00 9.00 Reconciling Items 0 9.00 2<u>, 229, 542</u> Total (line 8 minus line 9) 119, 806, 735 8, 665, 995 10.00 0 8, 665, 995 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 371, 158 0 1.00 2.00 Land Improvements 423, 901 0 2.00 3.00 Buildings and Fixtures 69, 823, 878 0 3.00 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 6, 341, 285 0 5.00 Movable Equipment 0 6.00 47, 282, 966 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 8.00 126, 243, 188 0 8.00 9.00 Reconciling Items 9.00

126, 243, 188

0

10.00 Total (line 8 minus line 9)

				Т	o 12/31/2015	Date/Time Prep 5/26/2016 11:	
			SU	JMMARY OF CAPIT	AL	372072010 11.	47 diii
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		0.00	10.00	44.00	instructions)	instructions)	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	9. 00	10.00	11.00 nd 2	12.00	13. 00	
1.00	NEW CAP REL COSTS-BLDG & FLXT	1, 926, 316		1, 159, 736	0	0	1. 00
1.00	NEW CAP REL COSTS-DEDG & TTXT	599, 837	0	1, 134, 730	0	l 0	1. 00
2. 00	NEW CAP REL COSTS-MVBLE EQUIP	4, 078, 222	0	0	0	1 0	2.00
2. 01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	o	Ö	0	l 0	2. 01
3.00	Total (sum of lines 1-2)	6, 604, 375	0	1, 159, 736	0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see instructions)	through 14)				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3, 086, 052				1.00
1. 01	NEW CAP REL COSTS-OFFSITE BLDG	0	599, 837			l	1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	o	4, 078, 222			ļ	2. 00
2. 01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0				2. 01
3.00	Total (sum of lines 1-2)	0	7, 764, 111				3. 00

Heal th	Financial Systems MAF	RGARET MARY COM	IMUNITY HOSPITA	ıL	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS				Peri od: From 01/01/2015 To 12/31/2015	Date/Time Prep 5/26/2016 11:	pared:
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col	instructions)	Insurance	
				2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	NEW CAP REL COSTS DEFOUTE PLACE	59, 356, 695	l e	59, 356, 69			
1.01	NEW CAP REL COSTS - OFFSITE BLDG	13, 262, 242	l	10,202,2.			1. 01
2. 00 2. 01	NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	53, 624, 251 0	0	,,	1 0. 424769 0 0. 000000	0	
3. 00	Total (sum of lines 1-2)	126, 243, 188		126, 243, 18		-	1
3.00	Total (Suil of Titles 1-2)		TION OF OTHER (			F CAPITAL	3.00
		ALLUCA	ITON OF OTTICK (	CAFITAL	JUIVIIVIAN I C	I CAFITAL	
	Cost Center Description	Taxes	Other	Total (sum of	f Depreciation	Lease	
			Capi tal -Relate		1		
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	0	)	0 1, 915, 326	0	1. 00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	)	0 610, 827	0	1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	)	0 3, 616, 731	0	2. 00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	)	0 158, 573		
3.00	Total (sum of lines 1-2)	0	0	)	0 6, 301, 457	0	3. 00
			St	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE			1	_		
1.00	NEW CAP REL COSTS-BLDG & FLXT	212, 653			0	2, 127, 979	
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	1	1	0 0	610, 827	1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	•	0	3, 616, 731	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0		1	0	158, 573	
3.00	Total (sum of lines 1-2)	212, 653	0	ין	0 0	6, 514, 110	3. 00

| Peri od: | Worksheet A-8 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 151329

				'.	o 12/31/2015		
				Expense Classification on	Worksheet A	5/26/2016 11: 2	49 am
				To/From Which the Amount is			
	Coot Contan Decement on	Dani o (Codo (2)	Amount	Cost Conton	line#	Wko+ A 7 Dof	
	Cost Center Description	1.00	2. 00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP		0	NEW CAP REL COSTS-BLDG &	1.00	0	1. 00
	REL COSTS-BLDG & FLXT (chapter 2)			FLXT			
1. 01	Investment income - NEW CAP		0	NEW CAP REL COSTS-OFFSITE	1. 01	0	1. 01
	REL COSTS-OFFSITE BLDG			BLDG			
2.00	(chapter 2) Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2. 00	o	2. 00
	REL COSTS-MVBLE EQUIP (chapter			EQUI P			
2. 01	2)   Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2. 01	0	2. 01
	REL COSTS-MVBLE EQUIP OFFSIT		_	EQUIP OFFSIT			
3. 00	(chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)		J				
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of		0		0. 00	0	5. 00
4 00	expenses (chapter 8)		0		0.00		4 00
6. 00	Rental of provider space by suppliers (chapter 8)		O		0. 00	0	6. 00
7. 00	Tel ephone servi ces (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10.00	Provi der-based physician	A-8-2	-3, 395, 220		0.00	O	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
	(chapter 23)				0.00		
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12. 00
13. 00	Laundry and linen service		0		0. 00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		0		0. 00 0. 00	0	14. 00 15. 00
15.00	and others		O		0.00		15.00
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
	patients						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0. 00	0	19. 00
17.00	books, etc.)		Ö		0.00	Ĭ	17.00
20. 00 21. 00	Vending machines Income from imposition of		0	i i	0. 00 0. 00	0	
21.00	interest, finance or penalty		O		0.00	Ö	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
22.00	overpayments and borrowings to	,	Ö		0.00	Ŭ	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	A 0 3	Ö	RESTRATORT MERALT	03.00		23.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
24.00	therapy costs in excess of	A 0 3	Ö	THISTORE THERAT	00.00		24.00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
23.00	physicians' compensation		O	cost center bereted	114.00		23.00
26. 00	(chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
	COSTS-BLDG & FLXT			FLXT			
26. 01	Depreciation - NEW CAP REL COSTS-OFFSITE BLDG		0	NEW CAP REL COSTS-OFFSITE BLDG	1. 01	0	26. 01
27. 00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
27. 01	COSTS-MVBLE EQUIP Depreciation - NEW CAP REL		0	EQUIP NEW CAP REL COSTS-MVBLE	2. 01	0	27. 01
	COSTS-MVBLE EQUIP OFFSIT			EQUIP OFFSIT		Ĭ	
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	n	28. 00 29. 00
	1	1 1		1	3.00	<u> </u>	

Provi der CCN: 151329 Peri od: Worksheet A-8 From 01/01/2015 | Worksheet A-8 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

					o 12/31/2015	Date/Time Pre 5/26/2016 11:	
				Expense Classification on	Worksheet A	3/20/2010 11.	49 аш
				To/From Which the Amount is			
					•		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	oost conten bescriptron	1.00	2. 00	3.00	4. 00	5. 00	
30. 00	Adjustment for occupational	A-8-3		OCCUPATI ONAL THERAPY	67.00		30. 00
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	  SPEECH PATHOLOGY	40.00		31. 00
31.00	pathology costs in excess of	A-8-3	Ü	SPEECH PATHULUGY	68. 00		31.00
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for	A	-302, 918	NEW CAP REL COSTS-MVBLE	2.00	9	32. 00
	Depreciation and Interest			EQUI P			
33. 00	OTHEROPERATING GIRLS ON THE	В	-25, 812	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
24.00	RUN REVE	В	2 24/	ADMINISTRATIVE & CENEDAL	F 00		24.00
34. 00	OTHEROPERATING OTHOP -	В	-2, 246	ADMINISTRATIVE & GENERAL	5. 00	0	34. 00
35. 00	MMCH OTHER OPERATING	В	-20 536	ADMINISTRATIVE & GENERAL	5. 00	0	35. 00
33. 00	COMMBENEFITS SC		20, 330	ADMINISTRATIVE & GENERAL	3.00		33.00
36. 00	OTHEROPERATING DI ABETES	В	-30, 306	ADMINISTRATIVE & GENERAL	5. 00	0	36. 00
	PROGRAM						
37.00	OTHEROPERATING OTHOP-COMMUNITY	В	-7, 899	ADMINISTRATIVE & GENERAL	5. 00	0	37. 00
	CLASS		0.547				
38. 00	OTHEROPERATING OTHOP-PURCHASE DI SCOU	В	-2, 547	ADMINISTRATIVE & GENERAL	5. 00	0	38. 00
40. 00	NON-OPERATING R OTHOP-MISC	В	-2 896	OPERATION OF PLANT	7. 00	0	40. 00
10.00	REVENUE		2,070	I LIGHT ON OF TEAM	7.00		10.00
41.00	OTHEROPERATING OTHOP-LAUNDRY	В	-555	LAUNDRY & LINEN SERVICE	8.00	0	41.00
	SERVI CE						
43. 00	OTHEROPERATI NG OTHOP-VENDI NG	В	-3, 461	DI ETARY	10. 00	0	43. 00
44.00	SALES	D	17 010	DI ETADY	10.00		44.00
44. 00	OTHEROPERATING OTHOP-DIET SUPP/INS	В	-17,812	DI ETARY	10.00	0	44. 00
45. 00	CAFETERIA OFFSET	В	-303 051	CAFETERI A	11. 00	0	45. 00
45. 01	NON-OPERATING OTHOP-CAFE SALES			CAFETERI A	11. 00	1	
45. 02	OTHEROPERATING OTHOP-MEDRED	В	-5, 361	MEDICAL RECORDS & LIBRARY	16.00	0	45. 02
	TRANSC						
45. 03	OTHEROPERATING OTHOP-PHYSICAL	В	-14, 699	PHYSI CAL THERAPY	66.00	0	45. 03
45 04	THERAP		0.47 0.00	NEW CAR REL COCTO DI DO 0	1 00	11	45 04
45. 04	INTEREST OFFSET	A	-947, 083	NEW CAP REL COSTS-BLDG &	1.00	11	45. 04
45. 05	TV OFFSET	A	-2.724	OPERATION OF PLANT	7. 00	0	45. 05
45. 06	LOBBYI NG EXPENSE	A	· ·	ADMI NI STRATI VE & GENERAL	5. 00		45. 06
45.07	MEDICAL STAFF RETENTION COST	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 07
45. 08	MEDICAL STAFF PLACEMENT FEE	A		ADMINISTRATIVE & GENERAL	5. 00	•	45. 08
45. 09	HAF	A		ADMINISTRATIVE & GENERAL	5. 00	l	
45. 10	BOUTI QUE OFFSET	A		RADI OLOGY-DI AGNOSTI C	54. 00	Ö	
45. 11			0		0.00		45. 11
45. 12			0		0.00		45. 12
45. 13			0		0.00	Ö	45. 13
50.00	TOTAL (sum of lines 1 thru 49)		-6, 660, 520				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provi der CCN: 151329

							5/26/2016 11:	49 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l 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	30.00	ADULTS & PEDIATRICS	175, 144	146, 81	1 28, 333	0	0	1. 00
2.00	43. 00	NURSERY	102, 337	102, 33	7 0	0	0	2. 00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	236, 030	212, 03	0 24, 000	0	0	3. 00
4.00		RADI OLOGY-DI AGNOSTI C	529, 241				0	4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	109, 996			0	0	5. 00
6. 00		LABORATORY	77, 520		0 77, 520		0	6. 00
7. 00		ELECTROCARDI OLOGY	179, 245				0	
8. 00		ELECTROCARDI OLOGY	27, 996		0 27, 996		0	8. 00
9. 00		ELECTROCARDI OLOGY	9, 996		0 9, 996		0	9. 00
10. 00		CLI NI C	462, 399		· ·		0	10.00
11. 00		EMERGENCY					0	11. 00
			28, 887					
12.00		EMERGENCY	1, 972, 095			0	0	12.00
13. 00	91.00	EMERGENCY	99, 883			1	0	13.00
200.00			4, 010, 769				0	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Provi der	Physician Cost	
		ldentifier	Limit		E Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1 00	2.00	8.00	9. 00	Education 12.00	12 13. 00	14.00	
1. 00	1.00	2. 00 ADULTS & PEDIATRICS	8.00		0 0		14.00	1. 00
2. 00		NURSERY			0 0		0	
3. 00		RADI OLOGY-DI AGNOSTI C					0	3. 00
4. 00		RADI OLOGY-DI AGNOSTI C					0	4. 00
5. 00		RADI OLOGY-DI AGNOSTI C					0	5. 00
6. 00		LABORATORY					0	6. 00
7. 00		ELECTROCARDI OLOGY					0	
8. 00		ELECTROCARDI OLOGY					0	8. 00
9. 00		ELECTROCARDI OLOGY				1	0	9. 00
10. 00		CLI NI C					0	10.00
11. 00		EMERGENCY				1	0	11. 00
12. 00		EMERGENCY			0 0		0	12. 00
13. 00	1	EMERGENCY				1	0	13. 00
200.00	71.00	LINERGENCT					_	200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	<u> </u>	Adjustment	U	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		Tuerrer er	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		0 0	146, 811		1. 00
2.00	43.00	NURSERY	0		o o	102, 337		2. 00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	0		ol o	212, 030		3. 00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0		ol o	529, 241		4. 00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	0		o o	75, 996		5. 00
6.00	60.00	LABORATORY	0		ol o	0		6. 00
7.00	69. 00	ELECTROCARDI OLOGY	0		ol o	179, 245		7. 00
8.00	69. 00	ELECTROCARDI OLOGY	0		o o			8. 00
9.00		ELECTROCARDI OLOGY	0		0 0	0		9. 00
10.00		CLINIC	0		0 0	462, 399		10.00
11.00		EMERGENCY	0		0 0			11. 00
12.00		EMERGENCY	0		0 0			12.00
13.00		EMERGENCY	0		0 0			13.00
200.00			0		0 0			200.00
		•		•	•			•

| Peri od: | Worksheet B | From 01/01/2015 | Part | To | 12/31/2015 | Date/Time Prepared: Provi der CCN: 151329

					To	12/31/2015	Date/Time Prep	pared:
					CAPITAL REL	ATED COSTS	5/26/2016 11:2	49 am
	Cost Cent	er Description	Net Expenses	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE	
	0031 0011	er beserretten	for Cost	FLXT	BLDG	EQUI P	EQUIP OFFSIT	
			Allocation					
			(from Wkst A col. 7)					
			0	1. 00	1. 01	2. 00	2. 01	
4 00	GENERAL SERVICE		0 407 070	0 407 070				4 00
1. 00 1. 01	1	EL COSTS-BLDG & FIXT EL COSTS-OFFSITE BLDG	2, 127, 979 610, 827	2, 127, 979 0	610, 827			1. 00 1. 01
2. 00		EL COSTS-MVBLE EQUIP	3, 616, 731	J	010, 027	3, 616, 731		2. 00
2.01	00201 NEW CAP R	EL COSTS-MVBLE EQUIP OFFSIT	158, 573			0	158, 573	2. 01
4.00		BENEFITS DEPARTMENT	12, 111, 720	10, 940	0	18, 593	0	4. 00
5. 00 7. 00	00500 ADMI NI STR 00700 OPERATI ON		9, 687, 565 1, 294, 978	260, 018 486, 824	0	441, 928 827, 408	0	5. 00 7. 00
7. 01	1 1	OF PLANT -OFFSITE	107, 129	400, 024	0	027, 400	0	7. 01
7.02	00702 OPERATI ON	OF PLANT - HOSPITAL & OFFS	498, 703	0	0	O	0	7. 02
8.00	00800 LAUNDRY &		132, 259	26, 784	0	45, 523	0	8. 00
9. 00 10. 00	00900 HOUSEKEEP 01000 DI ETARY	I NG	900, 133 151, 599	28, 691 12, 925	0	48, 763 21, 968	0	9. 00 10. 00
11. 00	01100 CAFETERI A		795, 084	68, 233	0	115, 970	0	11. 00
13. 00	01300 NURSING A		712, 845	6, 065	0	10, 307	0	13. 00
14. 00		ERVICES & SUPPLY	107	0	0	0	0	14. 00
15. 00 16. 00	01500 PHARMACY	ECORDS & LI BRARY	2, 900, 692	8, 148	0	13, 849 60, 691	0	15. 00 16. 00
16.00		NE SERVICE COST CENTERS	1, 035, 876	35, 709	U	60, 691]	U	10.00
30.00	03000 ADULTS &	PEDI ATRI CS	2, 031, 146	182, 535	0	310, 238	0	30. 00
31.00	03100 I NTENSI VE	CARE UNIT	369, 762	17, 722	0	30, 120	0	31.00
43. 00	04300 NURSERY	CE COST CENTERS	567, 098	9, 033	0	15, 352	0	43. 00
50. 00	05000 OPERATI NG		1, 626, 947	46, 383	0	78, 833	0	50. 00
52.00		ROOM & LABOR ROOM	107, 049	16, 021	0	27, 230	0	52.00
54.00	05400 RADI OLOGY		7, 246, 623	197, 947	0	336, 433	0	54. 00
60. 00 60. 01	06000 LABORATOR 06001 BLOOD LAB		3, 169, 270	49, 371 0	0	83, 912 0	0	60. 00 60. 01
65. 00	06500 RESPI RATO		525, 885	40, 496	0	68, 827	0	65. 00
66.00	06600 PHYSI CAL	THERAPY	1, 016, 014	48, 064	0	81, 690	0	66. 00
67. 00	06700 OCCUPATI 0		343, 888	12, 797	0	21, 751	0	67. 00
68. 00 69. 00	06800 SPEECH PA 06900 ELECTROCA		178, 153 675, 311	6, 949 27, 679	0	11, 811 47, 043	0	68. 00 69. 00
71. 00	1 1	UPPLIES CHARGED TO PATIENTS	2, 619, 735	10, 153	0	17, 257	0	71. 00
72. 00	07200 I MPL. DEV	. CHARGED TO PATIENT	1, 650, 682	49, 116	0	83, 478	0	72. 00
73. 00		RGED TO PATIENTS	0	0	0	0	0	73. 00
88. 00	08800 RURAL HEA	ICE COST CENTERS	579, 956	0	47, 410	ol	12, 308	88. 00
90.00	09000 CLI NI C	2111 321111 3	1, 062, 548	101, 652	0	172, 769	0	90.00
90. 01	09001 WOUND CLI		234, 390	6, 074	0	10, 324	0	90. 01
91.00	09100 EMERGENCY		1, 986, 255	122, 372	0	207, 984	0	91. 00 92. 00
92. 00		ON BEDS (NON-DISTINCT PART) BLE COST CENTERS						92.00
101.00	10100 HOME HEAL	TH AGENCY	1, 445, 883	33, 566	0	57, 049	0	101. 00
110.00	SPECIAL PURPOSE					T		110.00
	11300   I NTEREST 11600   HOSPI CE	EXPENSE	986, 289	0	0	0		113. 00 116. 00
118.00		(SUM OF LINES 1-117)	65, 265, 684	1, 922, 267	47, 410	3, 267, 101	12, 308	
	NONRE! MBURSABLE	COST CENTERS						
		S' PRIVATE OFFICES	9, 089, 305	184, 835	563, 417	314, 148	146, 265	
	19201   PRI VATE   D   07950   COMMUNI TY		465, 867	0 2, 487	0	4, 226		192. 01 194. 00
	07951 COMMUNI TY		451, 850	18, 390	0	31, 256		194. 00
194. 02	07952 OTHER NON	REIMBURSABLE COST CENTERS	9, 594	0	0	0	0	194. 02
	07953 EMS	+ Adiustmont-	56, 491	0	0	0		194. 03
200. 00 201. 00		t Adjustments Cost Centers		0	0	0		200. 00 201. 00
202.00		m lines 118-201)	75, 338, 791	2, 127, 979	610, 827	3, 616, 731	158, 573	
		•	,	'	,	·	•	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 151329

| Period: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 5/26/2016 | 11: 49 am

						5/26/2016 11:	49 am
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL		OPERATION OF PLANT -OFFSITE	
		4.00	4A	5. 00	7. 00	7. 01	
	GENERAL SERVICE COST CENTERS						
1. 00 1. 01 2. 00 2. 01	O0100 NEW CAP REL COSTS-BLDG & FIXT   O0101 NEW CAP REL COSTS-OFFSITE BLDG   O0200 NEW CAP REL COSTS-MVBLE EQUIP   O0201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						1. 00 1. 01 2. 00 2. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	12, 141, 253					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 798, 925	12, 188, 436		2 112 007		5. 00
7.00	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT -OFFSITE	0	2, 609, 210		3, 112, 806	127 00/	7.00
7. 01 7. 02	00701 OPERATION OF PLANT - OFFSITE	177, 890	107, 129 676, 593		0	127, 806 0	7. 01 7. 02
8. 00	00800 LAUNDRY & LINEN SERVICE	29, 885	234, 451		60, 848	0	8. 00
9. 00	00900 HOUSEKEEPI NG	232, 704	1, 210, 291		65, 180	0	9. 00
10. 00	01000 DI ETARY	45, 417	231, 909		29, 363	0	10.00
11. 00	01100 CAFETERI A	239, 796	1, 219, 083		155, 012	0	11. 00
13. 00	01300 NURSING ADMINISTRATION	253, 672	982, 889		13, 777	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	o	107	21	0	0	14. 00
15. 00	01500 PHARMACY	205, 791	3, 128, 480	603, 819	18, 511	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	322, 865	1, 455, 141	280, 852	81, 123	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00	03000 ADULTS & PEDIATRICS	750, 927	3, 274, 846		414, 682	0	30.00
31. 00	03100   NTENSIVE CARE UNIT	131, 660	549, 264		40, 260	0	31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	182, 876	774, 359	149, 457	20, 521	0	43. 00
50. 00	05000 OPERATING ROOM	482, 915	2, 235, 078	431, 386	105, 373	0	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	34, 577	184, 877		36, 397	0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	962, 863	8, 743, 866		449, 697	0	54. 00
60. 00	06000 LABORATORY	446, 772	3, 749, 325		112, 161	0	60.00
60. 01	06001 BLOOD LABORATORY	O	0		0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	159, 713	794, 921	153, 425	91, 998	0	65. 00
66.00	06600 PHYSI CAL THERAPY	351, 425	1, 497, 193	288, 969	109, 191	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	121, 226	499, 662	96, 438	29, 073	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	64, 545	261, 458		15, 787	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	193, 521	943, 554		62, 880	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 647, 145		23, 066	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	1, 783, 276		111, 581	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	U	73. 00
88. 00	08800 RURAL HEALTH CLINIC	183, 009	822, 683	158, 784	0	9, 920	88. 00
90. 00	09000 CLINIC	519, 029	1, 855, 998		230, 932	0,720	90.00
90. 01	09001 WOUND CLINC	81, 963	332, 751		13, 800	0	90. 01
91. 00	09100 EMERGENCY	564, 637	2, 881, 248		278, 003	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0				92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	458, 612	1, 995, 110	385, 070	76, 255	0	101. 00
	SPECIAL PURPOSE COST CENTERS	T		1			
	11300   INTEREST EXPENSE	220 400	1 21/ /00	224 024	0		113. 00
118.00	11600 HOSPICE   SUBTOTALS (SUM OF LINES 1-117)	230, 409 9, 227, 624	1, 216, 698 61, 087, 031		0 2 445 471		116. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	9, 221, 024	01,007,031	9, 437, 774	2, 645, 471	9, 920	116.00
192 00	19200 PHYSI CLANS' PRI VATE OFFI CES	2, 737, 057	13, 035, 027	2, 515, 824	419, 907	117, 886	192 00
	19201 PRI VATE DUTY	2,707,007	0,000,027		0		192. 01
	07950 COMMUNITY RELATIONS	46, 013	518, 593	100, 092	5, 649		194. 00
194. 01	07951 COMMUNITY BENEFITS	122, 229	623, 725		41, 779		194. 01
	07952 OTHER NONREIMBURSABLE COST CENTERS	3, 476	13, 070	2, 523	0	0	194. 02
	07953 EMS	4, 854	61, 345	11, 840	0	0	194. 03
200.00			0				200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	12, 141, 253	75, 338, 791	12, 188, 436	3, 112, 806	127, 806	202.00

Provider CCN: 151329 | Period: | Worksheet B | From 01/01/2015 | Part I | To 12/31/2015 | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Par Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				Fr To	om 01/01/2015 12/31/2015	Part I Date/Time Pre 5/26/2016 11:	
	Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	47 diii
		7. 02	8. 00	9. 00	10. 00	11. 00	
	GENERAL SERVICE COST CENTERS	1		I			
1. 00 1. 01 2. 00 2. 01 4. 00 5. 00 7. 01 7. 02 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-OFFSITE BLDG 00200 NEW CAP REL COSTS-MYBLE EQUIP 00201 NEW CAP REL COSTS-MYBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - OFFSITE 00702 OPERATION OF PLANT - HOSPITAL & OFFS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	807, 180 12, 430 13, 315 5, 998 31, 665 2, 814 0 3, 781 16, 571	352, 980 15, 417 409	1, 537, 798 11, 266 59, 474 5, 286 0	323, 705 0 0 0 0 0	1, 702, 684 66, 759 0 48, 645 121, 150	13. 00 14. 00 15. 00
30.00	03000 ADULTS & PEDI ATRI CS	84, 709	86, 662	159, 104	304, 709	274, 120	30. 00
31.00	03100 INTENSIVE CARE UNIT	8, 224	4, 505	15, 447	18, 996	47, 302	31. 00
43.00	04300 NURSERY	4, 192	17, 686	7, 873	0	60, 756	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	21, 525		· ·	0	171, 198	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 435	1		0	11, 489	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	91, 861	40, 684	172, 537	0	162, 895	
60.00	06000 LABORATORY	22, 912	0	43, 034	0	194, 589	60.00
60. 01	06001 BL00D LABORATORY	0	0	0	0	0	
65. 00	06500 RESPI RATORY THERAPY	18, 793	7, 511	35, 297	0	59, 543	1
66. 00	06600 PHYSI CAL THERAPY	22, 305			0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	5, 939			0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 225	ł	-,	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	12, 845	735	24, 126	0	58, 771	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 712	0	8, 850	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	22, 793	18, 675	42, 811	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	1					
88. 00	08800 RURAL HEALTH CLINIC	17, 105		,	0	0	
90.00	09000 CLI NI C	47, 174	30, 502		0	0	
90. 01	09001 WOUND CLINC	2, 819	l	5, 295	0	0	
91. 00	09100 EMERGENCY	56, 789	45, 730	106, 663	0	207, 637	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS		_				
101.00	10100 HOME HEALTH AGENCY	15, 577	0	29, 257	0	0	101. 00
440.00	SPECIAL PURPOSE COST CENTERS						1110 00
	11300   INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	0	000 777	000 705		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	557, 508	347, 122	998, 777	323, 705	1, 484, 854	]118.00
100.00		220,004	E 0E0	F20, 024	ol	1/1 101	102.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	239, 984	5, 858	520, 824	- 1	161, 131	
	19201 PRI VATE DUTY	1 154	0	2 140	0		192. 01 194. 00
	07950 COMMUNITY RELATIONS  07951 COMMUNITY BENEFITS	1, 154 8, 534		2, 168 16, 029	o o		194. 00
	07951 COMMONTTY BENEFITS	8, 534		10, 029	0		194. 01
	07953 EMS		0		0		194. 02
200.00	1			١	٩	1, 703	200. 00
201.00		0	n	0	n	n	201.00
202.00	1 9	807, 180	352, 980	1, 537, 798	323, 705	1, 702, 684	
			,		,1		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

 Y HOSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 151329
 Period: From 01/01/2015 To 12/31/2015
 Worksheet B Part I Date/Time Prepared:

			1	0 12/31/2015	5/26/2016 11:	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	17 4111
out deliter beserver.	ADMI NI STRATI ON	SERVICES &		RECORDS &	oub to tu.	
		SUPPLY		LI BRARY		
	13.00	14. 00	15. 00	16.00	24. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01   00101 NEW CAP REL COSTS-OFFSITE BLDG						1. 01
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
7. 01   OO701   OPERATION OF PLANT -OFFSITE						7. 01
7. 02   OO702   OPERATION OF PLANT - HOSPITAL & OFFS						7. 02
8. 00   00800 LAUNDRY & LINEN SERVICE						8.00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 261, 229					13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	5, 948				14. 00
15. 00 01500 PHARMACY	55, 361	1	3, 865, 700			15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	00,001	2	0,000,700	l l		16. 00
INPATIENT ROUTINE SERVICE COST CENTERS		-		1, 700, 701		10.00
30. 00 03000 ADULTS & PEDIATRICS	311, 965	104	0	1, 158, 284	6, 701, 253	30.00
31. 00 03100   NTENSIVE CARE UNIT	53, 833	9	•		843, 852	1
43. 00   04300   NURSERY	69, 144	ó	1	l l	1, 103, 988	
ANCI LLARY SERVI CE COST CENTERS	07,111	<u> </u>		9	1, 100, 700	10.00
50. 00   05000   OPERATING ROOM	0	3, 145	0	114, 890	3, 160, 607	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	13, 075	89		0	304, 676	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	185, 331	378		483, 009	12, 017, 885	1
60. 00   06000   LABORATORY	221, 454	1, 342		0	5, 068, 463	
60. 01   06001   BLOOD   LABORATORY	0	0			0	1
65. 00 06500 RESPIRATORY THERAPY	67, 764	96			1, 229, 348	1
66. 00   06600   PHYSI CAL THERAPY	0,,,01	19		- I	1, 990, 950	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	18			642, 285	1
68. 00 06800 SPEECH PATHOLOGY	0	1			336, 991	
69. 00 06900 ELECTROCARDI OLOGY	44, 761	37		21, 102	1, 350, 924	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		21, 102	3, 194, 691	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	ő	0		o o	2, 323, 321	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	ő	0			3, 865, 700	1
OUTPATIENT SERVICE COST CENTERS		<u> </u>	0,000,700	9	0,000,700	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	9	0	0	1, 040, 628	88. 00
90. 00   09000   CLI NI C	0	212			2, 691, 362	1
90. 01   09001   WOUND   CLI NC	0	163		77,720	419, 051	
91. 00   09100   EMERGENCY	236, 304	115	•	79, 720	4, 448, 310	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	200,001	110	Ĭ	77,720	1, 110, 010	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
101. 00 10100 HOME HEALTH AGENCY	0	32	0	0	2, 501, 301	101.00
SPECIAL PURPOSE COST CENTERS	-1	7 = 1	_	-1		1
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	o	14	0	ol	1, 451, 543	1
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 258, 992	5, 786		1, 936, 725	56, 687, 129	
NONREI MBURSABLE COST CENTERS	1, ===,=	27 . 22		.,		1
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	156	0	49, 239	17, 065, 836	192. 00
192. 01 19201 PRI VATE DUTY	0	0	0	l ' '		192. 01
194.00 07950 COMMUNITY RELATIONS	0	0	0	ol	643, 477	
194. 01 07951 COMMUNITY BENEFITS	0	6	0	o	849, 369	
194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS	o	n	Ö			194. 02
194. 03 07953 EMS	2, 237	n	ا م	ام		194. 03
200.00 Cross Foot Adjustments		Ĭ				200.00
201.00 Negative Cost Centers	n	n	n	n		201.00
202.00 TOTAL (sum lines 118-201)	1, 261, 229	5, 948	3, 865, 700	1, 985, 964	75, 338, 791	
		-,				

Provider CCN: 151329 | Period: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				To 12/31/2015	Date/Time Pro 5/26/2016 11:	
	Cost Center Description	Intern &	Total		5/20/2010 11.	49 alli
	•	Residents Cost				
		& Post				
		Stepdown Adjustments				
		25. 00	26.00			
	RAL SERVICE COST CENTERS					
i i	O NEW CAP REL COSTS-BLDG & FIXT					1.00
i i	1 NEW CAP REL COSTS-OFFSITE BLDG 0 NEW CAP REL COSTS-MVBLE EQUIP					1. 01 2. 00
1	1 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2. 00
	O EMPLOYEE BENEFITS DEPARTMENT					4. 00
	O ADMINISTRATIVE & GENERAL					5. 00
1	OOPERATION OF PLANT 1OPERATION OF PLANT -OFFSITE					7.00
1	2 OPERATION OF PLANT - HOSPITAL & OFFS					7. 01 7. 02
	O LAUNDRY & LINEN SERVICE					8. 00
1	O HOUSEKEEPI NG					9. 00
1	O DI ETARY					10.00
	O CAFETERIA O NURSING ADMINISTRATION					11. 00 13. 00
	O CENTRAL SERVICES & SUPPLY					14. 00
	O PHARMACY					15. 00
	MEDICAL RECORDS & LIBRARY					16. 00
	TIENT ROUTINE SERVICE COST CENTERS		( 704 050			
	O ADULTS & PEDIATRICS O INTENSIVE CARE UNIT	0	6, 701, 253 843, 852			30.00
1	O NURSERY	O	1, 103, 988			43. 00
ANCI I	LLARY SERVICE COST CENTERS					
1	O OPERATING ROOM	0	3, 160, 607			50.00
i i	O DELIVERY ROOM & LABOR ROOM O RADIOLOGY-DIAGNOSTIC		304, 676 12, 017, 885			52. 00 54. 00
1	O LABORATORY		5, 068, 463			60.00
1	BLOOD LABORATORY	0	0			60. 01
i i	O RESPIRATORY THERAPY	0	1, 229, 348			65. 00
1	O PHYSI CAL THERAPY	0	1, 990, 950			66. 00
1	O OCCUPATIONAL THERAPY O SPEECH PATHOLOGY		642, 285 336, 991			67. 00 68. 00
	O ELECTROCARDI OLOGY	o	1, 350, 924			69. 00
71. 00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 194, 691			71. 00
1	O I MPL. DEV. CHARGED TO PATIENT	0	2, 323, 321			72. 00
	O DRUGS CHARGED TO PATIENTS ATIENT SERVICE COST CENTERS	0	3, 865, 700			73. 00
	RURAL HEALTH CLINIC	0	1, 040, 628			88. 00
	D CLI NI C	0	2, 691, 362			90. 00
1	1 WOUND CLINC	0	419, 051			90. 01
1	O EMERGENCY O OBSERVATION BEDS (NON-DISTINCT PART)		4, 448, 310			91. 00 92. 00
	R REIMBURSABLE COST CENTERS					72.00
	O HOME HEALTH AGENCY	0	2, 501, 301			101. 00
	I AL PURPOSE COST CENTERS					112 00
116. 00 1160	O INTEREST EXPENSE	o	1, 451, 543			113. 00 116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	O	56, 687, 129			118. 00
	EIMBURSABLE COST CENTERS	,				
	O PHYSICIANS' PRIVATE OFFICES	0	17, 065, 836			192. 00
i i	1 PRIVATE DUTY O COMMUNITY RELATIONS	0	0 643, 477			192. 01 194. 00
i i	1 COMMUNITY BENEFITS		849, 369			194. 00
194. 02 0795	OTHER NONREIMBURSABLE COST CENTERS	0	15, 593			194. 02
194. 03 0795	l .	0	77, 387			194. 03
200.00	Cross Foot Adjustments	0	0			200. 00 201. 00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118-201)		75, 338, 791			201.00
	1	, -1				1

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 151329

					5/26/2016 11:	49 am
			CAPITAL REL	ATED COSTS		
Cost Center Description	Di rectly	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE	
	Assigned New	FLXT	BLDG	EQUI P	EQUIP OFFSIT	
	Capi tal					
	Related Costs					
	0	1.00	1. 01	2. 00	2. 01	
GENERAL SERVICE COST CENTERS		11.00		2.00	2.0.	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01   00101   NEW CAP REL COSTS-DEBU & TTXT						1. 01
						1
						2.00
2. 01   00201   NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		40.040		40 500		2. 01
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	10, 940		18, 593	0	1
5.00 00500 ADMINISTRATIVE & GENERAL	0	260, 018		441, 928	0	1
7.00 O0700 OPERATION OF PLANT	0	486, 824	0	827, 408	0	1
7.01  00701 OPERATION OF PLANT -OFFSITE	0	0	0	0	0	1
7.02   00702   OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	0	7. 02
8.00   00800 LAUNDRY & LINEN SERVICE	0	26, 784	0	45, 523	0	8. 00
9. 00   00900   HOUSEKEEPI NG	0	28, 691	0	48, 763	0	9.00
10. 00   01000   DI ETARY	0	12, 925	0	21, 968	0	10.00
11. 00   01100   CAFETERI A	ol	68, 233	0	115, 970	0	11.00
13.00 01300 NURSING ADMINISTRATION	0	6, 065	0	10, 307	0	1
14. 00 01400 CENTRAL SERVICES & SUPPLY	o	0, 000	0	0	0	
15. 00 01500 PHARMACY	o	8, 148	-	13, 849	0	1
16. 00 01600 MEDICAL RECORDS & LIBRARY		35, 709	0	60, 691	0	1
INPATIENT ROUTINE SERVICE COST CENTERS	l o	33, 709	l 0	00, 09 1	U	10.00
		100 505		210 220		20.00
30. 00   03000   ADULTS & PEDI ATRI CS	0	182, 535		310, 238	0	1
31. 00   03100   INTENSIVE CARE UNIT	0	17, 722	0	30, 120	0	
43. 00 04300 NURSERY	0	9, 033	0	15, 352	0	43. 00
ANCILLARY SERVICE COST CENTERS						1
50.00   05000   OPERATING ROOM	0	46, 383	0	78, 833	0	1
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	16, 021	0	27, 230	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	197, 947	0	336, 433	0	54. 00
60. 00   06000   LABORATORY	0	49, 371	0	83, 912	0	60.00
60. 01   06001   BLOOD   LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	40, 496	0	68, 827	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	o	48, 064	0	81, 690	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	12, 797	0	21, 751	0	1
68. 00 06800 SPEECH PATHOLOGY	0	6, 949	0	11, 811	0	
69. 00 06900 ELECTROCARDI OLOGY	0	27, 679		47, 043	0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		10, 153		17, 257	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT				83, 478	0	1
		49, 116 0	0	03, 4/0	0	
	U U	0	l O	υ	U	73.00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC		0	47 410	ما	12 200	00 00
	0	0		470.7(0	12, 308	1
90. 00   09000   CLI NI C	0	101, 652	1	172, 769	0	
90. 01   09001   WOUND CLINC	0	6, 074	0	10, 324	0	1
91. 00   09100   EMERGENCY	0	122, 372	0	207, 984	0	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	33, 566	0	57, 049	0	101.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	0	0	o	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	o	1, 922, 267	47, 410	3, 267, 101		118.00
NONREI MBURSABLE COST CENTERS	-1				,	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	184, 835	563, 417	314, 148	146, 265	192 00
192. 01 19201 PRI VATE DUTY	0	0.7,000	000,	01.7.10		192. 01
194. 00 07950 COMMUNITY RELATIONS		2, 487	o o	4, 226		194. 00
194. 01 07951 COMMUNITY RELATIONS		18, 390		31, 256		194. 00
194.01 07931 COMMUNITY BENEFITS 194.02 07952 OTHER NONREIMBURSABLE COST CENTERS		10, 390		31, 250		194. 01
		0		o o		
194. 03 07953 EMS	0	0	0	O	0	194. 03
200.00 Cross Foot Adjustments		=	_	_	=	200.00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	0	2, 127, 979	610, 827	3, 616, 731	158, 573	J202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MARGARET MARY COMMUNITY HOSPITAL
Provider CCN: 151329

				''	0 12/31/2013	5/26/2016 11:	
	Cost Center Description	Subtotal	EMPLOYEE	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	
			BENEFITS	& GENERAL	PLANT	PLANT -OFFSITE	
			DEPARTMENT				
		2A	4. 00	5. 00	7. 00	7. 01	
	ERAL SERVICE COST CENTERS	1		1			
	OO NEW CAP REL COSTS-BLDG & FIXT						1.00
	DI NEW CAP REL COSTS-OFFSITE BLDG						1. 01
	NEW CAP REL COSTS MYBLE EQUIP						2.00
	OI NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	20 522	20 522				2. 01
	DO EMPLOYEE BENEFITS DEPARTMENT DO ADMINISTRATIVE & GENERAL	29, 533 701, 946	29, 533 4, 377				4. 00 5. 00
	DO OPERATION OF PLANT	1, 314, 232	4, 3//				7.00
	O1 OPERATION OF PLANT -OFFSITE	1, 514, 232	0			l	7. 01
	O2 OPERATION OF PLANT - HOSPITAL & OFFS	0	433	.,		0	7. 02
	DO LAUNDRY & LINEN SERVICE	72, 307	73		26, 261	Ö	8.00
	DO HOUSEKEEPI NG	77, 454	566		·	0	9. 00
10.00 0100	DO DI ETARY	34, 893	111		12, 673	0	10.00
11. 00 0110	DO CAFETERI A	184, 203	583	13, 635	66, 900	0	11. 00
13.00 0130	DO NURSING ADMINISTRATION	16, 372	617	10, 994	5, 946	0	13. 00
	OO CENTRAL SERVICES & SUPPLY	0	0	1	0	0	14. 00
	DO PHARMACY	21, 997	501		·	l .	15. 00
	DO MEDICAL RECORDS & LIBRARY	96, 400	786	16, 276	35, 011	0	16. 00
	ATIENT ROUTINE SERVICE COST CENTERS	400 770	4 007	0,,,00	470.047		00.00
	DO ADULTS & PEDIATRICS DO INTENSIVE CARE UNIT	492, 773 47, 842	1, 827 320		·	0	30. 00 31. 00
	DO NURSERY	24, 385	445		8, 856	0	43.00
	LLARY SERVICE COST CENTERS	21,000	110	0,001	0,000		10.00
	OO OPERATING ROOM	125, 216	1, 175	24, 999	45, 477	0	50.00
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	43, 251	84	2, 068	15, 708	0	52. 00
54.00 0540	DO RADI OLOGY-DI AGNOSTI C	534, 380	2, 343	97, 800	194, 077	0	54. 00
	DO LABORATORY	133, 283	1, 087		· ·	l	60.00
	D1 BLOOD LABORATORY	0	0		0	0	60. 01
	OO RESPIRATORY THERAPY	109, 323	389		39, 704	0	65. 00
	DO PHYSI CAL THERAPY DO OCCUPATI ONAL THERAPY	129, 754	855 295			0	66. 00 67. 00
	DO SPEECH PATHOLOGY	34, 548 18, 760	157		12, 547 6, 813		68.00
	DO ELECTROCARDI OLOGY	74, 722	471			l e	69.00
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 410	0			l e	71. 00
	DO IMPL. DEV. CHARGED TO PATIENT	132, 594	0			l	72. 00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	0	0	0			73. 00
	PATIENT SERVICE COST CENTERS						
	DO RURAL HEALTH CLINIC	59, 718	445				•
	OO CLI NI C	274, 421	1, 263			l e	90.00
	D1 WOUND CLINC	16, 398	199		5, 956 119, 980		90. 01
	DO EMERGENCY DO OBSERVATION BEDS (NON-DISTINCT PART)	330, 356 0	1, 374	32, 227	119, 900	U	91. 00 92. 00
	ER REIMBURSABLE COST CENTERS	١					72.00
	DO HOME HEALTH AGENCY	90, 615	1, 116	22, 315	32, 910	0	101. 00
SPEC	CLAL PURPOSE COST CENTERS						
	00 INTEREST EXPENSE					l	113. 00
116. 00 1160	1	0	561				116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	5, 249, 086	22, 453	546, 930	1, 141, 725	93	118. 00
	REIMBURSABLE COST CENTERS DO PHYSICIANS' PRIVATE OFFICES	1, 208, 665	6, 651	145, 785	181, 222	1 105	192. 00
	D1 PRI VATE DUTY	1, 200, 003	0, 031		· ·		192. 01
	50 COMMUNITY RELATIONS	6, 713	112				194. 00
	51 COMMUNITY BENEFITS	49, 646	297			l	194. 01
	OTHER NONREIMBURSABLE COST CENTERS	0	8			0	194. 02
194. 03 0795	53 EMS	o	12	686	0	0	194. 03
200. 00	Cross Foot Adjustments	0					200. 00
201.00	Negative Cost Centers	0	0	_			201. 00
202. 00	TOTAL (sum lines 118-201)	6, 514, 110	29, 533	706, 323	1, 343, 416	1, 198	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

			To	12/31/2015	Date/Time Pre 5/26/2016 11:	pared:
Cost Center Description	OPERATION OF PLANT - HOSPITAL &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	47 (111)
	0FFS 7. 02	8. 00	9. 00	10. 00	11. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
1. 01   00101   NEW CAP REL COSTS-OFFSITE BLDG						1. 01
2.00   00200   NEW CAP REL COSTS-MVBLE EQUIP 2.01   00201   NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2. 00 2. 01
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
7.01   00701   OPERATION OF PLANT - OFFSITE 7.02   00702   OPERATION OF PLANT - HOSPITAL & OFFS	8, 001					7. 01 7. 02
8.00 00800 LAUNDRY & LINEN SERVICE	123	101, 386				8. 00
9. 00   00900   HOUSEKEEPI NG	132					9. 00
10. 00   01000   DI ETARY	59	117	910	51, 357		10.00
11. 00   01100   CAFETERI A	314	620		0	271, 060	1
13. 00 01300 NURSI NG ADMI NI STRATI ON	28	0		0	10, 628	1
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY	37	1, 672 0		0 0	0 7, 744	
16. 00 01600 MEDICAL RECORDS & LI BRARY	164			o	19, 287	1
INPATIENT ROUTINE SERVICE COST CENTERS			, , , , , , , , , , , , , , , , , , , ,	-,	,	
30. 00 03000 ADULTS & PEDIATRICS	840			48, 343	43, 638	1
31. 00   03100   INTENSIVE CARE UNIT	82	1, 294		3, 014	7, 530	1
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	42	5, 080	636	0	9, 672	43. 00
50. 00 05000 OPERATING ROOM	213	10, 795	3, 266	0	27, 254	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	74	479	1, 128	О	1, 829	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	911	11, 686		0	25, 932	
60. 00   06000   LABORATORY	227	0		0	30, 978	1
60. 01   06001   BLOOD LABORATORY 65. 00   06500   RESPI RATORY THERAPY	186	1	-	0 0	0 9, 479	
66. 00   06600   PHYSI CAL THERAPY	221	9, 013		ő	0,477	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	59			o	0	1
68.00 06800 SPEECH PATHOLOGY	32	0		0	0	
69. 00 06900 ELECTROCARDI OLOGY	127	211		0	9, 356	1
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00   07200   IMPL. DEV. CHARGED TO PATIENT	47 226	0 5, 364		0 0	0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			o	0	
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   RURAL HEALTH CLINIC	170	l e		0	0	
90. 00   09000   CLI NI C 90. 01   09001   WOUND CLI NC	468		7, 159 428	0	0	90. 00 90. 01
91. 00   09100   EMERGENCY	563	•		o	33, 055	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			2, 2.2		,	92. 00
OTHER REIMBURSABLE COST CENTERS						
101. 00 10100 HOME HEALTH AGENCY	154	0	2, 364	0	0	101. 00
SPECIAL PURPOSE COST CENTERS  113. 00 11300   INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	О	0	o	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5, 527	99, 703	80, 696	51, 357	236, 382	118. 00
NONREI MBURSABLE COST CENTERS				_1		
192. 00 19200  PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201  PRI VATE DUTY	2, 378			0		192. 00 192. 01
192.01 19201 PRIVATE DUTY 194.00 07950 COMMUNITY RELATIONS	11			ol Ol		194. 00
194. 01 07951 COMMUNITY BENEFITS	85	-	1, 295	Ö		194. 01
194.02 07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	o		194. 02
194. 03 07953 EMS	0	0	0	0	313	194. 03
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	_		0	0	200. 00 201. 00
202.00 TOTAL (sum lines 118-201)	8, 001	101, 386	124, 247	51, 357	271, 060	
						•

Provider CCN: 151329

Peri od:

ALLOCATION OF CAPITAL RELATED COSTS

From 01/01/2015 Part II 12/31/2015 Date/Time Prepared: 5/26/2016 11:49 am Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL Subtotal RECORDS & ADMI NI STRATI ON SERVICES & **SUPPLY** LI BRARY 13.00 15.00 24.00 14.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP REL COSTS-OFFSITE BLDG 1.01 1.01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7 00 7.01 00701 OPERATION OF PLANT -OFFSITE 7.01 7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS 7 02 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPING 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 45,012 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 1,673 14.00 15.00 01500 PHARMACY 1,976 15.00 75,810 01600 MEDICAL RECORDS & LIBRARY 16.00 170, 440 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 135 29 0 99, 406 951, 333 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 1,921 86, 773 04300 NURSERY 0 60, 245 43.00 43.00 2,468 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 884 0 9,860 249, 139 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 467 25 0 65, 113 52.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 6 614 106 0 41 453 929, 242 54 00 06000 LABORATORY 0 60.00 7,903 378 267, 675 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 0 0 65.00 06500 RESPIRATORY THERAPY 2,418 27 ol 175, 426 65.00 06600 PHYSI CAL THERAPY 0 0 207, 104 66.00 0 5 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 53, 944 67.00 06800 SPEECH PATHOLOGY 0 68.00 0 C 0 29, 175 68.00 69 00 06900 ELECTROCARDI OLOGY 1,597 10 0 1, 811 127, 946 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 C 67, 735 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 209, 745 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 75, 810 75, 810 73.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 72, 227 88.00 419, 398 09000 CLI NI C 0 0 6,842 90.00 60 90.00 90.01 09001 WOUND CLINC 0 46 0 26, 777 90.01 09100 EMERGENCY 0 91.00 6,842 91 00 8.433 32 554, 615 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 9 0 0 149, 483 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 116. 00 11600 HOSPI CE 14, 174 116. 00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 118.00 44, 932 75, 810 166, 214 4, 793, 079 118. 00 1,627 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 4, 226 1, 619, 491 192. 00 44 0 0 192. 01 19201 PRI VATE DUTY 0 0 192. 01 17, 768 194. 00 194, 00 07950 COMMUNITY RELATIONS 0 0 0 0 194. 01 07951 COMMUNITY BENEFITS 0 0 0 82, 527 194. 01 194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 154 194. 02 194. 03 07953 EMS 1, 091 194. 03 80 C 0 0 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00

45,012

1,673

75, 810

170, 440

6, 514, 110 202. 00

202.00

TOTAL (sum lines 118-201)

Provider CCN: 151329 | Period: | Worksheet B | From 01/01/2015 | Part II | To 1/21/2015 | Part II | Propagation Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				To 12/31/2015	Date/Time Prepared:
	Cost Center Description	Intern &	Total		5/26/2016 11: 49 am
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments 25.00	26. 00	_	
	GENERAL SERVICE COST CENTERS	20.00	20.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101 NEW CAP REL COSTS-OFFSITE BLDG				1. 01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
2. 01 4. 00	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2. 01
5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL				4. 00 5. 00
7. 00	00700 OPERATION OF PLANT				7.00
7. 01	00701 OPERATION OF PLANT -OFFSITE				7. 01
7.02	00702 OPERATION OF PLANT - HOSPITAL & OFFS				7. 02
8.00	00800 LAUNDRY & LINEN SERVICE				8. 00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON				11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00	01500 PHARMACY				15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	0	951, 333	l .	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	86, 773		31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	60, 245	)	43. 00
50. 00	05000 OPERATING ROOM	0	249, 139		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	65, 113	1	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	929, 242		54.00
60.00	06000 LABORATORY	0	267, 675		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
65. 00	06500 RESPI RATORY THERAPY	0	175, 426	1	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	207, 104 53, 944	1	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	29, 175	1	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	127, 946	1	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	67, 735	1	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	209, 745		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	75, 810	)	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS		70.007	,1	00.00
88. 00 90. 00	08800  RURAL HEALTH CLINIC   09000  CLINIC	0	72, 227 419, 398	l .	88. 00 90. 00
90. 00	09001 WOUND CLINC	0	26, 777	1	90. 01
91. 00	09100 EMERGENCY	0	554, 615	1	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92. 00
	OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY	0	149, 483	3	101. 00
112 00	SPECIAL PURPOSE COST CENTERS	1			113. 00
	11300   I NTEREST EXPENSE   11600   HOSPI CE	0	14, 174		116. 00
118. 00	1	0	4, 793, 079		118. 00
	NONREI MBURSABLE COST CENTERS		.,	1	
	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 619, 491		192. 00
	19201 PRI VATE DUTY	0	0	•	192. 01
	07950 COMMUNITY RELATIONS	0	17, 768		194. 00
	07951 COMMUNITY BENEFITS 2 07952 OTHER NONREIMBURSABLE COST CENTERS	0	82, 527	1	194. 01 194. 02
	307953 EMS		154 1, 091	•	194. 02
200.00	l l		1, 091	1	200. 00
201.00	1 1		0	•	201. 00
202.00	TOTAL (sum lines 118-201)	0	6, 514, 110	)	202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

			To	01/01/2013 0 12/31/2015	Date/Time Pre 5/26/2016 11:	
		CAPI TAL REI	ATED COSTS		372072010 11.	49 alli
Cost Center Description	NEW BLDG & FLXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
	1.00	1. 01	2. 00	2. 01	4. 00	
GENERAL SERVICE COST CENTERS  1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	216, 499					1. 00
1.01   O0100 NEW CAP REL COSTS-0EDG & FIXT	210, 499	48, 315				1. 00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	_		216, 499			2. 00
2.01   00201   NEW CAP REL COSTS-MVBLE EQUIP OFFSI 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	1, 113	0	0 1, 113	48, 315 0	33, 417, 670	2. 01 4. 00
5.00   00500   ADMINISTRATIVE & GENERAL	26, 454	0	26, 454	O	4, 951, 380	5. 00
7.00   00700   0PERATION OF PLANT 7.01   00701   0PERATION OF PLANT - 0FFSITE	49, 529	0	49, 529 0		0	7. 00 7. 01
7. 02 00702 OPERATION OF PLANT - HOSPITAL & OFF	s 0	0	0	o	489, 625	7. 02
8. 00   00800   LAUNDRY & LINEN SERVICE 9. 00   00900   HOUSEKEEPING	2, 725 2, 919	0	2, 725 2, 919		82, 256	8. 00 9. 00
10. 00   01000 DI ETARY	1, 315	0	2, 919 1, 315		640, 496 125, 005	1
11. 00 01100 CAFETERI A	6, 942	0	6, 942	0	660, 018	1
13. 00   01300   NURSI NG ADMINI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY	617	0	617	0	698, 209 0	13. 00 14. 00
15. 00   01500   PHARMACY	829	0	829	0	566, 420	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	3, 633	0	3, 633	0	888, 657	16. 00
30. 00 03000 ADULTS & PEDIATRICS	18, 571	0	18, 571	0	2, 066, 859	30. 00
31. 00   03100   INTENSIVE CARE UNIT 43. 00   04300   NURSERY	1, 803 919	0			362, 382	31.00
ANCI LLARY SERVI CE COST CENTERS	919	0	919	U <sub>I</sub>	503, 351	43. 00
50. 00 05000 OPERATING ROOM	4, 719	0			1, 329, 180	50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM 54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 630 20, 139	0		0	95, 169 2, 650, 194	52. 00 54. 00
60. 00 06000 LABORATORY	5, 023	0	5, 023	0	1, 229, 700	60. 00
60. 01   06001   BLOOD LABORATORY 65. 00   06500   RESPI RATORY THERAPY	0 4, 120	0	0 4, 120	0	0 439, 596	60. 01 65. 00
66. 00   06600   PHYSI CAL THERAPY	4, 890	0	4, 890		967, 266	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	1, 302 707	0	1, 302 707	0	333, 664	67.00
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	2, 816	0	2, 816	ŭ	177, 653 532, 650	68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0	.,		0	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENT 73.00 O7300 DRUGS CHARGED TO PATIENTS	4, 997 0	0	.,	0	0	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS			_			
88. 00   08800 RURAL HEALTH CLINIC 90. 00   09000 CLINIC	0 10, 342	3, 750 0	l	3, 750 0	503, 716 1, 428, 581	88. 00 90. 00
90. 01   09001   WOUND CLINC	618	0	618	0	225, 595	90. 01
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART	12, 450	0	12, 450	0	1, 554, 112	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	3, 415	0	3, 415	0	1, 262, 287	101. 00
113. 00 11300   NTEREST EXPENSE						113. 00
116.00 11600 HOSPICE 118.00  SUBTOTALS (SUM OF LINES 1-117)	0 195, 570	0 3, 750	-	0 3, 750	634, 181 25, 398, 202	
NONREI MBURSABLE COST CENTERS	195, 570	3, 750	195, 570	3, 750	23, 396, 202	1116.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	18, 805	44, 565	· ·		7, 533, 468	1
192. 01 19201 PRI VATE DUTY 194. 00 07950  COMMUNI TY RELATI ONS	253	0	253	0	126, 648	192. 01 194. 00
194.01 07951 COMMUNITY BENEFITS	1, 871	0	1, 871	0	336, 424	194. 01
194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS 194. 03 07953 EMS	0	0	0	0	9, 567 13, 361	194. 02 194. 03
200.00 Cross Foot Adjustments	Ĭ	0		Š	10, 001	200. 00
201.00 Negative Cost Centers	2 127 070	(10.027	2 /1/ 721	1E0 E70	12 141 252	201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	2, 127, 979	610, 827	3, 616, 731	158, 573	12, 141, 253	ZUZ. UU
203.00 Unit cost multiplier (Wkst. B, Part	9. 829048	12. 642595	16. 705532	3. 282066	0. 363318	1
204.00 Cost to be allocated (per Wkst. B, Part II)					29, 533	204. 00
205.00 Unit cost multiplier (Wkst. B, Part	:				0. 000884	205. 00
1 )	ı		l l			I

		RGARET MARY COM			In Lie	u of Form CMS-	
COST A	ILLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 01/01/2015 To 12/31/2015	Worksheet B-1 Date/Time Pre 5/26/2016 11:	pared:
	Cost Center Description	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SOUARE FEET)	47 2111
		5A	5. 00	7. 00	7. 01	7. 02	
	GENERAL SERVICE COST CENTERS	1		1	T		
1. 00 1. 01 2. 00 2. 01 4. 00 5. 00 7. 00 7. 01 7. 02 8. 00 9. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-OFFSITE BLDG 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - OFFSITE 00702 OPERATION OF PLANT - HOSPITAL & OFFS 00800 LAUNDRY & LINEN SERVICE	-12, 188, 436 0 0 0 0 0	2, 609, 210 107, 129 676, 593 234, 451 1, 210, 291	139, 403 ( ( 2, 725 2, 919	0 48, 315 0 0 5 0	176, 960 2, 725 2, 919	8. 00 9. 00
10.00	01000 DI ETARY	0	231, 909	1, 315	5 0	1, 315	1
11. 00	01100 CAFETERI A	0	1, 219, 083			6, 942	1
13.00	01300 NURSI NG ADMI NI STRATI ON	0	982, 889			617	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	107	1		0	
15.00	01500   PHARMACY   01600   MEDI CAL RECORDS & LI BRARY	0	3, 128, 480	1		829	1
16. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	J U	1, 455, 141	3, 633	S  U	3, 633	16. 00
30. 00	03000 ADULTS & PEDIATRICS	0	3, 274, 846	18, 571	ıl ol	18, 571	30.00
31. 00	03100   NTENSI VE CARE UNI T	l o	549, 264	1		1, 803	1
43. 00	04300 NURSERY	0	774, 359			919	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	2, 235, 078	4, 719	0	4, 719	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	184, 877			1, 630	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	8, 743, 866			20, 139	1
60.00	06000 LABORATORY	0	3, 749, 325			5, 023	1
60. 01 65. 00	06001   BLOOD LABORATORY   06500   RESPI RATORY THERAPY	0	0 794, 921	1		0 4, 120	
66. 00	06600 PHYSI CAL THERAPY	0	1, 497, 193	1		4, 120	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	499, 662			1, 302	1
68. 00	06800 SPEECH PATHOLOGY	O	261, 458	1		707	1
69.00	06900 ELECTROCARDI OLOGY	0	943, 554	1	6 0	2, 816	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 647, 145	1, 033	0	1, 033	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 783, 276	4, 997		4, 997	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS		000 (00	1		0.750	
88. 00	08800 RURAL HEALTH CLINIC	0	822, 683	1		3, 750	1
90. 00 90. 01	09001 WOUND CLINC	0	1, 855, 998 332, 751	1		10, 342 618	1
	09100 EMERGENCY	0	2, 881, 248	1			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,00.,2.0	12, 130	1	12, 100	92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	1, 995, 110	3, 415	5 0	3, 415	101. 00
	SPECIAL PURPOSE COST CENTERS	1		T	T		
	11300 I NTEREST EXPENSE		4 04/ /00				113.00
118.00	11600 HOSPICE   SUBTOTALS (SUM OF LINES 1-117)	12 100 424	1, 216, 698 48, 898, 595		0 1 3, 750	122, 224	116.00
110.00	NONREI MBURSABLE COST CENTERS	-12, 188, 436	40, 090, 393	118, 474	3, 730	122, 224	1110.00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	13, 035, 027	18, 805	44, 565	52, 612	192. 00
	19201 PRI VATE DUTY	l o	0	.5,555	0		192. 01
	07950 COMMUNITY RELATIONS	0	518, 593	253	s o		194. 00
	07951 COMMUNITY BENEFITS	0	623, 725	1, 871	0		194. 01
	07952 OTHER NONREIMBURSABLE COST CENTERS	0	13, 070	ı			194. 02
	07953 EMS	0	61, 345	(		0	194. 03
200.00	1 1						200.00
201. 00 202. 00			12, 188, 436	3, 112, 806	127, 806	807, 180	201.00
202.00	Part I)		12, 100, 430	3, 112, 000	127, 000	007, 100	202.00
203.00	1 1 '		0. 193007	22. 329548	2. 645265	4. 561370	203. 00
204.00	1		706, 323	1			204. 00
	Part II)						
205.00			0. 011185	9. 636923	0. 024796	0. 045214	205. 00
	1 )	í l		I	ı l		I

Heal th	Financial Systems MAF	RGARET MARY COM	<u>MUNITY HOSPITAI</u>	L	In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
				Fr   To	rom 01/01/2015 12/31/2015	Date/Time Pre	narod:
				10	12/31/2013	5/26/2016 11:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	· ·	LINEN SERVICE	(SQUARE	(MEALS	(HOURS OF	ADMI NI STRATI ON	
		(POUNDS OF	FEET)	SERVED)	SERVICE)		
		LAUNDRY)				(HOURS OF	
						SERVICE)	
		8. 00	9. 00	10. 00	11. 00	13. 00	
1 00	GENERAL SERVICE COST CENTERS					I	4 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	OO101 NEW CAP REL COSTS-OFFSITE BLDG   OO200 NEW CAP REL COSTS-MVBLE EQUIP						1. 01
2. 00 2. 01	00200 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2. 00 2. 01
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
7. 01	00701 OPERATION OF PLANT -OFFSITE						7. 01
7.02	00702 OPERATION OF PLANT - HOSPITAL & OFFS						7. 02
8.00	00800 LAUNDRY & LINEN SERVICE	276, 276					8. 00
9.00	00900 HOUSEKEEPI NG	12, 067	179, 496				9. 00
10.00	01000 DI ETARY	320	1, 315	17, 654			10. 00
	01100 CAFETERI A	1, 689	6, 942		432, 311	1	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	617		16, 950		1
	01400 CENTRAL SERVICES & SUPPLY	4, 555	0		0	0	14. 00
	01500 PHARMACY	0	829		12, 351	12, 351	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	3, 633	0	30, 760	0	16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	(7,000	10 571	1/ /10	/O F00	(0.500	20.00
	03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT	67, 830	18, 571	16, 618	69, 599		
43.00	04300 NURSERY	3, 526 13, 843	1, 803 919		12, 010	1	
43.00	ANCILLARY SERVICE COST CENTERS	13, 643	919	<u> </u>	15, 426	15, 420	43.00
50. 00	05000 OPERATING ROOM	29, 416	4, 719	O	43, 467	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 304	1, 630		2, 917		1
	05400 RADI OLOGY-DI AGNOSTI C	31, 843	20, 139		41, 359		1
60.00	06000 LABORATORY	0	5, 023		49, 406		
60. 01	06001 BLOOD LABORATORY	o	0		0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	5, 879	4, 120	0	15, 118	15, 118	65. 00
66.00	06600 PHYSI CAL THERAPY	24, 560	4, 890	0	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 302	0	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	707		0	0	68. 00
	06900 ELECTROCARDI OLOGY	575	2, 816		14, 922	9, 986	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 033		0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	14, 617	4, 997		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	0	3, 750	O	0	0	88. 00
	09000 CLINIC	23, 874	10, 342		0		90.00
	09001 WOUND CLINC	25, 674	618		0	0	90. 00
	09100 EMERGENCY	35, 793	12, 450		52, 719		1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	33,773	12, 430		32,717	32,717	92.00
, 2. 00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	0	3, 415	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS			'			1
113.00	11300   NTEREST EXPENSE						113. 00
116.00	11600 H0SPI CE	0	0		0		116. 00
118.00		271, 691	116, 580	17, 654	377, 004	280, 879	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	4, 585	60, 792		40, 911		192. 00
	19201 PRI VATE DUTY	0	0	0	0		192. 01
	07950 COMMUNITY RELATIONS	0	253		4, 017	l e	194. 00
	07951 COMMUNITY BENEFITS	0	1, 871		9, 880		194. 01
	07952 OTHER NONREIMBURSABLE COST CENTERS 07953 EMS	0	0	0	0 499		194. 02 194. 03
200.00	Cross Foot Adjustments	U	U	U	499	499	200.00
200.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	352, 980	1, 537, 798	323, 705	1, 702, 684	1, 261, 229	
202.00	Part I)	332, 700	1, 337, 770	323, 703	1, 702, 004	1, 201, 227	
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 277635	8. 567311	18. 336071	3. 938563	4. 482330	203. 00
204.00	Cost to be allocated (per Wkst. B,	101, 386			271, 060		204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 366974	0. 692199	2. 909086	0. 627002	0. 159970	205. 00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329 Pe

Peri od: Worksheet B-1 From 01/01/2015 To 12/31/2015 Date/Ti me Prepared:

5/26/2016 11:49 am Cost Center Description CENTRAL PHARMACY MEDI CAL SERVICES & RECORDS & (100% SUPPLY PHARMACY) LI BRARY (COSTED (TIME REQUIS.) SPENT) 15.00 14.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP REL COSTS-OFFSITE BLDG 1.01 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 7.01 00701 OPERATION OF PLANT -OFFSITE 7.01 00702 OPERATION OF PLANT - HOSPITAL & OFFS 7.02 7 02 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERIA 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 5, 545, 548 14.00 01500 PHARMACY 15 00 1 227 100 15 00 01600 MEDICAL RECORDS & LIBRARY 16.00 1, 709 0 847 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 97, 185 494 30.00 03100 INTENSIVE CARE UNIT O 31 00 8, 660 C 31.00 43.00 04300 NURSERY 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 932, 724 0 49 50.00 05200 DELIVERY ROOM & LABOR ROOM O 52.00 52.00 82, 694 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 352, 226 0 206 54.00 06000 LABORATORY 1, 250, 331 0 60.00 0 60.00 06001 BLOOD LABORATORY 60.01 0 0 60.01 06500 RESPIRATORY THERAPY 0 89.267 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 17, 904 0 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 16, 537 67.00 68.00 06800 SPEECH PATHOLOGY 958 0 0 68.00 06900 ELECTROCARDI OLOGY 9 69 00 34, 486 0 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 0 C 0 72.00 07300 DRUGS CHARGED TO PATIENTS 100 0 73.00 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 8.819 0 0 88.00 90.00 09000 CLI NI C 197, 951 34 90.00 0 09001 WOUND CLINC 90.01 C 0 90.01 151, 561 91.00 09100 EMERGENCY 106, 927 C 34 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 30, 252 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 13, 256 116, 00  $\cap$ 118.00 SUBTOTALS (SUM OF LINES 1-117) 5, 394, 674 100 826 118. 00 NONREI MBURSABLE COST CENTERS 192, 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192.00 145,049 21 192. 01 19201 PRI VATE DUTY 0 0 0 192. 01 194. 00 07950 COMMUNITY RELATIONS 0 0 0 194.00 194. 01 07951 COMMUNITY BENEFITS 5,825 0 0 194.01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS Ω 0 194. 02 0 194. 03 07953 EMS 0 C 0 194. 03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 5.948 3, 865, 700 1, 985, 964 202 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.001073 38,657.000000 2, 344. 703660 203.00 204.00 Cost to be allocated (per Wkst. B, 1.673 75, 810 170, 440 204.00 Part II) 205.00 0.000302 205. 00 Unit cost multiplier (Wkst. B, Part 758 100000 201 227863 II)

Health Financial Systems	MARGARET MARY COMMUNITY	Y HOSPITAL		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN:	151329	Peri od:	Worksheet C
				From 01/01/2015	
COMM CHATTON OF TAXIFO OF COSTS TO CHARGES		Troviaci con.	101027		Part I

				T	o 12/31/2015	Date/Time Pre 5/26/2016 11:	
			Ti +I	e XVIII	Hospi tal	Cost	47 (1111
	·		11 (1	L XVIII	Costs	0031	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	oost contor boson per on	(from Wkst. B,	Adj.	lotal oosts	Di sal I owance	10141 00313	
		Part I, col.	, naj .		Di Sai i Gwanee		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	6, 701, 253		6, 701, 253	0	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	843, 852		843, 852		0	31.00
43.00	04300 NURSERY	1, 103, 988		1, 103, 988		0	1
	ANCILLARY SERVICE COST CENTERS	,					
50.00	05000 OPERATI NG ROOM	3, 160, 607		3, 160, 607	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	304, 676		304, 676	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 017, 885		12, 017, 885	0	0	54.00
60.00	06000 LABORATORY	5, 068, 463		5, 068, 463	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0		0	0	0	60. 01
65.00	06500 RESPIRATORY THERAPY	1, 229, 348	l c	1, 229, 348	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 990, 950	C	1, 990, 950	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	642, 285	l c	642, 285	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	336, 991	l c	336, 991	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 350, 924		1, 350, 924	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 194, 691		3, 194, 691	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	2, 323, 321		2, 323, 321	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 865, 700		3, 865, 700	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	1, 040, 628		1, 040, 628	0	0	88. 00
90.00	09000 CLI NI C	2, 691, 362		2, 691, 362	0	0	90.00
90. 01	09001 WOUND CLINC	419, 051		419, 051	0	0	90. 01
91.00	09100 EMERGENCY	4, 448, 310		4, 448, 310	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 189, 030		1, 189, 030		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	2, 501, 301		2, 501, 301		0	101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	1, 451, 543		1, 451, 543		0	116. 00
200.00	Subtotal (see instructions)	57, 876, 159	C	57, 876, 159	0	0	200. 00
201.00	Less Observation Beds	1, 189, 030		1, 189, 030		0	201. 00
202.00	Total (see instructions)	56, 687, 129	[ c	56, 687, 129	0	0	202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 151329 Peri od: Worksheet C From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/26/2016 11:49 am Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 4, 732, 165 4, 732, 165 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 495, 255 495, 255 31.00 04300 NURSERY 2, 227, 221 2, 227, 221 43.00 43.00 ANCILLARY SERVICE COST CENTERS 0.000000 50.00 3, 670, 928 12, 369, 321 16, 040, 249 0.197042 50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 188,075 31, 726 219, 801 1. 386145 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 358, 258 50, 277, 154 51, 635, 412 0. 232745 0.000000 54.00 06000 LABORATORY 60.00 3, 024, 801 20, 719, 397 23, 744, 198 0.213461 0.000000 60.00 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 60 01 65.00 06500 RESPIRATORY THERAPY 2, 086, 601 687, 315 2, 773, 916 0.443181 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 247, 543 3, 163, 128 3, 410, 671 0.583741 0.000000 66.00 06700 OCCUPATIONAL THERAPY 1, 083, 240 979, 387 0.592930 0.000000 67.00 103,853 67.00 68.00 06800 SPEECH PATHOLOGY 68,748 305, 510 374, 258 0.900424 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 457, 930 3, 724, 398 4, 182, 328 0. 323008 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 241, 096 4, 229, 055 7, 470, 151 0.427661 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 1, 223, 434 1, 124, 307 2. 347. 741 0 989599 0.000000 72 00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 439, 886 8, 360, 662 11, 800, 548 0.327586 0.00000073.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 637, 463 88.00 637, 463 90.00 09000 CLI NI C 166, 685 5, 577, 799 5, 744, 484 0.468512 0.000000 90.00 90.01 09001 WOUND CLINC 5,045 1, 430, 288 1, 435, 333 0. 291954 0.000000 90.01 91.00 09100 EMERGENCY 251, 513 6, 682, 000 6, 933, 513 0.641567 0.000000 91.00 13, 985 1. 260708 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 929 160 943, 145 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 25 1, 871, 486 1, 871, 511 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 782, 338 1, 782, 338 116. 00

27, 003, 047

27, 003, 047

124, 881, 894

124, 881, 894

151, 884, 941

151, 884, 941

200.00

201 00

202.00

200.00

201 00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Health Financial Systems	MARGARET MARY COMMUNI	TY HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 151329	Peri od: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/26/2016 11:49 am

				5/26/2016 11:49 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Rati o			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDIATRICS				30.00
31.00  03100   INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 000000			50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00   06000   LABORATORY	0. 000000			60.00
60. 01   06001   BLOOD LABORATORY	0. 000000			60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88. 00
90. 00  09000   CLI NI C	0. 000000			90.00
90. 01  09001 WOUND CLINC	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	· ·			
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300   I NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151329	
		From 01/01/2015   Part   To 12/31/2015   Date/Time Prepared

				Γο 12/31/2015	Date/Time Pre 5/26/2016 11:	
		Ti t	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				_1 _1		
30. 00   03000   ADULTS & PEDI ATRI CS	6, 701, 253		6, 701, 25		6, 701, 253	
31. 00   03100   INTENSIVE CARE UNIT	843, 852		843, 85		843, 852	31.00
43. 00 04300 NURSERY	1, 103, 988		1, 103, 98	3 0	1, 103, 988	43. 00
ANCILLARY SERVICE COST CENTERS	0.4/0./07		0.440.40	-l ol	0.4/0./07	F0 00
50. 00 05000 OPERATING ROOM	3, 160, 607		3, 160, 60		3, 160, 607	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	304, 676		304, 67		304, 676	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 017, 885		12, 017, 88	1	12, 017, 885	1
60. 00 06000 LABORATORY	5, 068, 463		5, 068, 46	3	5, 068, 463	
60. 01   06001   BL00D LABORATORY 65. 00   06500   RESPI RATORY   THERAPY	1 220 240	0	1 220 24		1 220 240	60. 01 65. 00
	1, 229, 348	0	., == .,	1	1, 229, 348	
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	1, 990, 950	0	1, 990, 950	1	1, 990, 950	1
	642, 285	0	642, 28	1	642, 285 336, 991	
	336, 991	U	336, 99	1		
69. 00 06900 ELECTROCARDI OLOGY	1, 350, 924		1, 350, 92	1	1, 350, 924	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 194, 691		3, 194, 69		3, 194, 691	1
72.00   07200   IMPL. DEV. CHARGED TO PATIENT 73.00   07300   DRUGS CHARGED TO PATIENTS	2, 323, 321		2, 323, 32		2, 323, 321	1
73.00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	3, 865, 700		3, 865, 70	기 이	3, 865, 700	73. 00
88. 00 08800 RURAL HEALTH CLINIC	1, 040, 628		1, 040, 62		1, 040, 628	88. 00
90. 00   09000  CLI NI C	2, 691, 362		2, 691, 36	1	2, 691, 362	
90. 01   09001   WOUND CLI NC	419, 051		419, 05	1	419, 051	1
91. 00   09100   EMERGENCY	4, 448, 310		4, 448, 310	1	4, 448, 310	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 189, 030		1, 189, 030	1	1, 189, 030	
OTHER REIMBURSABLE COST CENTERS	1, 107, 030		1, 107, 03	اــــــــــــا	1, 107, 030	72.00
101. 00 10100 HOME HEALTH AGENCY	2, 501, 301		2, 501, 30	1	2, 501, 301	101 00
SPECIAL PURPOSE COST CENTERS	2,001,001		2,001,00	'	2,001,001	1101.00
113. 00 11300   NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	1, 451, 543		1, 451, 54	3	1, 451, 543	
200.00 Subtotal (see instructions)	57, 876, 159	0			57, 876, 159	
201.00 Less Observation Beds	1, 189, 030		1, 189, 030		1, 189, 030	
202.00 Total (see instructions)	56, 687, 129	0		1		

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 151329 Peri od: Worksheet C From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/26/2016 11:49 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 4, 732, 165 4, 732, 165 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 495, 255 495, 255 31.00 04300 NURSERY 2, 227, 221 2, 227, 221 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 3, 670, 928 12, 369, 321 16, 040, 249 0.197042 0.000000 50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 188,075 31, 726 219, 801 1. 386145 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 358, 258 50, 277, 154 51, 635, 412 0. 232745 0.000000 54.00 06000 LABORATORY 60.00 3, 024, 801 20, 719, 397 23, 744, 198 0.213461 0.000000 60.00 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 60 01 65.00 06500 RESPIRATORY THERAPY 2, 086, 601 687, 315 2, 773, 916 0.443181 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 247, 543 3, 163, 128 3, 410, 671 0.583741 0.000000 66.00 06700 OCCUPATIONAL THERAPY 1, 083, 240 979, 387 0.592930 0.000000 67.00 103,853 67.00 68.00 06800 SPEECH PATHOLOGY 68,748 305, 510 374, 258 0.900424 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 457, 930 3, 724, 398 4, 182, 328 0. 323008 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 241, 096 4, 229, 055 7, 470, 151 0.427661 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 1, 223, 434 1, 124, 307 2. 347. 741 0 989599 0.000000 72 00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 439, 886 8, 360, 662 11, 800, 548 0.327586 0.00000073.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 637, 463 0.000000 88.00 637, 463 1.632452 90.00 09000 CLI NI C 166, 685 5, 577, 799 5, 744, 484 0.468512 0.000000 90.00 90.01 09001 WOUND CLINC 5,045 1, 430, 288 1, 435, 333 0.291954 0.000000 90.01 91.00 09100 EMERGENCY 251, 513 6, 682, 000 6, 933, 513 0.641567 0.000000 91.00 13, 985 1. 260708 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 929 160 943, 145 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 25 1, 871, 486 1, 871, 511 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00

27, 003, 047

27, 003, 047

1, 782, 338

124, 881, 894

124, 881, 894

1, 782, 338

151, 884, 941

151, 884, 941

116. 00

200.00

201 00

202.00

116. 00 11600 HOSPI CE

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

201 00

202.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15	From 01/01/2015	Worksheet C Part I Date/Time Prepared: 5/26/2016 11:49 am

				5/26/2016 11:49 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00  03000 ADULTS & PEDIATRICS				30.00
31.00   03100   INTENSIVE CARE UNIT				31. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 000000			50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00  06000 LABORATORY	0. 000000			60.00
60. 01   06001   BLOOD LABORATORY	0. 000000			60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS				
88.00   08800   RURAL HEALTH CLINIC	0. 000000			88. 00
90. 00  09000  CLI NI C	0. 000000			90. 00
90. 01  09001 WOUND CLINC	0. 000000			90. 01
91. 00  09100 EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202. 00

ealth Financial Systems MARGARET MARY COMMUNIT		TY HOSPITAL	In Lie	u of Form CMS-2552-10
ADDODTIONMENT OF INDATIENT ANCIL	LADV SEDVICE CADITAL COSTS	Drovi don CCN: 151220	Pori od:	Workshoot D

Health Financial Systems MA	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS			Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/26/2016 11:	
			e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00				
ANOLILIABLY OF DUTY OF AGOT OF MITTERS	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.40, 4.00	1/ 0/0 0/0	0.04550	1 000 010	40 (70	F0 00
50. 00   05000   OPERATI NG ROOM	249, 139		•			
52. 00   05200   DELI VERY ROOM & LABOR ROOM	65, 113		•		766	52.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	929, 242		•			54.00
60. 00   06000   LABORATORY	267, 675				17, 544	60.00
60. 01   06001   BLOOD   LABORATORY	0	-	0. 00000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY	175, 426					65. 00
66. 00 06600 PHYSI CAL THERAPY	207, 104					66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	53, 944					67. 00
68. 00 06800 SPEECH PATHOLOGY	29, 175					68. 00
69. 00  06900   ELECTROCARDI OLOGY	127, 946					69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	67, 735					71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	209, 745					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	75, 810	11, 800, 548	0. 00642	4 1, 711, 989	10, 998	73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	72, 227				0	88. 00
90. 00  09000  CLI NI C	419, 398					90.00
90. 01  09001 WOUND CLINC	26, 777					90. 01
91. 00   09100   EMERGENCY	554, 615					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	168, 798		•		0	92.00
200.00   Total (lines 50-199)	3, 699, 869	140, 776, 451		9, 225, 510	257, 537	200. 00

Cost Center Description  Non Physician Nursing School Allied Health All Other Medical Sum of col 1  Cost  Cost  Cost  1.00  2.00  3.00  4.00  5/26/2016 11: 49 am  5/26/2016 11: 49 am  Cost  Cost  Total Cost (sum of col 1  Education Cost 4)  1.00  5.00
Cost Center Description  Non Physician Nursing School Allied Health Medical (sum of col 1 Education Cost through col. 4)  1.00 2.00 3.00 4.00 5.00
Anesthetist Cost Medical (sum of col 1 through col. 4)  1.00 2.00 3.00 4.00 5.00
Cost Education Cost through col. 4)  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
ANCILLARY SERVICE COST CENTERS
50. 00 05000 OPERATING ROOM 0 0 0 50. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   0   0   52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0   0   0   54. 00
60. 00   06000   LABORATORY   0 0 0 0 0 0 60. 00
60. 01   06001   BLOOD LABORATORY   0   0   0   0   60. 01
65. 00   06500   RESPI RATORY THERAPY   0   0   0   65. 00
66. 00   06600   PHYSI CAL THERAPY   0   0   0   66. 00
67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   67. 00
68. 00   06800   SPEECH PATHOLOGY   0   0   0   68. 00
69. 00   06900   ELECTROCARDI OLOGY   0   0   0   69. 00
71.00  07100  MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENT   0 0 0 0 0 72.00
73. 00   <u>07300   DRUGS CHARGED TO PATIENTS   0 0 0 0 0 73. 00 </u>
OUTPATIENT SERVICE COST CENTERS
88.00   08800   RURAL HEALTH CLINIC   0 0 0 0 0 88.00
90. 00   09000  CLI NI C   0   0   0   0   90. 00
90. 01   09001   WOUND_CLI NC   0   0   0   0   90. 01
91. 00   09100   EMERGENCY   0   0   0   91. 00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   92. 00
200.00   Total (lines 50-199)   0   0   0   0   0   200.00

	<u> </u>	ARGARET MARY COM				u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der		Period: From 01/01/2015	Worksheet D Part IV	
THRUUG	H COSTS				To 12/31/2015		pared:
						5/26/2016 11:	49 am
				e XVIII	Hospi tal	Cost	
	Cost Center Description	Total		Ratio of Cost		Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col . 5 ÷ col		Charges	
		col. 2, 3 and	8)	7)	(col . 6 ÷ col .		
		4)	7.00		7)	40.00	
	ANOULL ARV. CERVILOE, COCT. CENTERS	6.00	7. 00	8. 00	9. 00	10.00	
FO 00	ANCILLARY SERVICE COST CENTERS	1 0	1/ 0/0 0/4	0.00000	0 000000	1 202 212	
50.00	05000 OPERATING ROOM		16, 040, 249	1		1, 202, 212	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		219, 801	1			
54.00	05400 RADI OLOGY-DI AGNOSTI C		51, 635, 412	1			
60.00	06000 LABORATORY		23, 744, 198	1		1, 556, 287	
60. 01	06001 BLOOD LABORATORY 06500 RESPIRATORY THERAPY		2 772 01/	0.0000		1 204 520	00.0.
65. 00	06600 PHYSI CAL THERAPY		2, 773, 916	1		1, 394, 538 159, 562	
66. 00 67. 00			3, 410, 671	1			
	06700 OCCUPATI ONAL THERAPY		1, 083, 240	1		66, 883	
68. 00 69. 00	06800   SPEECH PATHOLOGY   06900   ELECTROCARDI OLOGY		374, 258 4, 182, 328	1			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS						
71.00	07200 MPL. DEV. CHARGED TO PATIENT		7, 470, 151 2, 347, 741	1		1, 261, 073	
	07300 DRUGS CHARGED TO PATIENTS		11, 800, 548				
73.00	OUTPATIENT SERVICE COST CENTERS		11, 600, 540	o. 00000	0.00000	1, /11, 707	73.00
88. 00	08800 RURAL HEALTH CLINIC		637, 463	0.00000	0. 000000	0	88. 00
90. 00	09000 CLINIC		5, 744, 484			J	
90.00	09001 WOUND CLINC		1, 435, 333				
91. 00	09100 EMERGENCY		6, 933, 513	1			
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		943, 145	1		33, 134	1
200.00	,			1	0.000000	9. 225. 510	

140, 776, 451

9, 225, 510 200. 00

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART) 200. 00 | Total (lines 50-199)

Health Financial Systems	MARGARET MARY CO	OMMUNITY HOSPITAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AND THROUGH COSTS	ICILLARY SERVICE OTHER PA		From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared:

					5/26/2016 11:49 am	_
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12. 00	13. 00			
ANCI LLARY SERVI CE COST CENTERS						
50.00   05000   OPERATING ROOM	0	C	) (		50. 00	
52.00  05200   DELIVERY ROOM & LABOR ROOM	0	C	) (	O	52.00	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	C	) (	O	54.00	
60. 00  06000   LABORATORY	0	C	) (	O	60.00	
60. 01  06001   BL00D   LABORATORY	0	C	) (	O	60. 01	
65. 00  06500  RESPI RATORY THERAPY	0	C	) (	O	65.00	Э
66. 00   06600 PHYSI CAL THERAPY	0	C	) (		66.00	Э
67. 00  06700 OCCUPATI ONAL THERAPY	0	C	) (		67.00	Э
68. 00   06800   SPEECH PATHOLOGY	0	C	) (		68.00	Э
69. 00   06900   ELECTROCARDI OLOGY	0	C	) (		69.00	Э
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	) (		71.00	Э
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C	) (		72. 00	Э
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	) (		73. 00	Э
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C	) (	D	88. 00	O
90. 00  09000   CLINIC	0	C			90.00	O
90. 01   09001   WOUND CLI NC	0	C			90. 01	1
91. 00 09100 EMERGENCY	o	C			91. 00	O
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C			92. 00	O
200.00 Total (lines 50-199)	0	C	) (		200. 00	Э

Health Financial Systems	MARGARET MARY COMMUNI	TY HOSPI TAL	In Lie	u of Form CMS-2552-10
ADDODTIONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151320	Pari ad:	Workshoot D

Hearth Finar	nciai systems - MA	RGARET MARY COM	INUNITY HUSPITA	L	In Lie	u of Form CMS-2	2552-10
APPORTI ONME	NT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
					From 01/01/2015		
					To 12/31/2015		
			T: +1	o VVIII	Hooni tal	5/26/2016 11:	49 am_
			11 (1	e XVIII	Hospi tal	Cost	
	Ct Ct Diti	0+ +- 0	DDC D-!	Charges	0+	Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To Ded. & Coins	Subject To Ded. & Coins.		
		1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
ANCLI	LARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	O OPERATING ROOM	0. 197042	1 0	2, 989, 94	E 0	0	50.00
	D DELIVERY ROOM & LABOR ROOM	1. 386145		2, 969, 94		0	
						0	
	RADI OLOGY-DI AGNOSTI C	0. 232745	0	17, 872, 62		ı	54.00
	LABORATORY	0. 213461	0	5, 432, 41		0	60.00
	1 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
	RESPI RATORY THERAPY	0. 443181	0	247, 05		0	65. 00
	PHYSI CAL THERAPY	0. 583741	0	836, 16		0	66. 00
	OCCUPATIONAL THERAPY	0. 592930		241, 05		0	67. 00
	SPEECH PATHOLOGY	0. 900424		34, 55		0	00.00
	ELECTROCARDI OLOGY	0. 323008	0	1, 430, 86		0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 427661	0	1, 238, 75		0	
	IMPL. DEV. CHARGED TO PATIENT	0. 989599		385, 42		0	
	DRUGS CHARGED TO PATIENTS	0. 327586	0	3, 047, 13	9 825	0	73. 00
	ATLENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC	0. 000000				0	
	CLI NI C	0. 468512		1, 755, 60		0	
90. 01   09001	1 WOUND CLINC	0. 291954	0	586, 72	3 53	0	90. 01
91.00 09100	EMERGENCY	0. 641567	0	1, 785, 90	6 0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	1. 260708	0	409, 44	3 527	0	92.00
200. 00	Subtotal (see instructions)		0	38, 294, 08	6 4, 747	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	38, 294, 08	6 4, 747	0	202. 00
	, , , , , , , , , , , , , , , , , , , ,	•	•	•	•	•	•

				To 12/31/2015	Date/Time Pre 5/26/2016 11:	pared: 49 am
		Ti tl	e XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLILIARY OFFICE OFFICE	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	500 445	_	1			
50. 00   05000   OPERATI NG ROOM	589, 145	l .	1			50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	563	l .				52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	4, 159, 764	l .	1			54.00
60. 00   06000   LABORATORY	1, 159, 609	0				60.00
60. 01   06001   BLOOD   LABORATORY	0	0	1			60. 01
65. 00 06500 RESPI RATORY THERAPY	109, 490	l	1			65. 00
66. 00   06600   PHYSI CAL THERAPY	488, 103	l .	1			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	142, 929	l e	1			67. 00
68. 00 06800 SPEECH PATHOLOGY	31, 116		1			68. 00
69. 00 06900 ELECTROCARDI OLOGY	462, 182		1			69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	529, 769	ł	1			71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	381, 412	l e	1			72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	998, 200	270	1			73. 00
OUTPATIENT SERVICE COST CENTERS	1					
88. 00 08800 RURAL HEALTH CLINIC	0	0	1			88. 00
90. 00   09000   CLI NI C	822, 521	0				90.00
90. 01   09001   WOUND   CLI NC	171, 296	l e	1			90. 01
91. 00   09100   EMERGENCY	1, 145, 778	l e	1			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	516, 188	l e	1			92.00
200.00 Subtotal (see instructions)	11, 708, 065	1, 727				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges	11 700 0/5	1 707	ŀ			202 00
202.00   Net Charges (line 200 +/- line 201)	11, 708, 065	1, 727	I			202. 00

Health Financial Systems	MARGARET MARY COMMUNITY	In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST	P		Peri od: From 01/01/2015	Worksheet D-1	
			To 12/31/2015	Date/Time Prep 5/26/2016 11:	
		Title XVIII	Hospi tal	Cost	
Cost Center Description					

		Title XVIII	Hospi tal	5/26/2016 11: Cost	49 am_
	Cost Center Description	THE ATTENDED	110001 (41		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			5, 309	1.00
2.00	Inpatient days (including private room days, excluding swing-bed			5, 309	1
3. 00	Private room days (excluding swing-bed and observation bed days) do not complete this line.	. IT you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		4, 367	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December '	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	uays) arter becember .	or or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room o	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room o	Your ) after December 2	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	lays) al lei beceiibei 3	i or the cost	0	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 914	9. 00
10.00	newborn days)	. (:1			10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		Joil days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
12.00	December 31 of the cost reporting period (if calendar year, enter				10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of through December 31 of the cost reporting period	only (Including private	e room days)	0	12. 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX of	only (including private	e room days)	0	13. 00
44.00	after December 31 of the cost reporting period (if calendar year				44.00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of	f the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18. 00
	reporting period				
19. 00					19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services a	after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)	21 of the cost managet	ng popied (line	6, 701, 253	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	31 of the cost reporti	ng period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3	l of the cost reporting	g period (line 6	0	23. 00
24.00	x line 18)	14 -£ +b+	(1:		24.00
24. 00	Swing-bed cost applicable to NF type services through December $(7 \times 1)$ ine 19)	si oi the cost reportii	ig period (iine	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting $% \label{eq:cost_reporting} % % \label{eq:cost_reporting} % \label{eq:cost_reporting} % \label{eq:cost_reporting} % % \label{eq:cost_reporting} % % \label{eq:cost_reporting} % % \label{eq:cost_reporting} % % \label{eq:cost_reporting} % % \label{eq:cost_reporting} % % \label{eq:cost_reporting} % % \label{eq:cost_reporting} % % \label{eq:cost_reporting} % % \label{eq:cost_reporting} % % \label{eq:cost_reporting} % % \label{eq:cost_reporting} % % \label{eq:cost_report} % % \label{eq:cost_report} % % \label{eq:cost_report} % % eq:cost_report_r$	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (Li	ne 21 minus line 26)		6, 701, 253	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			-, -, -	
	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	•
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ 1	ine 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	Line 22) (see instrue	tions)	0.00	1
34. 00 35. 00	Average per diem private room charge differential (line 32 minus Average per diem private room cost differential (line 34 x line		LI UIIS)	0. 00 0. 00	1
36.00	Private room cost differential adjustment (line 3 x line 35)	- /		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost di	fferential (line	6, 701, 253	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in	nstructions)		1, 262. 24	
39.00	Program general inpatient routine service cost (line 9 x line 38	-		2, 415, 927	ı
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +			0 2, 415, 927	40.00
11.00	1.02a ogram gonorar impatront routine service cost (Tine 37 +			2,710,721	

	Financial Systems MAI ATION OF INPATIENT OPERATING COST	RGARET MARY COMM		AL - CCN: 151329	In Lie	eu of Form CMS-2 Worksheet D-1	
					From 01/01/2015 To 12/31/2015		
			Ti +	le XVIII	Hospi tal	5/26/2016 11: Cost	49 am
	Cost Center Description	Total Inpatient Cost	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0.0	00 0	0	42. 00
43. 00	INTENSIVE CARE UNIT	843, 852	36	0 2, 344. 0	03 205	480, 526	43. 00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					3, 478, 137	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instructi	ons)		6, 374, 590	49. 00
50.00	Pass through costs applicable to Program inp.	atient routine	services (fro	m Wkst. D, sur	n of Parts I and	0	50.00
51. 00	III) Pass through costs applicable to Program inp	ationt ancillar	v sorvicos (f	rom Wkst D 4	cum of Darte II	0	51.00
J 1. UU	and IV)	acrone and Hali	y services (I	I OIII WAST. D, S	Juni Di FaltS II		31.00
52.00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	9 1	rated, non-pn	ysician anestr	netist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	56. 00
57.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (	line 56 minus	line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	ompounded by the	0.00	
(0.00	market basket		J-4-J L., 4L-			0.00	
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line				the amount by	0.00	60.00
	which operating costs (line 53) are less tha	n expected cost					
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost reporti	ng period (See	0	64. 00
	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reporting	j period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	eporting period	0	67. 00
	(line 12 x line 19)	3			. 5 .		
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil				)		70.00
71. 00	Adjusted general inpatient routine service c						71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v l	ine 35)			72.00
74. 00	Total Program general inpatient routine serv						74.00
75. 00	Capital -related cost allocated to inpatient	routine service	costs (from	Worksheet B, F	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der recor	ds)			78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the c			nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (	see instruction	•				83. 00
84. 00	Program inpatient ancillary services (see in		ne)				84.00
0E 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
85. 00 86. 00							1
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					0.40	07.00
		)	line 2)			942 1, 262. 24	1

Health Financial Systems MAI	RGARET MARY COM	MMUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/26/2016 11:	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	951, 333	6, 701, 253	0. 14196	1, 189, 030	168, 798	90.00
91.00 Nursing School cost	C	6, 701, 253	0.00000	1, 189, 030	0	91.00
92.00 Allied health cost	C	6, 701, 253	0.00000	1, 189, 030	0	92.00
93.00 All other Medical Education	c	6, 701, 253	0. 00000	1, 189, 030	0	93. 00

Health Financial Systems	MARGARET MARY COMMUNI	TY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 151329	Peri od: From 01/01/2015	Worksheet D-1	
			To 12/31/2015	Date/Time Pre 5/26/2016 11:	pared: 49 am
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

		Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		5, 309	1.00
2.00	Inpatient days (including private room days, excluding swing-be			5, 309	2. 00
3.00	Private room days (excluding swing-bed and observation bed days)	). If you have only pri	vate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation bed		21 of the cost	4, 367 0	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through becember	31 OF the Cost	Ü	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December 3	31 of the cost	0	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 3°	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Drogram (eveluding	swing had and	139	9. 00
9.00	newborn days)	the Program (excluding	Swifig-bed and	139	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	y (including private ro	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruction		,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, ent				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar yea			· ·	10.00
14.00	Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)			928	
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services	through Docombon 21 of	f the cost		17. 00
17.00	reporting period	thi dagii becember 31 of	the cost		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0. 00	20. 00
20.00	reporting period	arter becomber 31 or tr	10 0031	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)			6, 701, 253	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	0	22. 00
22.00	5 x line 17)	1 -6 +1++!		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	i or the cost reporting	g period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	na 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
27.00	x line 20)			0	27 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ino 21 minus Lino 26)		6, 701, 253	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	The 21 millius Title 20)		0, 701, 233	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	a lina 22) (aaa inatmus	ti ana)	0.00	33.00
34. 00 35. 00	Average per diem private room charge differential (line 32 minu: Average per diem private room cost differential (line 34 x line		LI OIIS)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	01)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost dit	fferential (line	6, 701, 253	37. 00
	27 minus line 36)	· 	,		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	THENTO			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS		T	1 2/2 2/	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see in Program general inpatient routine service cost (line 9 x line 3)	-		1, 262. 24 175, 451	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Program	•		175, 451	40.00
41. 00	Total Program general inpatient routine service cost (line 39 +	•		175, 451	

	Financial Systems M TATION OF INPATIENT OPERATING COST	MARGARET MARY COM				Period:	wof Form CMS- Worksheet D-1	
COMPUT	ATTON OF INPATIENT OFERATING COST		FIOV	i dei		From 01/01/2015 To 12/31/2015	Date/Time Pre	epared:
				Ti t	le XIX	Hospi tal	5/26/2016 11: Cost	49 am
	Cost Center Description	Total Inpatient Cost	Total I npati ent	Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2. 00		col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1, 103, 988		928	1, 189. 6			42.00
	Intensive Care Type Inpatient Hospital Unit							
43. 00 44. 00	INTENSIVE CARE UNIT	843, 852		360	2, 344. 0	3 3	7, 032	43.00
45. 00	BURN INTENSIVE CARE UNIT							45. 00
46. 00	4							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)							47. 00
	Cost Center Description						1.00	
48. 00	Program inpatient ancillary service cost (W	Wkst. D-3, col. 3	3, line 200	0)			216, 464	48. 00
49. 00	Total Program inpatient costs (sum of lines	s 41 through 48)(	see instr	ucti o	ns)		398, 947	49. 00
F0 00	PASS THROUGH COST ADJUSTMENTS			(6	WI+ D	-£ D 11		1 50 00
50. 00	Pass through costs applicable to Program ir	ipatient routine	services	(Trom	WKSt. D, Sum	or Parts I and	0	50.00
51.00	Pass through costs applicable to Program in	npatient ancillar	y services	s (fr	om Wkst. D, s	um of Parts II	0	51.00
	and IV)	50 L 54)						
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		lated no	n_nhv	sician anesth	atist and	0	1
33.00	medical education costs (line 49 minus line		nateu, noi	т-риу	si ci ali allestii	etist, and	٥	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	•						
	Program discharges						0	
56. 00	Target amount per discharge Target amount (line 54 x line 55)						0.00	
57. 00		ating cost and ta	ırget amoui	nt (I	ine 56 minus	line 53)	Ö	
58. 00	Bonus payment (see instructions)						0	
59. 00	Lesser of lines 53/54 or 55 from the cost r market basket	reporting period	endi ng 199	96, u	pdated and co	mpounded by the	0.00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by	the m	arket basket		0.00	60.00
61.00	If line 53/54 is less than the lower of lin	nes 55, 59 or 60	enter the	Less	er of 50% of		0	61. 00
	which operating costs (line 53) are less th		s (lines!	54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	e mstructrons)					0	62. 00
	Allowable Inpatient cost plus incentive pay	ment (see instru	ıcti ons)				0	63. 00
( 4 .00	PROGRAM INPATIENT ROUTINE SWING BED COST	+b		C 11.				
64. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	osts through Dece	ember 31 o	the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine co	osts after Decemb	er 31 of	the c	ost reporting	period (See	0	65. 00
// 00	instructions)(title XVIII only)	(1:	// -l 13		F) (+: +1 - )((1)	ll>		
66. 00	Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	Tine costs (Tine	64 prus ri	ne 6	5)(title XVII	i oniy). For	0	66. 00
67.00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December	31 o	f the cost re	porting period	О	67. 00
	(line 12 x line 19)							
68.00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after L	ecember 3	I OT	tne cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	t routine costs (	line 67 +	line	68)		О	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER		•				Г	
70. 00 71. 00	Skilled nursing facility/other nursing faciladjusted general inpatient routine service							70.00
72.00	Program routine service cost (line 9 x line	,	THE 70 + 1	THE	2)			72.00
73. 00	Medically necessary private room cost appli	cable to Program			ne 35)			73. 00
74. 00	Total Program general inpatient routine ser	•		,				74. 00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	COSTS (TI	rom w	orksneet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ l	ine 2)						76. 00
77. 00	Program capital-related costs (line 9 x lir							77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 mir Aggregate charges to beneficiaries for exce		rovi dor r	acord	c)			78. 00 79. 00
80.00					*.	us line 79)		80.00
81. 00	Inpatient routine service cost per diem lim	•				- ,		81. 00
82.00	Inpatient routine service cost limitation (	•	* .					82.00
83. 00 84. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see i	•	15)					83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)					85. 00
	Total Program inpatient operating costs (su	um of lines 83 th						86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PA							
07 00							047	
87. 00 88. 00	Total observation bed days (see instruction Adjusted general inpatient routine cost per	*	line 2)				942 1, 262. 24	

Health Financial Systems MA	ARGARET MARY COM	MMUNITY HOSPITA	L	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 Fo 12/31/2015		
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	951, 333	6, 701, 253	0. 141963	1, 189, 030	168, 798	90.00
91.00 Nursing School cost	0	6, 701, 253	0. 000000	1, 189, 030	0	91.00
92.00 Allied health cost	0	6, 701, 253	0. 000000	1, 189, 030	0	92. 00
93.00 All other Medical Education	0	6, 701, 253	0. 000000	1, 189, 030	0	93. 00

Heal th Financial	Systems MARGARET MARY	COMMUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
	LARY SERVICE COST APPORTIONMENT		CCN: 151329	Peri od:	Worksheet D-3	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/26/2016 11:	
		Ti tl	e XVIII	Hospi tal	Cost	
Cos	t Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
I NPATI ENT	ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	LTS & PEDIATRICS			1, 827, 785		30.00
31. 00 03100 I NTI	ENSIVE CARE UNIT			351, 162		31.00
43. 00 04300 NUR	SERY					43.00
	SERVI CE COST CENTERS					
	RATING ROOM		0. 19704		236, 886	
1 1	IVERY ROOM & LABOR ROOM		1. 38614		3, 586	
	I OLOGY-DI AGNOSTI C		0. 23274			
60. 00 06000 LAB			0. 21346		332, 207	60.00
	OD LABORATORY		0.00000		0	
	PI RATORY THERAPY		0. 44318		618, 033	
	SI CAL THERAPY		0. 58374		93, 143	
1 1	UPATI ONAL THERAPY ECH PATHOLOGY		0. 59293 0. 90042	·		1
	CTROCARDI OLOGY		0. 32300			
1 1	I CAL SUPPLIES CHARGED TO PATIENTS		0. 32300			
	L. DEV. CHARGED TO PATIENT		0. 98959			1
	GS CHARGED TO PATIENTS		0. 32758			
	T SERVICE COST CENTERS			., ., ., ., ., .,		1
88. 00 08800 RUR	AL HEALTH CLINIC		0.00000	00	0	88. 00
90. 00 09000 CLII	NI C		0. 46851	94, 615	44, 328	90.00
90. 01 09001 WOUI	ND CLINC		0. 29195	3, 428	1, 001	90. 01
91. 00 09100 EMEI			0. 64156	33, 134	21, 258	91.00
	ERVATION BEDS (NON-DISTINCT PART)		1. 26070	0 8	0	,
	al (sum of lines 50–94 and 96–98)			9, 225, 510		
	s PBP Clinic Laboratory Services-Program only o	charges (line 61)		0		201. 00
202.00   Net	Charges (line 200 minus line 201)			9, 225, 510		202. 00

Health Financial Systems MARGARET MARY COMMU	JNITY HOSPITA	L	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 151329	Peri od:	Worksheet D-3	
			From 01/01/2015 To 12/31/2015	Date/Time Pre 5/26/2016 11:	
	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	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			154, 101		30.00
31. 00 03100 INTENSIVE CARE UNIT			8, 121		31.00
43. 00   04300   NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00   05000 OPERATI NG ROOM		0. 1970			
52.00   05200   DELIVERY ROOM & LABOR ROOM		1. 38614			
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 23274			
60. 00   06000   LABORATORY		0. 21346		17, 263	
60. 01   06001   BLOOD   LABORATORY		0.00000		0	
65. 00 06500 RESPIRATORY THERAPY		0. 44318			
66. 00   06600   PHYSI CAL THERAPY		0. 58374			
67. 00 06700 OCCUPATI ONAL THERAPY		0.59293			
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY		0. 90042 0. 32300			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 32300			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 98959	· ·		
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 32758			
OUTPATIENT SERVICE COST CENTERS		0.0270	70,007	20,001	70.00
88. 00 08800 RURAL HEALTH CLINIC		1. 6324!	52 0	0	88. 00
90. 00   09000   CLI NI C		0. 4685	12 45	21	90.00
90. 01 09001 WOUND CLINC		0. 2919	54 0	0	90. 01
91. 00 09100 EMERGENCY		0. 64156	57 172	110	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 26070	0 8	0	,
200.00 Total (sum of lines 50-94 and 96-98)			459, 991	216, 464	
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)			459, 991		202. 00

Health Financial Systems	MARGARET MARY COMMUNI	TY HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151329	From 01/01/2015	Worksheet E Part B Date/Time Prepared: 5/26/2016 11:49 am

Next   House				To 12/31/2015	Date/Time Pre 5/26/2016 11:	
Next 8 - MeDICAL AND OTHER REALTH SERVICES   1.00   Medical and other services (see Instructions)   1.709,792   1.00			Title XVIII	Hospi tal		17 Gill
Next 8 - MeDICAL AND OTHER REALTH SERVICES   1.00   Medical and other services (see Instructions)   1.709,792   1.00					4.00	
Medical and other services (see instructions)		PART R - MEDICAL AND OTHER HEALTH SERVICES			1.00	
98   PS   payments   0   3   0.00	1.00				11, 709, 792	1. 00
0.01   fir payment (see Instructions)   0.000   5.00   1.00   5.00   1.00   2.10   5.00   5.00   1.00   2.10   5.00   5.00   1.00   2.10   5.00   5.00   5.00   1.00   5	2.00		ons)		0	2. 00
Enter the fixes pital specific payment to cost ratio (see instructions)   0.000   5.00	3.00	PPS payments			0	3. 00
Line 2 times line 5   0.6.00		, , ,				
2.00   Sum of Tine 3 plus line 4 divided by line 6   0.00 7.00			i ons)			
1   1   1   1   1   1   1   1   1   1						
		,				
0			col 13 line 200			
COMPUTATION OF LESSER OF COST OR CHARGES			,, 200			
Reasonable charges	11. 00	Total cost (sum of lines 1 and 10) (see instructions)			11, 709, 792	11. 00
2.00   Ancil lary service charges   0   12.00   13.00   Total reasonable charges (sum of lines 12 and 13)   0   13.00   13.00   10   10   10   13.00   13.00   13.00   10   14.00						
13.00   Organ acquist lion charges (from West. D-4, Pt. III., col. 4, line 69)	10.00				0	10.00
14. 00   Total reasonable charges (sum of lines 12 and 13)			o 40)			
Customery_charges			e 69)			
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.00	14.00				U	14.00
16.00   Amounts that would have been realized from patients   iable for payment for services on a chargebasis   nad such payment been made in accordance with 42 CFR \$413.13(e)   0.000000   17.00	15.00		yment for services on	a charge basis	0	15. 00
17. 00	16.00				0	16. 00
18. 00   Total customary charges (see instructions)		1 7				
19. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   0   19. 00						
instructions			if line 19 eveneds li	no 11) (coo	_	
20. 00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20. 00   11,826,890   21. 00   22	19.00	, , , , ,	II IIIle to exceeds II	ile II) (See	U	19.00
Instructions	20. 00		if line 11 exceeds li	ne 18) (see	0	20. 00
22.00   Interns and residents (see instructions)   0   22.00   23.00   23.00   25.00   Total prospective payment (sum of lines 3, 4, 8 and 9)   0   24.00   24.00   25.00				, ,		
23. 00   Cost of physicians' services in a teaching hospital (see instructions)   24. 00   Total prospective payment (sum of lines 3, 4, 8 and 9)   24. 00   COMPUTATION OF REIMBURSEMENT SETTLEMENT   25. 00   Deductible is and Coinsurance (for CAH, see instructions)   6,583,333   26. 00   27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   6,583,333   26. 00   27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0   28. 00			instructions)			
24.00   Total prospective payment (sum of lines 3, 4, 8 and 9)   24.00   24.00   25.		1				
COMPUTATION OF REIMBURSEMENT SETTLEMENT   Deductibles and coinsurance (For CAH, see instructions)   0.94.64   25.00   26.00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   6.583, 333   26.00   27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0.28.00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0.28.00   28.00   Direct graduate medical education costs (from Wkst. E-4, line 50)   0.29.00   28.00   Subtotal (sum of lines 27 through 29)   5.144,093   30.00   30.00   Subtotal (sum of lines 27 through 29)   5.144,093   30.00   31.00   Primary payer payments   3.800   31.00   32.00   Subtotal (line 30 minus line 31)   5.140,293   32.00   33.00   Composite rate ESRO (from Wst. 1-5, line 11)   0.0   33.00   34.00   Allowable bad debts (see instructions)   1.002,276   34.00   35.00   Allowable bad debts (see instructions)   6.51,479   35.00   36.00   Allowable bad debts (see instructions)   6.51,479   36.00   37.00   Subtotal (see instructions)   6.51,479   37.00   38.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0.39.00   39.90   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0.39.00   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0.39.95   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0.39.95   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0.39.95   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0.39.95   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0.39.95   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0.39.95   39.90   The manufacturers for contractors use only   0.00   39.00   The rate used to calculate the Time Value of Mon			CTI ONS)			
25.00   Deductibles and coinsurance (for CAH, see instructions)   Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)   6,583,333   26.00   27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0	24.00				0	24.00
27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   5,144,093   27.00   1   1   1   1   1   1   1   1   1	25. 00				99, 464	25. 00
instructions   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28		Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)			
28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   ESRD direct medical education costs (from Wkst. E-4, line 36)   0   28.00   29.00   30.00   Subtotal (sum of lines 27 through 29)   5,144,093   30.00   31.00   7 inarry payer payments   3,800   31.00   31.00   7 inarry payer payments   3,800   31.00   31.00   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I -5, line 11)   0   33.00   33.00   34.00   Allowable bad debts (see instructions)   1,002,276   34.00   35.00   34.00   Allowable bad debts (see instructions)   651,479   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   639,173   36.00   37.00   Subtotal (see instructions)   639,173   36.00   37.00   Subtotal (see instructions)   5,791,772   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   39.99   RECOVERY OF ACCELERATED DEPRECIATION   5,791,772   40.00   40.01   Sequestration adjustment (see instructions)   5,791,772   40.00   40.01   Sequestration adjustment (see instructions)   5,791,772   40.00   40.00   Subtotal (see instructions)   5,791,772   40.00   40.00   Subtotal (see instructions)   5,791,772   40.00   40.00   Sequestration adjustment (see instructions)   5,791,772   40.00   40.00   5,701,256   41.00   41.	27. 00		us the sum of lines 22	2 and 23] (see	5, 144, 093	27. 00
29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   0   29.00   30.00	20 00	1	o EO)		0	20 00
30. 00   Subtotal (sum of lines 27 through 29)   5,144,093   30. 00   31. 00   7 rimary payer payments   3,800   31. 00   32. 00   Subtotal (line 30 minus line 31)   5,140,293   32. 00			e 50)			
31.00   Primary payer payments   3,800   31.00   Subtotal (line 30 minus line 31)   5,140,293   32.00   Subtotal (see instructions)   5,140,293   32.00   33.00   34.00   Allowable bad debts (see instructions)   651,479   35.00   36.00   Allowable bad debts (see instructions)   651,479   35.00   37.00   Subtotal (see instructions)   5,791,772   37.00   Subtotal (see instructions)   5,791,772   37.00   39.00   39.50   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 39.90   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0 39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0 39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0 39.99   40.00   Subtotal (see instructions)   5,791,772   40.00   10.00   Subtotal (see instructions)   5,791,726   41.00   42.00   Tentative settlement (for contractors use only)   43.00   Balance due provider/program (see instructions)   -595,319   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,					_	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33. 00   Composite rate ESRD (from Wkst. I-5, Iine 11)   0   0   33. 00     34. 00   Allowable bad debts (see instructions)   1,002,276     35. 00   Adjusted reimbursable bad debts (see instructions)   651,479     36. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   639,173     36. 00   Subtotal (see instructions)   5,791,772     37. 00   Subtotal (see instructions)   0   38. 00     39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 00     39. 90   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39. 90     39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 98     39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99     40. 00   Subtotal (see instructions)   5,791,772     40. 01   Sequestration adjustment (see instructions)   115,835     41. 00   Interim payments   6,271,256   41. 00     42. 00   Tentative settlement (for contractors use only)   42. 00     43. 00   Balance due provider/program (see instructions)   -595,319   43. 00     44. 00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0     50. 00   Outlier reconciliation adjustment amount (see instructions)   0   91. 00     90. 00   Outlier reconciliation adjustment amount (see instructions)   0   91. 00     90. 00   Time Value of Money (see instructions)   0   93. 00     91. 00   Outlier reconciliation adjustment amount (see instructions)   0   93. 00     92. 00   Time Value of Money (see instructions)   0   93. 00     93. 00   Time Value of Money (see instructions)   0   93. 00     93. 00   Time Value of Money (see instructions)   0   93. 00     93. 00   Time Value of Money (see instructions)   0   93. 00     93. 00   Time Value of Money (see instructions)   0   93. 00     93. 00   Time Value of Money (see instructions)   0   93. 00     93. 00   Time Value of Money (see instructions)   0   93. 00     93. 00   Time Value of Money (s						
33. 00 Composite rate ESRD (from Wkst. I-5, line 11)  34. 00 All lowable bad debts (see instructions)  35. 00 Adjusted reimbursable bad debts (see instructions)  36. 00 All lowable bad debts (see instructions)  37. 00 All lowable bad debts for dual eligible beneficiaries (see instructions)  38. 00 MSP-LCC reconciliation amount from PS&R  39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS)  39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 99 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  5, 791, 772  40. 00  40. 01 Interim payments  6, 271, 256  41. 00  42. 00  43. 00  44. 00  44. 00  44. 00  45. 00  46. 071, 256  47. 00  47. 00  48. 00  49. 00  49. 00  40. 01  40. 01  41. 00  42. 00  43. 00  44. 00  44. 00  45. 01  46. 071, 256  47. 00  47. 00  48. 00  49. 00  49. 00  40. 01  40. 01  40. 01  41. 00  42. 00  43. 00  44. 00  44. 00  45. 02  46. 071, 256  47. 072  47. 072  48. 00  49. 00  49. 00  40. 01  40. 01  41. 00  42. 00  43. 00  44. 00  44. 00  45. 06  46. 071, 256  47. 072  47. 072  48. 00  49	32.00	Subtotal (line 30 minus line 31)			5, 140, 293	32. 00
34. 00       Allowable bad debts (see instructions)       1,002,276       34. 00         35. 00       Adjusted reimbursable bad debts (see instructions)       651,479       35. 00         36. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       639,173       36. 00         37. 00       Subtotal (see instructions)       5,791,772       37. 00         38. 00       MSP-LCC reconciliation amount from PS&R       0       38. 00         39. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39. 00         39. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       39. 90         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       5, 791, 772       40. 00         40. 01       Interim payments       6, 271, 256       41. 00         41. 00       Interim payments       6, 271, 256       41. 00         42. 00       Balance due provi der/program (see instructions)       -595, 319       43. 00         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0       44. 00 <t< td=""><td></td><td></td><td>S)</td><td></td><td></td><td></td></t<>			S)			
35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.90 Pioneer ACO demonstration payment adjustment (see instructions) 39.90 RECOVERY OF ACCELERATED DEPRECIATION 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.01 Sequestration adjustment (see instructions) 40.01 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 TO BE COMPLETED BY CONTRACTOR 90.00 The rate used to calculate the Time Value of Money Time Value of Money (see instructions) 5, 79.00 93.00 Time Value of Money (see instructions) 6, 29.00 93.00 Time Value of Money (see instructions) 7, 791, 772 40.00 1, 10						
36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  37. 00 Subtotal (see instructions)  38. 00 MSP-LCC reconciliation amount from PS&R  39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  39. 50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 98 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  40. 01 Sequestration adjustment (see instructions)  40. 01 Interim payments  41. 00 Interim payments  42. 00 Tentative settlement (for contractors use only)  43. 00 Bal ance due provider/program (see instructions)  44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{2}\$\$115. 2  TO BE COMPLETED BY CONTRACTOR  90. 00 Original outlier amount (see instructions)  70. 00 Other are used to calculate the Time Value of Money  91. 00 Onco The rate used to calculate the Time Value of Money  92. 00 Time Value of Money (see instructions)  93. 00 Onco Time Value of Money (see instructions)  94. 00 Onco Time Value of Money (see instructions)  95. 791, 772 oncodes instructions		1				
37. 00 Subtotal (see instructions) 38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Bal ance due provider/program (see instructions) 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115. 2  TO BE COMPLETED BY CONTRACTOR  90. 00 Tig inal outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Time Value of Money (see instructions) 93. 00 Time Value of Money (see instructions) 94. 00 Og 39. 00 95. 00 Time Value of Money (see instructions) 95. 791, 772 Sp. 39. 90 97. 00 Og 39. 00		1 3	ctions)			
38.00       MSP-LCC reconciliation amount from PS&R       0       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.00         39.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       39.50         39.98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39.98         39.99       RECOVERY OF ACCELERATED DEPRECIATION       0       39.99         40.00       Subtotal (see instructions)       5,791,772       40.00         40.01       Interim payments       115,835       40.01         41.00       Interim payments       6,271,256       41.00         42.00       Tentative settlement (for contractors use only)       -595,319       43.00         43.00       Balance due provider/program (see instructions)       -595,319       43.00         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0       44.00         §115.2       TO BE COMPLETED BY CONTRACTOR       0       90.00         90.00       Original outlier amount (see instructions)       0       90.00         91.00       Time value of Money (see instructions)       0       90.00         93.00       Time valu			,			
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.99 94.00 95.791,772 96.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00	38. 00	MSP-LCC reconciliation amount from PS&R				
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39.98 RECOVERY OF ACCELERATED DEPRECIATION  40.00 Subtotal (see instructions)  5,791,772 40.00  40.01 Interim payments  115,835 40.01  41.00 Tentative settlement (for contractors use only)  42.00 Balance due provider/program (see instructions)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 044.00  44.00 Original outlier amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  10 90.00  91.00 The rate used to calculate the Time Value of Money  11 me Value of Money (see instructions)  12 39.98 and 39.98 alone instructions)  13 39.98 alone instructions)  14 0.00 condition adjustment instructions)  15 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , ,				
39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99   40. 00   Subtotal (see instructions)   5, 791, 772   40. 00   40. 01   Sequestration adjustment (see instructions)   115, 835   40. 01   41. 00   42. 00   Tentative settlement (for contractors use only)   6, 271, 256   41. 00   43. 00   Balance due provider/program (see instructions)   -595, 319   43. 00   44. 00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44. 00   44. 00   44. 00   44. 00   45. 00						
40.00 Subtotal (see instructions) 5, 791, 772 40.00 Sequestration adjustment (see instructions) 115, 835 40.01 11, 00 Interim payments Tentative settlement (for contractors use only) 42.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 10 Outlier reconciliation adjustment amount (see instructions) 10 Outlier reconciliation adjustment amount (see instructions) 115, 835 40.01 42.00 42.00 42.00 43.00 44.00 44.00 44.00 44.00 45.01 46.02 47.02 48.00 49.00 49.00 49.00 40.00		•	d devices (see instruc	ctions)		
40.01 Sequestration adjustment (see instructions)  41.00 Interim payments  42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)					_	
41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Time Value of Money (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)		1				
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 0 The rate used to calculate the Time Value of Money 1 Time Value of Money (see instructions) 0 93.00						
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 9 44.00 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00 45.00 Fig. 15-2, chapter 1, 9 44.00		, ,				
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	43.00	Balance due provider/program (see instructions)			-595, 319	43.00
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)	44. 00		e with CMS Pub. 15-2,	chapter 1,	0	44. 00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00	90 00				n	90 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00						
93.00 Time Value of Money (see instructions) 0 93.00		,				
94.00  Total (sum of lines 91 and 93)   0   94.00						
	94. 00	Total (sum of lines 91 and 93)			0	94. 00

| Peri od: | Worksheet E-1 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: | 5/26/2016 | 11: 49 am Health Financial Systems MARGARE ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 151329

					5/26/2016 11: 4	49 am
		Ti t	le XVIII	Hospi tal	Cost	
		Inpatie	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		4, 950, 9	77	6, 271, 256	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	07/16/2015	147, 50		0	3. 01
3. 02				0	0	3. 02
3.03				0	0	3. 03
3. 04				0	0	3. 04
3.05				0	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		147, 50	00	0	3. 99
	3. 50-3. 98)		- aaa 4			
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		5, 098, 4	/ /	6, 271, 256	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after		1			5. 00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				o	l ol	5. 02
5. 03				0	l ol	5. 03
	Provi der to Program		•			
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVI DER		659, 0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	595, 319	6. 02
7. 00	Total Medicare program liability (see instructions)		5, 757, 5		5, 675, 937	7. 00
				Contractor	NPR Date	
			0	Number	(Mo/Day/Yr)	
0.00	Name of Contractor		0	1.00	2. 00	0.00
8. 00	Name of Contractor	I			ı l	8. 00

Heal th	u of Form CMS-2	2552-10					
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 151329   Period: From 01/01/2015   Part II   To 12/31/2015   Part II   Date/Ti   5/26/20							
		Title XVIII	Hospi tal	Cost			
				1. 00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1. 00		
1. 00							
2.00							
3.00	00   Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2   378						
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		4, 727	4. 00		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			151, 884, 941	5. 00		
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li			2, 311, 419	6. 00		
7. 00	CAH only - The reasonable cost incurred for the purchase of celline 168	rtified HIT technology	Wkst. S-2, Pt. I	548, 279	7. 00		
8.00	Calculation of the HIT incentive payment (see instructions)			403, 753	8.00		
9.00	Sequestration adjustment amount (see instructions)			8, 075	9. 00		
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		395, 678	10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH						
30.00	Initial/interim HIT payment adjustment (see instructions)	·		0	30.00		
31.00	Other Adjustment (specify)			0	31.00		
22 00	200 Palance due provider (line 10) minus line 20 and line 21) (see instructions)						

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

0 30.00 0 31.00 395,678 32.00

Health Financial Systems	MARGARET MARY COMMUNI	TY HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151329	From 01/01/2015	Worksheet E-3 Part V Date/Time Pre 5/26/2016 11:	pared:
		Title XVIII	Hospi tal	Cost	

				5/26/2016 11:	49 am_
		Title XVIII	Hospi tal	Cost	
	<u> </u>				
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR PART V - CALCULATION OF REIMBURSEMENT FOR PART V - CALCULATION OF REIMBURSEMENT FOR V - CALCULATION OF REIMBURSEMENT FOR V - CALCULATION OF REIMBURSEMENT FOR V - CALCULATION OF REIMBURSEMENT FOR V - CALCULATION OF REIMBURSEMENT FOR V - CALCULA	ART A SERVICES - COST	RELMBURSEMENT	11.00	
1.00	Inpatient services	THE PERSON SERVINGES SOUTH	KETMBOROEMENT	6, 374, 590	1.00
2. 00	Nursing and Allied Health Managed Care payment (see instruction	c)		0, 374, 370	2. 00
		5)		0	
3.00	Organ acqui si ti on				3. 00
4.00	Subtotal (sum of lines 1 through 3)			6, 374, 590	
5.00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			6, 438, 336	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routine service charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	
10. 00	Total reasonable charges			0	
10.00	Customary charges				10.00
11. 00	Aggregate amount actually collected from patients liable for pa	umont for sorvices on	a chargo basis	0	11. 00
12. 00	Amounts that would have been realized from patients liable for			0	
12.00		payment for services of	ii a ciiaiye basis	U	12.00
40.00	had such payment been made in accordance with 42 CFR 413.13(e)			0.000000	40.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
14. 00	Total customary charges (see instructions)			0	
15. 00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)			_	
16. 00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds lin	e 14) (see	0	16. 00
	instructions)				
17. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4,	line 49)		0	18. 00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			6, 438, 336	19. 00
20.00	Deductibles (exclude professional component)			613, 532	20. 00
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			5, 824, 804	
23. 00	Coi nsurance			315	
24. 00	Subtotal (line 22 minus line 23)			5, 824, 489	
25. 00		a) (ass instructions)		77, 785	
	Allowable bad debts (exclude bad debts for professional service	s) (see mstructions)			
26. 00	Adjusted reimbursable bad debts (see instructions)			50, 560	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		38, 002	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			5, 875, 049	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 99	Recovery of Accelerated Depreciation			0	29. 99
30.00	Subtotal (see instructions)			5, 875, 049	30. 00
30. 01	Sequestration adjustment (see instructions)			117, 501	
31. 00	Interim payments			5, 098, 477	
32. 00	Tentative settlement (for contractor use only)			0, 070, 177	32. 00
33. 00	Balance due provider/program (line 30 minus lines 30.01, 31, an	4 33)		659, 071	
34. 00	Protested amounts (nonallowable cost report items) in accordance	•	chantor 1	034, 071	34. 00
34.00	§115. 2	e with two rub. 15-2,	Chapter I,	Ü	34.00
	[3113. 2		١		

Health Financial Systems	MARGARET MARY COMMUNI	TY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151329		Worksheet E-3 Part VII Date/Time Prepared: 5/26/2016 11:49 am

			10 12/31/2015	5/26/2016 11:	
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		398, 947		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		398, 947	0	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		398, 947	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routine service charges		162, 221		8.00
9.00	Ancillary service charges		459, 991	0	
10. 00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0	_	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		622, 212	0	12. 00
40.00	CUSTOMARY CHARGES	<u>.</u>	0.00.00.0		40.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	260, 226	0	13. 00
14. 00	basis	normant for compless on	0	0	14. 00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42		0	Ü	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	CIR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		622, 212	0.000000	1
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	223, 265	0	
17.00	line 4) (see instructions)	TT TTHE TO EXCEEDS	220, 200	· ·	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16	)	398, 947	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provide	ers.		
22. 00	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	
24.00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		398, 947	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	20.00
30. 00 31. 00	Excess of reasonable cost (from line 18)		0 398, 947	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		398, 947	0	
33. 00	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
35. 00	Utilization review		0	Ü	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	398, 947	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	370, 747	0	
	Subtotal (line 36 ± line 37)		398, 947	0	
	Direct graduate medical education payments (from Wkst. E-4)		0,0,747	O	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		398, 947	0	1
41. 00	Interim payments		260, 226	0	1
42. 00	Balance due provider/program (line 40 minus line 41)		138, 721	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	1
	chapter 1, §115.2	•			
	Gridptor 1, \$110.2		1		1

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

Provi der CCN: 151329

Peri od: Worksheet G From 01/01/2015 To 12/31/2015 Date/Time Prepared:

			'	0 12/31/2013	5/26/2016 11:	
	<u> </u>	General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1. 00	Cash on hand in banks	6, 114, 396	J 0	0	0	1.00
2. 00	Temporary investments	0,111,070		o	0	2.00
3.00	Notes recei vabl e	O	0	0	0	3. 00
4.00	Accounts receivable	11, 840, 873	0	0	0	4. 00
5.00	Other recei vable	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	2, 868, 830	0	0	0	7. 00
8.00	Prepaid expenses	0	0	0	0	8. 00
9.00	Other current assets	1, 700, 167		0	0	9.00
10.00	Due from other funds	0	0		0	10.00
11. 00	Total current assets (sum of lines 1-10)	22, 524, 266	0	0	0	11. 00
12 00	FI XED ASSETS Land	2 271 150	0	0	0	12 00
12. 00 13. 00	Land improvements	2, 371, 158 423, 901	1	-		12. 00 13. 00
14. 00	Accumulated depreciation	-376, 753	1	-	0	14.00
15. 00	Buildings	69, 823, 878		0	0	15. 00
16. 00	Accumulated depreciation	-36, 623, 022	1	0	Ö	16.00
17. 00	Leasehold improvements	00,020,022	0	o	ő	17. 00
18.00	Accumul ated depreciation	O	o	0	0	18. 00
19.00	Fi xed equipment	6, 341, 285	0	0	0	19. 00
20.00	Accumulated depreciation	-5, 519, 345	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21. 00
22.00	Accumulated depreciation	0	0	0	0	22. 00
23.00	Major movable equipment	47, 282, 966	0	0	0	23. 00
24.00	Accumul ated depreciation	-29, 463, 969	0	0	0	24. 00
25.00	Mi nor equi pment depreciable	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	_	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	54, 260, 099	0	0	0	30. 00
04.00	OTHER ASSETS					04 00
31. 00	Investments	0	0		0	31.00
32. 00 33. 00	Deposits on leases	0	0	-	0	32. 00 33. 00
34. 00	Due from owners/officers Other assets	71, 193, 563			0	34.00
35. 00	Total other assets (sum of lines 31-34)	71, 193, 563		-	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	147, 977, 928			0	36.00
30.00	CURRENT LIABILITIES	147, 777, 720	, <u> </u>	<u> </u>	0	30.00
37. 00	Accounts payable	4, 201, 459	) 0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	5, 712, 142	1	0	0	38. 00
39. 00	Payroll taxes payable	0,7.12,1.12		0	0	39. 00
40. 00	Notes and Loans payable (short term)	1, 700, 167	, o	0	Ō	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3, 098, 502	2 0	0	0	44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	14, 712, 270	0	0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	-	0	46. 00
47. 00	Notes payable	0	0	0		47. 00
48. 00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	28, 765, 615	1	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	28, 765, 615			0	50. 00
51. 00	Total liabilites (sum of lines 45 and 50)	43, 477, 885	0	0	0	51.00
	CAPI TAL ACCOUNTS	104 500 040	.1			
52. 00	General fund balance	104, 500, 043				52.00
53. 00	Specific purpose fund		0			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant		1		0	57.00
58. 00	Plant fund balance - reserve for plant improvement,					58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	104, 500, 043	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	147, 977, 928			0	60.00
55. 55	59)	117, 777, 720				55. 55
		ı	1	1	•	'

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10 Provi der CCN: 151329 

					То	12/31/2015	Date/Time Prep 5/26/2016 11:4	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	7 4111
	T	1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		100, 369, 029			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4, 131, 014					2.00
3.00	Total (sum of line 1 and line 2)		104, 500, 043			0		3. 00
4.00	Additions (credit adjustments) (specify)	0			0		0	4. 00
5.00		0			0		0	5. 00
6.00		0			0		0	6. 00
7.00		0			0		0	7. 00
8. 00 9. 00		0			0		0	8. 00
10.00	Total additions (sum of line 4-9)	١	0		U	0	Ĭ	9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)		104, 500, 043			0		10.00
			104, 500, 043			U		
12. 00 13. 00	Deductions (debit adjustments) (specify)				0		0	12. 00 13. 00
14. 00					0		0	14. 00
15. 00					0		0	15. 00
16. 00					0		0	16. 00
17. 00					0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0		٧	0	-	18. 00
19. 00	Fund balance at end of period per balance	1	104, 500, 043			0		19. 00
17.00	sheet (line 11 minus line 18)		104, 300, 043			O		17.00
	Torrest (11110 11 III III III III III)	Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	0	_		0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4.00
5.00			0					5. 00
6.00			0					6. 00
7.00			0					7. 00
8.00			0					8. 00
9. 00 10. 00	Total additions (our of line 4.0)		U					9. 00 10. 00
	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)				0			10.00
11. 00 12. 00	Deductions (debit adjustments) (specify)	١	0		U			12. 00
13. 00	beductions (debit adjustments) (specify)	-	0					13. 00
14. 00		-	0					14. 00
15. 00			0					15. 00
16. 00		1	0					16. 00
17. 00			0					17. 00
18. 00	Total deductions (sum of lines 12-17)		O I		0			18. 00
19. 00	Fund balance at end of period per balance				0			19. 00
50	sheet (line 11 minus line 18)				Ĭ			
	1			•	- 1			

Health Financial Systems MARGA STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 151329

			10	12/31/2015	Date/IIme Prep   5/26/2016 11:4	
	Cost Center Description	I npati er	t	Outpati ent	Total	
		1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	5, 449	928		5, 449, 928	1. 00
2.00	SUBPROVI DER - I PF					2. 00
3.00	SUBPROVI DER - I RF					3. 00
4. 00	SUBPROVI DER					4. 00
5. 00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY				-	7. 00
8.00	NURSING FACILITY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	5, 449	928		5, 449, 928	10.00
	Intensive Care Type Inpatient Hospital Services	57	,20		0/ 117/ 720	
11. 00	INTENSIVE CARE UNIT	705	229		705, 229	11. 00
12. 00	CORONARY CARE UNIT					12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of li	nes 705	229		705, 229	16. 00
	11-15)	, , , ,			7007227	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	6, 155	157		6, 155, 157	17. 00
18. 00	Ancillary services	21, 109		108, 083, 744	129, 193, 256	18. 00
19. 00	Outpatient services		221	20, 394, 326	20, 955, 547	19. 00
20. 00	RURAL HEALTH CLINIC		0	637, 463	637, 463	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY			1, 871, 511	1, 871, 511	22. 00
23. 00	AMBULANCE SERVI CES			.,,	.,,	23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )					25. 00
26. 00	HOSPI CE		0	1, 782, 338	1, 782, 338	26. 00
27. 00	PHYSI CI AN OFFI CES		0	13, 949, 662	13, 949, 662	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 27, 825	890	146, 719, 044	174, 544, 934	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES	•				
29.00	Operating expenses (per Wkst. A, column 3, line 200)			81, 999, 311		29.00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	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)			O		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(	transfer		81, 999, 311		43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems MARGARET MARY COMMUNI	TY HOSPITAL	In Lie	u of Form CMS-2	2552-10		
STATE	MENT OF REVENUES AND EXPENSES	Provi der CCN: 151329	Peri od:	Worksheet G-3			
			From 01/01/2015 To 12/31/2015	Date/Time Pre 5/26/2016 11:			
				1. 00			
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			174, 544, 934	1. 00		
2.00	Less contractual allowances and discounts on patients' accounts	<b>&gt;</b>		87, 358, 773	2. 00		
3.00	Net patient revenues (line 1 minus line 2)			87, 186, 161	3. 00		
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		81, 999, 311	4. 00		
5. 00	Net income from service to patients (line 3 minus line 4)			5, 186, 850	5. 00		
,	OTHER I NCOME				,		
6.00	Contributions, donations, bequests, etc			1, 413	6. 00		
7.00	Income from investments			0	7. 00		
	8.00 Revenues from telephone and other miscellaneous communication services				8. 00		
9.00	Revenue from television and radio service			0	9. 00		
10.00	Purchase di scounts			0	10.00		
11.00	Rebates and refunds of expenses			0	11. 00		
12. 00	Parking lot receipts			0	12. 00		
13. 00	Revenue from Laundry and Linen service			0	13. 00		
14. 00	Revenue from meals sold to employees and guests			0	14. 00		
15. 00	Revenue from rental of living quarters			0	15. 00		
16. 00	Revenue from sale of medical and surgical supplies to other that	ın patients		0	16. 00		
17. 00	Revenue from sale of drugs to other than patients			0	17. 00		
18. 00	Revenue from sale of medical records and abstracts			0	18. 00		
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00		
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00		
21. 00	Rental of vending machines			0	21. 00		
22. 00	Rental of hospital space			0	22. 00		
23. 00	Governmental appropriations			0	23.00		
24. 00	OTHER REVENUE			1, 085, 188			
24. 01	NONOPERATING GAIN			389, 926			
	Total other income (sum of lines 6-24)			1, 476, 527			
	Total (line 5 plus line 25)			6, 663, 377			
27 00	HINDEALLZED LOSS ON DEDLIVATES			ON TIMPEALIZED LOSS ON DEDIVATES 2 532 363			

2, 532, 363 27. 00 2, 532, 363 28. 00 4, 131, 014 29. 00

27. 00 UNREALIZED LOSS ON DERIVATES

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

				TITIA CCIV.	15/145	0 12/31/2013	5/26/2016 11:	
						Home Health Agency I	PPS	
		Sal ari es	Empl oyee	Transportati or	Contracted/Pur		Total (sum of	
			Benefits	(see	chased		cols. 1 thru	
		1.00	2. 00	instructions) 3.00	Servi ces 4.00	5. 00	5) 6. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	0.00	
1.00	Capital Related - Bldg. &			(		0	0	1.00
0.00	Fixtures							
2. 00	Capital Related - Movable Equipment			(	7	0	0	2.00
3. 00	Plant Operation & Maintenance	0	0			0	О	3.00
4.00	Transportation	0	0	(		0	0	4. 00
5.00	Administrative and General	381, 997	0	(		183, 596	565, 593	5.00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	425, 906	0			0	425, 906	6.00
7. 00	Physical Therapy	332, 762	0		1	-		
8. 00	Occupational Therapy	68, 143	0	<b>I</b>		o o	68, 143	1
9. 00	Speech Pathology	1, 339	0	(		0	1, 339	1
10.00	Medical Social Services	14, 182	0	(		0	14, 182	1
11. 00 12. 00	Home Heal th Ai de	37, 958	0			0	37, 958	11.00
13. 00	Supplies (see instructions) Drugs	0	0	1				1
14. 00	DME	0	0			o o		1
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	0			-	0	15.00
16. 00 17. 00	Respiratory Therapy	0	0	(		0	0	16.00
18.00	Private Duty Nursing Clinic	0	0				0	18.00
19. 00	Health Promotion Activities	0	0			o o	Ö	19.00
20. 00	Day Care Program	0	0	(		0	0	20.00
21. 00	Home Delivered Meals Program	0	0	C		0	0	21.00
22. 00	Homemaker Service	0	0			0	0	22.00
23. 00 24. 00	All Others (specify) Total (sum of lines 1-23)	1, 262, 287	0			183, 596	1, 445, 883	23.00
21.00	Total (Sam of Filles 1 25)	Recl assi fi cati	Reclassi fied	Adjustments	Net Expenses	100,070	1, 110, 000	21.00
		on	Trial Balance		for Allocation	ו		
			(col. 6 +		(col. 8 + col.			
		7. 00	col . 7) 8. 00	9. 00	9)	_		-
	GENERAL SERVICE COST CENTERS		3.33					
1.00	Capital Related - Bldg. &	0	0	(	0	)		1. 00
2. 00	Fixtures Capital Related - Movable		0	,				2.00
2.00	Equipment	0	Ü			,		2.00
3.00	Plant Operation & Maintenance	0	0					3. 00
4.00	Transportati on	0	0	C				4. 00
5. 00	Administrative and General	0	565, 593		565, 593	3		5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	425, 906		425, 906			6.00
7. 00	Physical Therapy	0	332, 762					7. 00
8.00	Occupational Therapy	0	68, 143		68, 143			8. 00
9. 00	Speech Pathology	0	1, 339		1, 339			9. 00
10.00	Medical Social Services	0	14, 182		14, 182			10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	0	37, 958	(	37, 958	3		11. 00
13. 00	Drugs	0	0					13. 00
14. 00	DME	0	0					14. 00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	1	1			15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing		0					16. 00 17. 00
18. 00	Clinic	0	0			ó		18.00
19. 00	Health Promotion Activities	0	0	0				19. 00
20. 00	Day Care Program	0	0	(				20. 00
21. 00	Home Delivered Meals Program	0	0					21.00
22. 00 23. 00	Homemaker Service All Others (specify)	0	0					22. 00 23. 00
	Total (sum of lines 1-23)	0	1, 445, 883		1, 445, 883	ś		24.00
00	1.11. (34 3. 11103 1 20)	1	., 110, 505	1	., 110,000	-1		00

						Agency I	PPS	
			Capital Rel	ated Costs		Agency	1	
			<u> </u>					
		Net Expenses	BI dgs &	Movabl e	PI ant	Transportation	Subtotal	
		for Cost	Fi xtures	Equi pment	Operation &		(cols. 0-4)	
		Allocation			Mai ntenance			
		(from Wkst. H,						
		col . 10) 0	1.00	2.00	2.00	4. 00	4A. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2. 00	3. 00	4.00	4A. UU	
1. 00	Capital Related - Bldg. &	0	0				0	1.00
1.00	Fixtures						O	1.00
2.00	Capital Related - Movable	0		C			0	2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	C	) (		0	3. 00
4.00	Transportation	0	0	C		1		4. 00
5. 00	Administrative and General	565, 593	0	C	) (	0	565, 593	5. 00
	HHA REIMBURSABLE SERVICES	425.00/	ما		\	J 0	425 007	/ 00
6.00	Skilled Nursing Care	425, 906 332, 762	0	C		·	425, 906	1
7. 00 8. 00	Physical Therapy Occupational Therapy	68, 143	0			-	332, 762 68, 143	
9. 00	Speech Pathology	1, 339	0			1	1, 339	1
10. 00	Medical Social Services	14, 182	o	C		-	14, 182	
11. 00	Home Health Aide	37, 958	0	C		o	37, 958	
12.00	Supplies (see instructions)	0	0	C		o	0	12. 00
13.00	Drugs	0	0	C			0	13. 00
14. 00	DME	0	0	C		0	0	14. 00
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	0	C		-	0	
16.00	Respiratory Therapy	0	0	C		1	0	
17. 00 18. 00	Private Duty Nursing	0	0	C		-	0	17.00
19. 00	Clinic Health Promotion Activities		0			-	0	18. 00 19. 00
20. 00	Day Care Program		0				0	20.00
21. 00	Home Delivered Meals Program	0	o	C			0	21.00
22. 00	Homemaker Service	0	o	C		ol ol	0	22. 00
23. 00	All Others (specify)	O	0	C		o	0	23. 00
24. 00	Total (sum of lines 1-23)	1, 445, 883	0	C		0	1, 445, 883	24. 00
		Admi ni strati ve	,					
		& General	4A + 5)					
	CENEDAL CEDALCE COCT CENTEDO	5. 00	6. 00					
1. 00	GENERAL SERVICE COST CENTERS  Capital Related - Bldg. &							1.00
1.00	Fixtures							1.00
2.00	Capital Related - Movable							2. 00
	Equi pment							
3.00	Plant Operation & Maintenance							3. 00
4.00	Transportati on							4. 00
5. 00	Administrative and General	565, 593						5. 00
	HHA REIMBURSABLE SERVICES	070 (10	/00 FEE					, ,,
6. 00	Skilled Nursing Care	273, 649	699, 555					6.00
7. 00 8. 00	Physical Therapy Occupational Therapy	213, 802 43, 782	546, 564 111, 925					7. 00 8. 00
9. 00	Speech Pathology	860	2, 199					9. 00
10. 00	Medical Social Services	9, 112	23, 294					10.00
11. 00	Home Heal th Ai de	24, 388	62, 346					11. 00
12. 00	Supplies (see instructions)	0	0					12. 00
13.00	Drugs	0	0					13. 00
14. 00	DME	0	0					14. 00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing		0					17.00
18. 00 19. 00	Clinic Health Promotion Activities		0					18. 00 19. 00
20. 00	Day Care Program		0					20.00
21. 00	Home Delivered Meals Program		0					21.00
22. 00	Homemaker Service		0					22. 00
23. 00	All Others (specify)	0	O					23. 00
	Total (sum of lines 1-23)		1, 445, 883					24. 00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HHA STATISTICAL BASIS	Provi der CCN:	151329 157143	From 01/01/2015	
	HHA CCN:	15/143	10 12/31/2015	Date/Time Prepared: 5/26/2016 11:49 am

							5/26/2016 11:4	49 am
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	Pl ant	Transportation	nReconciliation	Administrative	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
			(DOLLAR VALUE)	Mai ntenance	(MI EE/IOE)		(ACCUM. COST)	
		(SQUARE TEET)	(DOLLAN WILDL)	(SQUARE FEET)			(71000m: 0001)	
		1.00	2. 00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1. 00
	Fi xtures							l
2.00	Capital Related - Movable		0			0		2. 00
	Equi pment							l
3.00	Plant Operation & Maintenance	0	0	C	)	0		3. 00
4.00	Transportation (see	0	0	C	)	O		4. 00
	instructions)							
5.00	Administrative and General	0	0	C	)  (	565, 593	880, 290	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	C	)	0	425, 906	6. 00
7.00	Physi cal Therapy	0	0	C	)	0	332, 762	7. 00
8.00	Occupational Therapy	0	0	C	)	0	68, 143	
9.00	Speech Pathology	0	0	C	)	0	1, 339	
10.00	Medical Social Services	0	0	C	) (	0	14, 182	
11. 00	Home Health Aide	0	0	C	) (	0	37, 958	
12.00	Supplies (see instructions)	0	0	C	) (	0	0	12. 00
13.00	Drugs	0	0	C	)	0	0	13. 00
14.00	DME	0	0	C	) (	0	0	14. 00
	HHA NONREIMBURSABLE SERVICES							l
15. 00	Home Dialysis Aide Services	0	0	C	)	0	0	15. 00
16. 00	Respiratory Therapy	0	0	C	)	0	0	16. 00
17. 00	Private Duty Nursing	0	0	C	) (	0	0	17. 00
18. 00	Clinic	0	0	C	) (	0	0	18. 00
19. 00	Health Promotion Activities	0	0	C	)	0	0	19. 00
20. 00	Day Care Program	0	0	C	) (	0	0	20. 00
21. 00	Home Delivered Meals Program	0	0	C	) (	0	0	21. 00
22. 00	Homemaker Service	0	0	C		0	0	22. 00
23. 00	All Others (specify)	0	0	C		0	0	23. 00
24.00	Total (sum of lines 1-23)	0	0	C	) (	565, 593	880, 290	
25. 00	Cost To Be Allocated (per	0	0	C	) (	O	565, 593	25. 00
	Worksheet H-1, Part I)							l
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 000000	O	0. 642508	26. 00

Heal th Financial Systems MARGARE ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 5/26/2016 11: 49 am Provi der CCN: 151329 Peri od: From 01/01/2015 To 12/31/2015 HHA CCN: 157143 Home Health PPS

						Agency I		
				CAPI TAL REI	LATED COSTS			
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	EMPLOYEE BENEFITS DEPARTMENT	
		0	1. 00	1. 01	2. 00	2. 01	4. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0 699, 555 546, 564 1111, 925 2, 199 23, 294 62, 346 0 0 0 0 0 0 0 0 0 0	33, 566 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57, 049 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	458, 612 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 21. 00
	Cost Center Description	Subtotal	ADMI NI STRATI VE & GENERAL		OPERATION OF PLANT -OFFSITE	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	
		4A	5. 00	7. 00	7. 01	7. 02	8. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.	549, 227 699, 555 546, 564 111, 925 2, 199 23, 294 62, 346 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	106, 005 135, 019 105, 491 21, 602 424 4, 496 12, 033 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 385, 070	76, 255 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0	15, 577 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00

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

Heal th Financial Systems MARGARE ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 5/26/2016 11:49 am Provi der CCN: 151329 Peri od: From 01/01/2015 To 12/31/2015 HHA CCN: 157143

						Home Health Agency I	PPS	17 diii
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL	PHARMACY	
		9. 00	10.00	11.00	13.00	14.00	15. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	29, 257 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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
	6 decimal places.  Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16. 00	24. 00	25. 00	26.00	27. 00	28. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0 0 0 0 0 0 0 0 0 0 0 0	776, 353 834, 574 652, 055 133, 527 2, 623 27, 790 74, 379 0 0 0 0 0 0 0 0 0 0 2, 501, 301		834, 574 652, 055 133, 527 2, 623 27, 790	375, 619 293, 472 60, 097 1, 181 12, 508 33, 476 0 0 0 0 0 0 0 0 0 0 0 0	1, 210, 193 945, 527 193, 624 3, 804 40, 298 107, 855 0 0 0 0 0 0 0 0 0 0 2, 501, 301	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

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

BASIS 157143 HHA CCN:

						Home Health	PPS	
			CADITAI DEI	LATED COSTS		Agency I		
			OALLIAE REI	LATED COSTS				
	Cost Center Description	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE	EMPLOYEE	Reconciliation	
		FIXT	BLDG	EQUI P	EQUIP OFFSIT	BENEFITS		
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS		
		1 1 1 1 1	ILLI)	''LL')	'''	SALARI ES)		
		1.00	1. 01	2.00	2. 01	4. 00	5A	
1.00	Administrative and General	3, 415	0		0	1, 262, 287	0	1. 00
2.00	Skilled Nursing Care	0	0		1	_	0	2. 00
3.00	Physical Therapy	0	0	_	1	0	0	3. 00
4. 00 5. 00	Occupational Therapy Speech Pathology		0		0	0	0	4. 00 5. 00
6. 00	Medical Social Services	0	0	_	0		o o	6. 00
7.00	Home Health Aide	O	0	0	0	0	0	7. 00
8.00	Supplies (see instructions)	0	0		0	0	0	8. 00
9.00	Drugs	0	0		-	0	0	
10.00	DME	0	0		1	0	0	10.00
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy	0	0			-	0	11. 00 12. 00
13. 00	Private Duty Nursing	0	0		1	_	0	13. 00
14. 00	Clinic	0	0		Ō	0	0	14. 00
15. 00	Health Promotion Activities	0	0	0	0	0	0	15. 00
16. 00	Day Care Program	0	0	0	0	0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18. 00 19. 00	Homemaker Service All Others (specify)	0	0	0	0	0	0	18. 00 19. 00
20. 00	Total (sum of lines 1-19)	3, 415	0	3, 415		1, 262, 287	_	20. 00
21. 00	Total cost to be allocated	33, 566	0	57, 049		458, 612		21. 00
22. 00	Unit cost multiplier	9. 828990	0. 000000		0.000000			22. 00
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL (ACCUM.	PLANT (SQUARE	PLANT -OFFSITE	PLANT - HOSPITAL &	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	
		COST)	FEET)	(SQUARE	0FFS	LAUNDRY)	1 1 1 1 1 1	
			,	FEET)	(SQUARE	210112111)		
					FEET)			
1.00		5.00	7.00	7. 01	7. 02	8. 00	9. 00	4 00
1. 00 2. 00	Administrative and General Skilled Nursing Care	549, 227 699, 555	3, 415 0	l .	-,	0	3, 415 0	1. 00 2. 00
3.00	Physical Therapy	546, 564	0				0	3. 00
4. 00	Occupational Therapy	111, 925	0	-		0	ő	4. 00
5.00	Speech Pathology	2, 199	0	0	0	0	0	5. 00
6.00	Medical Social Services	23, 294	0		0	0	0	6. 00
7.00	Home Heal th Ai de	62, 346	0		0	0	0	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs	0	0		1	0	0	8. 00 9. 00
10. 00	DME	0	0	_	1		0	10. 00
11. 00	Home Dialysis Aide Services	O	0	-	Ō	0	O	11. 00
12.00	Respiratory Therapy	0	0	0	0	0	0	12. 00
13. 00	Private Duty Nursing	0	0	0	0	0	0	13. 00
14.00		0	0	0	0	0	0	14.00
15. 00 16. 00	Health Promotion Activities Day Care Program		0	0			0	15. 00 16. 00
17. 00	Home Delivered Meals Program	0	0	0	0		0	
18. 00		o	0	_	Ö	0	Ö	18. 00
19. 00	All Others (specify)	0	0	0	0	0	0	19. 00
	Total (sum of lines 1-19)	1, 995, 110			3, 415		3, 415	
21. 00	Total cost to be allocated	385, 070			15, 577		29, 257	
22. 00	Unit cost multiplier	0. 193007	22. 329429	0. 000000	4. 561347	0. 000000	8. 567204	22.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lie	In Lieu of Form CMS-2552-10		
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST BASIS	CENTERS STATISTICAL Provider (	CN: 151329   Period: From 01/01/2015	Worksheet H-2		
DASI 3	HHA CCN:		Date/Time Prepared:		

5/26/2016 11:49 am Home Health PPS Agency I Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL (MEALS (HOURS OF ADMI NI STRATI ON SERVICES & (100% RECORDS & SERVED) SERVICE) SUPPLY PHARMACY) LI BRARY (HOURS OF (COSTED (TIME SERVICE) SPENT) REQUIS.) 10.00 11.00 13.00 14.00 15.00 16.00 1.00 Administrative and General 30, 252 1.00 000000000000000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 2.00 0 Ω ol 2.00 Skilled Nursing Care 3.00 Physical Therapy 0 0 3.00 Occupational Therapy 4.00 0 0 0 0 4.00 5.00 Speech Pathology 0 5.00 ol Medical Social Services 0 6.00 6.00 7.00 Home Heal th Aide 0 7.00 0 0 8.00 Supplies (see instructions) 8.00 0 9.00 0 Drugs 9.00 10.00 DMF 0 10.00 11.00 Home Dialysis Aide Services 0 0 11.00 0 12.00 Respiratory Therapy 0 12.00 Private Duty Nursing 0 13.00 13.00 14.00 Clinic 0 0 14.00 15.00 Health Promotion Activities 15.00 0 0 Day Care Program 16, 00 16.00 0 17.00 Home Delivered Meals Program 0 17.00 0 18.00 Homemaker Service 0 18.00 All Others (specify) 19.00 0 0 0 19.00 0 0 0 Total (sum of lines 1-19) 20.00 20.00 0 30, 252 21.00 Total cost to be allocated 32 21.00 22.00 Unit cost multiplier 0.000000 0.000000 0.000000 0.001058 0.000000 0. 000000 22.00

Heal th	Financial Systems	MAF	RGARET MARY COM	MUNITY HOSPI	ΙΤΑΙ	I	In lie	u of Form CMS-2	552-10
	TIONMENT OF PATIENT SERVICE COST		CONTENTION			CCN: 151329	Peri od:	Worksheet H-3	1002 10
				нна сс	:N:	157143	From 01/01/2015 To 12/31/2015	Part I Date/Time Prep 5/26/2016 11:4	
				Ti	itl	e XVIII	Home Health Agency I	PPS	+7 alli
	Cost Center Description	From, Wkst.	Facility Costs	Shared		Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary		Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (fro Part II)	om	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00		3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER				TH				
	BENEFICIARY COST LIMITATION								
1.00	Cost Per Visit Computation Skilled Nursing Care	2.00	1, 210, 193			1, 210, 19	5, 012	241. 46	1. 00
2. 00	Physical Therapy	3.00			0			326. 49	2. 00
3. 00	Occupational Therapy	4. 00			0			348. 87	3. 00
4.00	Speech Pathology	5. 00			0			70. 44	4.00
5.00	Medical Social Services	6. 00				40, 29		2, 238. 78	5.00
6.00	Home Heal th Ai de	7. 00			_	107, 85		225. 64	6. 00
7. 00	Total (sum of lines 1-6)		2, 501, 301		0	2,501,30 Program Visit			7. 00
							art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A		Not Subject t			
						Deductibles			
		0	1.00	2. 00		Coi nsurance		F 00	
	Limitation Cost Computation	0	1.00	2.00		3.00	4. 00	5. 00	
8.00	Skilled Nursing Care		17140		0		0		8. 00
8. 01	Skilled Nursing Care		50031		0	1, 86	04		8. 01
8.02	Skilled Nursing Care		50034		0				8. 02
8. 03	Skilled Nursing Care		50035		0				8. 03
8. 04 8. 05	Skilled Nursing Care Skilled Nursing Care		50042 99915		0		0		8. 04 8. 05
9. 00	Physical Therapy		17140		0		0		9. 00
9. 01	Physical Therapy		50031		0	94			9. 01
9. 02	Physi cal Therapy		50034		0	27	0		9. 02
9. 03	Physi cal Therapy		50035		0				9. 03
9.04	Physical Therapy		50042		0		7		9. 04
9. 05 10. 00	Physical Therapy Occupational Therapy		99915 17140		0		0		9. 05 10. 00
10. 00	Occupational Therapy		50031		0				10. 00
10. 02	Occupational Therapy		50034		0		26		10. 02
10. 03	Occupational Therapy		50035		0	8	35		10. 03
10. 04	Occupational Therapy		50042		0		7		10. 04
10.05	Occupational Therapy		99915		0		0		10.05
11. 00 11. 01	Speech Pathology Speech Pathology		17140 50031		0		0		11. 00 11. 01
11. 02	Speech Pathology		50034		0		6		11. 02
	Speech Pathology		50035		0		21		11. 03
11. 04	Speech Pathology		50042		0		0		11. 04
11. 05	Speech Pathology		99915		0		0		11. 05
12.00	Medical Social Services		17140		0		0		12.00
12. 01 12. 02	Medical Social Services Medical Social Services		50031 50034		0		8		12. 01 12. 02
12. 02	Medical Social Services		50035		0		2		12. 02
12. 04	Medical Social Services		50042		0	•	0		12. 04
12. 05	Medical Social Services	•	99915		0		0		12.05
13.00	Home Health Aide		17140		0		0		13. 00
13. 01	Home Health Aide		50031		0				13. 01
13. 02 13. 03	Home Health Aide Home Health Aide		50034 50035		0		7		13. 02 13. 03
13. 03	Home Health Aide		50035		0		5		13. 03
13. 05	d .		99915		0		0		13. 05
	Total (sum of lines 8-13)				0		80		14. 00
							'	'	

	Financial Systems TONMENT OF PATIENT SERVICE COST		RGARET MARY COM		CCN: 151329	Peri od:	in Lie	u of Form CMS-2 Worksheet H-3	
PPURI	TUNMENT OF PATTENT SERVICE COST	5		HHA CCN:	157143	From 01	/01/2015 /31/2015	Part I Date/Time Preps/26/2016 11:4	pared
				Ti tl	e XVIII		Heal th	PPS	,,
	Cost Center Description	From Wkst. H-2	Eacility Costs	Shared	Total HHA	Agen		Ratio (col. 3	
	odst denter bescription	Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from Part II)	Costs (cols. + 2)	1 (fro	om HHA cord)	÷ col . 4)	
		0	1.00	2.00	3.00	4.	. 00	5. 00	
	Supplies and Drugs Cost Comput		_		1	_1			
5. 00 6. 00	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00			1	0	30, 252 0	0. 000000 0. 000000	
0. 00	Josef C. Bruge		Program Visits		Cost of			0.00000	
			Don	t B	Servi ces	Dou	rt B		
	Cost Center Description	Part A	Not Subject to		Part A		bject to	Subject to	
	<b>'</b>		Deductibles &	Deductibles &		Deduct	ibles &	Deductibles &	
		6.00	Coi nsurance 7.00	Coi nsurance 8.00	9.00		urance 0.00	Coi nsurance 11.00	
	PART I - COMPUTATION OF LESSER								
	BENEFICIARY COST LIMITATION								
. 00	Cost Per Visit Computation Skilled Nursing Care	Ιο	2, 915		I	0	703. 856		1.
. 00	Physical Therapy	Ö				0	552, 095		2.
. 00	Occupational Therapy	0	T			0	121, 058		3.
00	Speech Pathology Medical Social Services	0	46 13			0	3, 240 29, 104		4. 5.
. 00	Home Heal th Aide					0	83, 036		6.
. 00	Total (sum of lines 1-6)	0	5, 380			0 1	, 492, 389		7.
	Cost Center Description	6.00	7. 00	8. 00	9.00	10	0. 00	11. 00	
	Limitation Cost Computation	0.00	7.00	8.00	9.00	10	7. 00	11.00	
. 00	Skilled Nursing Care								8.
. 01 . 02	Skilled Nursing Care Skilled Nursing Care								8. 8.
. 02	Skilled Nursing Care								8.
. 04	Skilled Nursing Care								8.
. 05	Skilled Nursing Care								8.
. 00 . 01	Physical Therapy Physical Therapy				•				9. 9.
. 02	Physical Therapy								9.
. 03	Physical Therapy								9.
. 04	Physical Therapy Physical Therapy				•				9.
0. 00	Occupational Therapy								10
0. 01	Occupational Therapy								10
0. 02	Occupational Therapy								10
0. 03	Occupational Therapy Occupational Therapy								10.
0. 05									10
1.00	Speech Pathology								11
I. 01 I. 02	Speech Pathology Speech Pathology								11
1. 02	1 33								11
	Speech Pathology								11
. 05									11
2. 00	Medical Social Services Medical Social Services								12 12
2. 02	Medical Social Services								12
2. 03	Medical Social Services								12
2. 04	Medical Social Services								12
2. 05 3. 00	Medical Social Services Home Health Aide								12. 13.
3. 01	Home Heal th Ai de								13
3. 02	Home Health Aide								13
3. 03 3. 04	Home Health Aide								13.
< 11/1	Home Health Aide								13. 13.
3. 05	Home Health Aide								

Heal th	Financial Systems	MAI	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-:	2552-10
APPOR1	TIONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 151329	Peri od: From 01/01/2015 To 12/31/2015	Worksheet H-3 Part I Date/Time Pre	
					157143		5/26/2016 11:	
				Ti tl	e XVIII	Home Health Agency I	PPS	
		Prog	ram Covered Cha	rges	Cost of Services			
	Cost Center Description	Part A	Part Not Subject to Deductibles &	Subject to Deductibles &	Part A	Part B Not Subject to Deductibles &	Subject to Deductibles &	
		6. 00	Coi nsurance 7.00	Coi nsurance 8. 00	9. 00	Coi nsurance 10.00	Coi nsurance 11.00	
	Supplies and Drugs Cost Comput	ati ons						
15. 00 16. 00	Cost of Medical Supplies Cost of Drugs	C	0	0		0 0	0	
10.00	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00	y y					10.00
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION		PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	?	
4 00	Cost Per Visit Computation	700 5=:						
1. 00 2. 00	Skilled Nursing Care Physical Therapy	703, 856 552, 095						1. 00 2. 00
3.00	Occupational Therapy	121, 058						3. 00
4. 00 5. 00	Speech Pathology Medical Social Services	3, 240 29, 104						4. 00 5. 00
6. 00	Home Heal th Ai de	83, 036						6.00
7. 00	Total (sum of lines 1-6)	1, 492, 389						7. 00
	Cost Center Description	12. 00	-					-
	Limitation Cost Computation	12.00						
8.00	Skilled Nursing Care							8. 00 8. 01
8. 01 8. 02	Skilled Nursing Care Skilled Nursing Care							8.01
8. 03	Skilled Nursing Care							8. 03
8. 04 8. 05	Skilled Nursing Care Skilled Nursing Care							8. 04 8. 05
9. 00	Physical Therapy							9.00
9. 01	Physi cal Therapy							9. 01
9. 02	Physical Therapy							9. 02
9. 03 9. 04	Physical Therapy Physical Therapy							9. 03 9. 04
9. 05	Physical Therapy							9. 05
10.00	Occupational Therapy							10.00
10. 01 10. 02	Occupational Therapy Occupational Therapy							10. 01
	Occupational Therapy							10. 02
10. 04	Occupational Therapy							10. 04
10.05	Occupational Therapy							10.05
11. 00 11. 01	Speech Pathology Speech Pathology							11. 00 11. 01
11. 02	Speech Pathology							11. 02
11. 03	11.11.11.11.11.11.11.11.11.11.11.11.11.							11. 03
11. 04	Speech Pathology							11. 04
11. 05 12. 00	Speech Pathology Medical Social Services							11. 05 12. 00
12. 01	Medical Social Services							12. 01
12. 02	Medical Social Services							12. 02
12. 03 12. 04	Medical Social Services Medical Social Services							12. 03 12. 04
12. 04	Medical Social Services							12. 04
13.00	Home Health Aide							13.00
13. 01	Home Health Aide							13. 01
13. 02 13. 03	Home Health Aide Home Health Aide							13. 02 13. 03
	Home Health Aide							13. 03
13.04								
13. 05	Home Health Aide Total (sum of lines 8-13)							13. 05 14. 00

Heal th	Financial Systems	RGARET MARY COM	IMUNI 7	ΓΥ HOSPITA	ıL.		In Lie	u of Form CMS-2	2552-10	
APPOR	FIONMENT OF PATIENT SERVICE COST	S			Provi der	CCN: 151329	Peri oc		Worksheet H-3	
					HHA CCN:	157143		01/01/2015 12/31/2015	Part II Date/Time Prep 5/26/2016 11:4	
					Ti tl	e XVIII	Home	e Health	PPS	
							Ag	ency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	То	tal HHA	HHA Shared	Tra	nsfer to		
		Part I, col.	Rati o	Charge (from		Ancillary	Pa	rt I as		
		9, line		pr	rovi der	Costs (col.	1 In	di cated		
				re	ecords)	x col. 2)				
		0	1.00		2.00	3.00		4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	CES FURNI SHED B	Y SHA	ARED HOSPI	TAL DEPARTMEN	NTS			
1.00	Physi cal Therapy	66. 00	0. 583741		O		0 col.	2, line 2	. 00	1.00
2.00	Occupational Therapy	67. 00	0. 592930		0		0 col.	2, line 3	. 00	2.00
3.00	1		0. 900424		0		0 col .	2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71.00	0. 427661		0		0 col .	2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 327586		0		0 col .	2, line 1	6. 00	5. 00

th Financial Systems MARGARET MARY COMMUNICULATION OF HHA REIMBURSEMENT SETTLEMENT		CCN: 151329	Peri od:	u of Form CMS-2 Worksheet H-4	
	HHA CCN:	157143	From 01/01/2015	Part I-II	epar
	Ti tl	e XVIII	Home Health Agency I	PPS	
				t B	
		Part A	Not Subject to Deductibles &		
			Coi nsurance	Coi nsurance	
		1.00	2. 00	3. 00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM	ARY CHARGE				
Reasonable Cost of Part A & Part B Services					
O Reasonable cost of services (see instructions)			0 0	0	
O Total charges			0 0	0	1 2
Customary Charges					4
O Amount actually collected from patients liable for payment for	servi ces		0 0	0	1 3
on a charge basis (from your records)					
O Amount that would have been realized from patients liable for p			0 0	0	4
for services on a charge basis had such payment been made in ac with 42 CFR §413.13(b)	cordance				
0 Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	, ,
O Total customary charges (see instructions)		0.0000	0 0.00000	0.000000	
0 Excess of total customary charges over total reasonable cost (c	omplete		0 0	0	
only if line 6 exceeds line 1)					
0 Excess of reasonable cost over customary charges (complete only	ifline		0 0	0	
1 exceeds line 6)					
O Primary payer amounts			0 0	0	1
			Part A	Part B	
			Servi ces 1.00	Servi ces 2. 00	$\vdash$
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	$\vdash$
00 Total reasonable cost (see instructions)			0	0	10
00 Total PPS Reimbursement - Full Episodes without Outliers			0	917, 254	
00 Total PPS Reimbursement - Full Episodes with Outliers			0	4, 495	
00 Total PPS Reimbursement - LUPA Episodes			0	15, 741	1:
00 Total PPS Reimbursement - PEP Episodes			0	11, 842	1 1
00 Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	68	1!
00 Total PPS Outlier Reimbursement - PEP Episodes			0	0	1
00 Total Other Payments			0	0	1
00 DME Payments			0	0	1
00 Oxygen Payments			0	0	1
00 Prosthetic and Orthotic Payments			0	0	
00 Part B deductibles billed to Medicare patients (exclude coinsur	ance)			0	
00  Subtotal (sum of lines 10 thru 20 minus line 21)			0	949, 400	
00 Excess reasonable cost (from line 8)			0	0	
00 Subtotal (line 22 minus line 23)			0	949, 400	
OO   Coinsurance billed to program patients (from your records)				0	
00 Net cost (line 24 minus line 25)			0	949, 400	
00 Reimbursable bad debts (from your records)					2
00 Reimbursable bad debts for dual eligible beneficiaries (see ins		)		040 400	2
00  Total costs - current cost reporting period (line 26 plus line 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	21)			949, 400	
			0	0	
50 Pioneer ACO demonstration payment adjustment (see instructions)				040 400	
00   Subtotal (see instructions) 01   Seguestration adjustment (see instructions)			0	949, 400	
01   Sequestration adjustment (see instructions) 00   Interim payments (see instructions)				18, 988 930, 411	
OU TITLETTII DAVIIETLA LACE TITALI UCLI UITA)			0	930, 411	
, , , , , , , , , , , , , , , , , , , ,					1 0.
OO Tentative settlement (for contractor use only)	4 33)		٥		
, , , , , , , , , , , , , , , , , , , ,		S Pub 15-2	0	1 0	34

PROGRAM BENEFICIARIES

HHA CCN:

Home Health

				Agency I	PPS	
		I npati en	nt Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider			0	930, 411	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		T		1 -	
3. 01 3. 02			1	0	0 0	3. 01 3. 02
3. 02			1	0		3. 02
3. 04				0		3. 04
3. 05			1	Ö	l ő	3. 05
	Provi der to Program	•	'			
3.50			1	0	0	3. 50
3.51			1	0	0	3. 5
3. 52			1	0	0	3. 52
3. 53 3. 54				0		3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 99
0. 77	3. 50-3. 98)				Ĭ	0. 7
4.00	Total interim payments (sum of lines 1, 2, and 3.99)			0	930, 411	4.00
	(transfer to Wkst. H-4, Part II, column as appropriate,					
	Tine 32)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		1			5. 00
5.00	desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01			1	0	0	5.0
5. 02				0	0	5. 02
5. 03	Provider to Program			0	0	5. 03
5. 50	Frovider to Frogram			0	0	5. 50
5. 51			1	Ö	0	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 9
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	1	6. 0°
6. 02	SETTLEMENT TO PROGRAM		1	0	Ö	6. 02
7. 00	Total Medicare program liability (see instructions)		1	0	930, 412	7. 00
				Contractor	NPR Date	
			-	Number	(Mo/Day/Yr)	
0.00	Name of Contractor		0	1. 00	2. 00	0.00
8.00	Name of Contractor	I		1	1	8. 00

			nospi ce (	JON. 131331 1	0 12/31/2013	5/26/2016 11:	
					Hospi ce I	0, 20, 20, 0	
		Salaries (from	Employee	Transportati on		Other	
			Benefits (from		Services (from		
		,	Wkst. K-2)	,	Wkst. K-3)		
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			C		0	1.00
2.00	Capital Related Costs-Movable Equip.			l c		0	2. 00
3.00	Plant Operation and Maintenance	0	0	l c	ol	0	3. 00
4.00	Transportation - Staff	0	0	l c	ol	0	4. 00
5.00	Volunteer Service Coordination	0	0	l c	ol	0	5. 00
6.00	Administrative and General	165, 494	0	366	ol ol	282, 887	6. 00
	I NPATI ENT CARE SERVI CE	<u>'</u>		<u>'</u>			
7.00	Inpatient - General Care	0	0	C	0	0	7. 00
8.00	Inpatient - Respite Care	0	0	l c	ol	0	8. 00
	VISITING SERVICES	<u>.                                      </u>					
9.00	Physi ci an Servi ces	0	0	C	0	0	9. 00
10.00	Nursing Care	300, 676	0	37, 722	el ol	0	10.00
11. 00	Nursing Care-Continuous Home Care	0	0	C	ol	0	11. 00
12.00	Physi cal Therapy	0	0	l c	ol	0	12. 00
13.00	Occupational Therapy	O	0	l c	ol ol	0	13. 00
14.00	Speech/ Language Pathology	O	0	l c	ol ol	0	14. 00
15. 00	,	58, 532	0	6, 405	ol ol	0	15. 00
16.00	Spiritual Counseling	O	0		ol ol	0	16. 00
17. 00	Di etary Counseling	O	0	l c	ol	0	17. 00
18. 00	Counseling - Other	O	0	l c	ol ol	0	18. 00
19. 00	Home Health Aide and Homemaker	84, 812	0	22, 266	ol ol	0	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0		ol ol	0	20.00
21. 00	Other	24, 667	0	2, 462	el ol	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy	0	0	C	0	0	22. 00
23. 00	Anal gesi cs	0	0	l c	ol	0	23. 00
24.00	Sedatives / Hypnotics	0	0	l c	ol	0	24. 00
25. 00	Other - Specify	0	0	1	ol ol	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0	0	ol ol	0	26. 00
27. 00	Pati ent Transportation	0	0		ol ol	0	27. 00
28. 00	I maging Services	0	0		ol ol	0	28. 00
29. 00	Labs and Diagnostics	0	0		ol	0	29. 00
30. 00	Medical Supplies	0	0		ol ol	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0		ol ol	0	31. 00
32. 00	Radi ati on Therapy	0	0	0	ol ol	0	32. 00
33. 00	Chemotherapy	0	0	l o	ol ol	0	33. 00
34. 00	Other	0	0	l o	ol ol	0	34. 00
	HOSPI CE NONREI MBURSABLE SERVI CE	1			-1		
35. 00	Bereavement Program Costs	0	0	С	ol	0	35. 00
36. 00	Volunteer Program Costs	0	0		ol ol	0	36. 00
37. 00	Fundrai si ng	0	0		ol ol	0	37. 00
38. 00	Other Program Costs	0	0		ol ol	0	38. 00
	Total (sum of lines 1 thru 38)	634, 181	0	69, 221	o	282, 887	1
	1		· ·	,	١	,,	

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 151329	Peri od: Worksheet K
		From 01/01/2015
		T- 10/01/001F   D-+-/T! D

12/31/2015 Date/Time Prepared: Hospi ce CCN: 151551 To 5/26/2016 11:49 am Hospi ce I Reclassificati Subtotal (col Total (cols. Total (col. 8 Adiustments ± col . 9) 1-5)on 6 ± col. 7) 9. 00 7 00 6 00 8 00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 0 1.00 0 0 Capital Related Costs-Movable Equip. 0 2.00 0 0 2.00 0 3 00 3 00 Plant Operation and Maintenance 0 0 4.00 Transportation - Staff 0 0 0 0 0 4.00 Volunteer Service Coordination 5.00 5.00 6.00 Administrative and General 448, 747 0 448, 747 448, 747 6.00 INPATIENT CARE SERVICE 7.00 Inpatient - General Care 0 0 0 0 0 7.00 8.00 Inpatient - Respite Care 0 0 0 0 0 8.00 VISITING SERVICES 9.00 Physi ci an Servi ces 0 Ω 9.00 10.00 Nursing Care 338, 398 338, 398 0 338, 398 10.00 Nursing Care-Continuous Home Care 0 11.00 0 11.00 0 0 0 0 0 12.00 Physical Therapy 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 0 0 0 0 0 13.00 Speech/ Language Pathology 14.00 14.00 Medical Social Services 0 64, 937 15.00 64, 937 15.00 64.937 16.00 Spiritual Counseling 0 0 0 Ω 16.00 17.00 Dietary Counseling 0 0 17.00 0 18.00 Counseling - Other 0 0 0 18.00 Home Heal th Aide and Homemaker 107, 078 19.00 107,078 0 107, 078 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 20.00 21.00 27, 129 27, 129 27, 129 21.00 OTHER HOSPICE SERVICE COSTS 0 22.00 Drugs, Biological and Infusion Therapy Λ 22.00 0 23.00 Anal gesi cs 0 0 0 23.00 Sedatives / Hypnotics 0 24.00 0000000000 0 0 0 0 0 0 0 0 0 24.00 0 0 25.00 Other - Specify 0 25.00 Durable Medical Equipment/Oxygen 0 0 26.00 0 26.00 0 27.00 Patient Transportation 0 0 27.00 0 0 28. 00 Imaging Services 28.00 0 29 00 Labs and Diagnostics Ω 29.00 0 0 30.00 Medical Supplies 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 Radiation Therapy 32.00 0 0 0 32.00 0 0 33.00 Chemotherapy 0 33.00 34.00 0ther 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35 00 0 0 O n 35.00 Bereavement Program Costs 0 0 0 36.00 Volunteer Program Costs 0 0 36.00 37.00 Fundrai si ng 0 0 0 0 37.00 0 38.00 Other Program Costs 0 0 0 0 38.00 986, 289 986, 289 986, 289 39.00 Total (sum of lines 1 thru 38) O 39.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10	
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES	Provi der CCN: 151329	Peri od:	Worksheet K-1

Hospi ce CCN: 151524 | Per Form 01/01/2015 | From 01/01/2015 | Date/Time Prepared:

			nospi ce c	JON. 151551 10	12/31/2015	5/26/2016 11:	
					Hospi ce I		
		Admi ni strator	Di rector	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2. 00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3. 00
4.00	Transportation - Staff	0	0	0	0	0	4. 00
5.00	Volunteer Service Coordination	0	0	0	0	0	5. 00
6.00	Administrative and General	0	165, 494	0	0	0	6. 00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0	0		0	0	
8.00	Inpatient - Respite Care	0	0	0	0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0		0	0	
10.00	Nursi ng Care	0	0	0	0	300, 676	
11. 00	Nursing Care-Continuous Home Care	0	0	0	0	0	
12.00	Physi cal Therapy	0	0	0	0	0	12. 00
13.00	Occupational Therapy	0	0	0	0	0	13. 00
14. 00	Speech/ Language Pathology	0	0		0	0	14. 00
15. 00	Medical Social Services	0	0	58, 532	0	0	15. 00
16. 00	Spiritual Counseling	0	0	0	0	0	16. 00
17. 00	Di etary Counseling	0	0	0	0	0	17. 00
18. 00	Counseling - Other	0	0	0	0	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0	0	0	0	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0	_	0	0	20. 00
21. 00	Other	0	0	0	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS			T			
22. 00	Drugs, Biological and Infusion Therapy						22. 00
23. 00	Anal gesi cs						23. 00
24. 00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26. 00	Durable Medical Equipment/Oxygen						26. 00
27. 00	Pati ent Transportation	0	0	0	0	0	
28. 00	I maging Services	0	0	0	0	0	28. 00
29. 00	Labs and Diagnostics	0	0	0	0	0	
30.00	Medical Supplies	0	0	0	U	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0	0	U	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33. 00	Chemotherapy	0	0	_	0	0	33. 00
34. 00	Other	l U	0	0	U	0	34. 00
25 00	HOSPI CE NONREI MBURSABLE SERVI CE				O	0	25 00
35. 00 36. 00	Bereavement Program Costs Volunteer Program Costs		0		0	0	35. 00 36. 00
36.00	Fundraising		0		ol Ol	0	
37.00	Other Program Costs		0		U O	0	37.00
	Total (sum of lines 1 thru 38)		165, 494	58, 532	0	300, 676	
37.00	Tiotal (Sum of Titles I till a 30)	١	100, 494	1 56, 552	Ч	300, 676	J 37. UU

Health Financial Systems	MARGARET MARY COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAG	ES	Provi der CCN:	151329		Worksheet K-1
		Hospi ce CCN:	151551	From 01/01/2015 To 12/31/2015	Date/Time Prepared

			Hospi ce CC	CN: 151551	To 12/31/2015	Date/Time Prepared: 5/26/2016 11:49 am
					Hospi ce I	372072010 11.47 4111
		Total	Ai des	All-Other	Total (1)	
		Therapists	711 403	711 Other	10141 (1)	
		6.00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.					1, 00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0		o o	3.00
4.00	Transportation - Staff		0		o o	4.00
5.00	Volunteer Service Coordination		0		o o	5. 00
6.00	Administrative and General		0		0 165, 494	6.00
	I NPATI ENT CARE SERVI CE					
7.00	Inpatient - General Care		0		0 0	7. 00
8.00	Inpatient - Respite Care		0		0 0	8.00
	VI SI TI NG SERVI CES	<u>'</u>				
9.00	Physi ci an Servi ces		0		0 0	9. 00
10.00	Nursing Care		0		0 300, 676	10.00
11. 00	Nursing Care-Continuous Home Care		0		0 0	11.00
	Physi cal Therapy	0	0		0 0	12. 00
13.00	Occupational Therapy	0	О		0 0	13. 00
	Speech/ Language Pathology	0	О		0 0	14. 00
15.00	Medical Social Services		О		0 58, 532	15. 00
16.00	Spiritual Counseling		О		0 0	16. 00
17. 00	Di etary Counseling		О		0 0	17. 00
18.00	Counseling - Other		О		0 0	18. 00
19.00	Home Health Aide and Homemaker		84, 812		0 84, 812	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care		0		0 0	20.00
21.00	Other		О	24, 66	24, 667	21. 00
	OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy					22. 00
23.00	Anal gesi cs					23. 00
24.00	Sedatives / Hypnotics					24. 00
25.00	Other - Specify					25. 00
26.00	Durable Medical Equipment/Oxygen					26. 00
27. 00	Patient Transportation		0		0	27. 00
28. 00	I maging Services		0		0	28. 00
29. 00	Labs and Diagnostics		0		0 0	29. 00
30.00	Medical Supplies		0		0	30.00
31.00	Outpatient Services (including E/R Dept.)		0		0	31.00
32.00	Radiation Therapy		0		0 0	32. 00
33.00	Chemotherapy		0		0 0	33.00
34.00	Other		0		0 0	34.00
	HOSPICE NONREIMBURSABLE SERVICE					
35.00	Bereavement Program Costs		0		0 0	35. 00
36.00	Volunteer Program Costs		0		0 0	36. 00
37. 00	Fundrai si ng		0		0 0	37. 00
38. 00	Other Program Costs		0		0 0	38. 00
39. 00	Total (sum of lines 1 thru 38)	0	84, 812	24, 66	634, 181	39.00

Health Financial Systems

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

			nospi ce c	CN. 131331	10 12/31/2013	5/26/2016 11:	
					Hospi ce I	0, 20, 20, 0	
			CAPI TAL RE	LATED COST			
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATION	
		FOR COST	FIXTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MAI NT.		
		0	1.00	2.00	3. 00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0			0		2.00
3.00	Plant Operation and Maintenance	0	0		0		3. 00
4. 00	Transportation - Staff	0	0		0	o o	4. 00
5. 00	Volunteer Service Coordination	o o	0		0 0		5. 00
6. 00	Administrative and General	448, 747	0		0 0		6. 00
0.00	I NPATI ENT CARE SERVI CE	110,717	J		<u> </u>	ή	0.00
7.00	Inpatient - General Care	O	0		0 0	0	7. 00
8.00	Inpatient - Respite Care		0		0 0	l .	
0.00	VI SI TI NG SERVI CES	١	0		9	,	0.00
9. 00	Physician Services	0	0		0 0	0	9. 00
10. 00	Nursing Care	338, 398	0		0 0		10.00
11. 00	Nursing Care-Continuous Home Care	330, 370	0		0		11.00
12. 00	Physical Therapy		0		0	ή "	12.00
13. 00	Occupational Therapy		0		0		13.00
14. 00			0		0 0	1	14. 00
15. 00	Speech/ Language Pathology	(4 027	0		0 0		15. 00
16. 00	Medical Social Services	64, 937	0		0 0	ή	16.00
	Spiritual Counseling		0		0 0	0	17. 00
17. 00	Di etary Counsel i ng	0	0		0 0	ή	
18.00	Counseling - Other	107 070	0		-	0	18.00
19. 00	Home Health Aide and Homemaker	107, 078	0		0	1	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	27 120	0		0		20.00
21. 00	Other	27, 129	0		0 0	0	21. 00
22.00	OTHER HOSPICE SERVICE COSTS		0		0	0	22.00
22. 00	Drugs, Biological and Infusion Therapy		-		0	1	22. 00
23. 00	Anal gesi cs	0	0		0		23. 00
24. 00	Sedatives / Hypnotics	0	0		0	0	24. 00
25. 00	Other - Specify	0	0		0 0	Ί ,	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0		-	ή "	26. 00
27. 00	Pati ent Transportation	0	0		0	1	27. 00
28. 00	I maging Services	0	0		0	Ί ,	28. 00
29. 00	Labs and Diagnostics	0	0		0	0	29. 00
30.00	Medical Supplies	0	0		0 0	ή	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32. 00	Radi ati on Therapy	0	0		0 0	1	32. 00
33. 00	Chemotherapy	0	0		0 0		33. 00
34. 00	Other	0	0		0 0	0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE				_		
	Bereavement Program Costs	0	0		0 0		35. 00
36.00	Volunteer Program Costs	0	0		0		36. 00
37. 00	Fundrai si ng	0	0		0 0	0	37. 00
38. 00	Other Program Costs	0	0		0 0		38. 00
39. 00	Total (sum of lines 1 thru 38)	986, 289	0		0 0	0	39. 00

 TY HOSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 151329
 Period: From 01/01/2015
 Worksheet K-4 Part I Part I To 12/31/2015

 Hospice CCN: 151551
 To 12/31/2015
 Date/Time Prepared: From CMS-2552-10

			Hospi ce (	CN: 151551 1	0 12/31/2015	5/26/2016 11:49 am
					Hospi ce I	372072010 11: 47 4111
		VOLUNTEER	SUBTOTAL	ADMI NI STRATI VE	TOTAL (col. 5A	
		SERVI CES	(col s. 0 - 5)	& GENERAL	± col . 6)	
		COORDI NATOR	(55.5. 5 5)			
		5. 00	5A	6.00	7. 00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2. 00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5. 00
6.00	Administrative and General	0	448, 747	448, 747		6.00
	INPATIENT CARE SERVICE					
7.00	Inpatient - General Care	0	C	0	0	7. 00
8.00	Inpatient - Respite Care	0	C	0	0	8. 00
	VISITING SERVICES					
9.00	Physi ci an Servi ces	0	C	_		9. 00
10.00	Nursi ng Care	0	338, 398	282, 499	620, 897	10.00
11.00	Nursing Care-Continuous Home Care	0	C	0	0	11. 00
12.00	Physi cal Therapy	0	C	0	0	12. 00
13.00	Occupational Therapy	0	C	0	0	13. 00
14.00	Speech/ Language Pathology	0	C	0	0	14. 00
15.00	Medical Social Services	0	64, 937	54, 210	119, 147	15. 00
	Spiritual Counseling	0	C	0	0	16. 00
17. 00	Di etary Counsel i ng	0	C	0	0	17. 00
18. 00	Counseling - Other	0	C	0	0	18. 00
19. 00	Home Health Aide and Homemaker	0	107, 078	89, 390	196, 468	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0		0	0	20. 00
21. 00	Other	0	27, 129	22, 648	49, 777	21. 00
	OTHER HOSPICE SERVICE COSTS					
22. 00	Drugs, Biological and Infusion Therapy	0		1	0	22. 00
23. 00	Anal gesi cs	0	C	0	0	23. 00
	Sedatives / Hypnotics	0	C	0	0	24. 00
25. 00	Other - Specify	0	C	0	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	C	0	0	26. 00
27. 00	Patient Transportation	0	C	0	0	27. 00
	I maging Services	0		0	0	28. 00
	Labs and Diagnostics	0	C	0	0	29. 00
	Medical Supplies	0		0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	C	1	0	31.00
32. 00	Radi ati on Therapy	0	C	1	0	32.00
33. 00	Chemotherapy	0		1	_	33.00
34. 00	Other	0	<u> </u>	0	0	34. 00
25 22	HOSPI CE NONREI MBURSABLE SERVI CE		ı -			05.00
35. 00	Bereavement Program Costs	0	}	1	-	35. 00
36. 00	Volunteer Program Costs	0	C	0	0	36.00
37. 00	Fundrai si ng			y o	0	37. 00
38. 00	Other Program Costs		004 200	, O	004 200	38.00
39.00	Total (sum of lines 1 thru 38)	0	986, 289	Ί	986, 289	39.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

						5/26/2016 11:	49 am
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
		,	ĺ	FT. )		(HOURS)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS				•		
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0				3. 00
4. 00	Transportation - Staff	0	0		0		4. 00
5. 00	Volunteer Service Coordination		0			0	5.00
		0	0			0	1
6. 00	Administrative and General	0	0		J U	U	6.00
7.00	I NPATI ENT CARE SERVI CE		_	1		0	7 00
7.00	Inpatient - General Care	0			0		7. 00
8.00	Inpatient - Respite Care	0	0		0	0	8. 00
	VI SI TI NG SERVI CES	1		ı	1		
9.00	Physi ci an Servi ces	0	0		0	0	9. 00
10. 00	Nursing Care	0	0		0	0	10. 00
11. 00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12.00	Physi cal Therapy	0	0		0	0	12. 00
13.00	Occupational Therapy	0	0		0	0	13.00
14.00	Speech/ Language Pathology	0	0		0	0	14. 00
15.00	Medical Social Services	0	0		0	0	15. 00
16.00	Spiritual Counseling	0	0		0	0	16. 00
17. 00	Di etary Counsel i ng	0	0		0	0	17. 00
18. 00	Counseling - Other	0	0		0	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0		0	0	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	Ö	•	0	0	20.00
21. 00	Other	0	0		o o	0	21. 00
21.00	OTHER HOSPICE SERVICE COSTS	, ,			<u> </u>	U	21.00
22. 00	Drugs, Biological and Infusion Therapy	0	0		0	0	22. 00
23. 00	Anal gesi cs	0	0	•		0	23. 00
24. 00	Sedatives / Hypnotics	0	0			0	24.00
25. 00		0	0			0	25. 00
	Other - Specify	0	0				
26. 00	Durable Medical Equipment/Oxygen	0	ı		٥	0	26.00
27. 00	Pati ent Transportation	0	0		0	0	27. 00
28. 00	I maging Services	0	0		0	0	28. 00
29. 00	Labs and Diagnostics	0	0		0	0	29. 00
30.00	Medical Supplies	0	0		0	0	30. 00
31. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	31. 00
32.00	Radiation Therapy	0	0		0	0	32. 00
33.00	Chemotherapy	0	0		0	0	33. 00
34.00	Other	0	0		0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0		0	0	35. 00
36.00	Volunteer Program Costs	0	0		0	0	36. 00
37.00	Fundrai si ng	0	0		0	0	37. 00
38. 00	Other Program Costs	0	0	1	0	0	38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)	l n	n		o n	Ö	39. 00
	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0. 000000	_	
10.00	Join C 300C mar cr pr ror	0.00000	0.00000	0.00000	3. 333000	0.00000	1 .0.00

						5/26/2016 11:49 am
					Hospi ce I	
		RECONCI LI ATI ON				
			& GENERAL			
			(ACC. COST)			
		6A	6. 00			
	GENERAL SERVICE COST CENTERS					
1. 00	Capital Related Costs-Bldg and Fixt.	0				1.00
2.00	Capital Related Costs-Movable Equip.	0				2. 00
3.00	Plant Operation and Maintenance	0				3.00
4.00	Transportation - Staff	0				4. 00
5.00	Volunteer Service Coordination					5. 00
6.00	Administrative and General	-448, 747	537, 542			6. 00
	INPATIENT CARE SERVICE					
7.00	Inpatient - General Care	0	0			7. 00
8.00	Inpatient - Respite Care	0	0			8. 00
	VISITING SERVICES					
9.00	Physi ci an Servi ces	0	0			9. 00
10.00	Nursi ng Care	0	338, 398			10.00
11.00	Nursing Care-Continuous Home Care	0	0			11. 00
12.00	Physi cal Therapy	0	0			12. 00
13.00	Occupational Therapy	o	0			13. 00
14.00	Speech/ Language Pathology	o	0			14. 00
15.00	Medical Social Services	o	64, 937			15. 00
16.00	Spiritual Counseling	o	0			16. 00
17.00	, .	o	0			17. 00
18.00	Counseling - Other	o	0			18. 00
19.00		o	107, 078			19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	l ol	. 0			20. 00
21. 00	Other	o	27, 129			21. 00
	OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy	0	0			22. 00
23.00	Anal gesi cs	o	0			23. 00
24.00		o	0			24. 00
25.00	Other - Specify	o	0			25. 00
26. 00	Durable Medical Equipment/Oxygen	o	0			26.00
27. 00	Pati ent Transportation	o	0			27. 00
28. 00	Imaging Services	o	0			28.00
29. 00		أم	0			29.00
30.00	Medical Supplies		0			30.00
31. 00			0			31.00
32. 00	Radi ati on Therapy		0			32.00
33. 00	Chemotherapy	l o	0			33.00
34. 00	Other		0			34.00
5 1. 00	HOSPI CE NONREI MBURSABLE SERVI CE	. — Ч	0			34.00
35. 00	Bereavement Program Costs	O	0			35. 00
36. 00	Volunteer Program Costs		0			36.00
37. 00	1		0			37.00
38. 00	Other Program Costs		0			38.00
39. 00			448, 747			39.00
	Unit Cost Multiplier	1	0. 834813			40.00
40.00	Join C 003C Multiplifel	1	0. 054013	I		1 40.00

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provider C Provi der CCN: 151329 Hospi ce CCN: 151551

						5/26/2016 11:	49 am	
				Hospi ce I				
				CAPITAL RE	LATED COSTS			
					<b>I</b>			
	Cost Center Description	Hospi ce Tri al	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE		
		Bal ance (1)	FLXT	BLDG	EQUI P	EQUIP OFFSIT		
		0	1.00	1. 01	2. 00	2. 01		
1.00	Administrative and General		0	0	0	0		
2.00	Inpatient - General Care	0	0	0	0	0	2. 00	
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00	
4.00	Physi ci an Servi ces	0	0	0	0	0		
5.00	Nursi ng Care	620, 897	0	0	0	0	5. 00	
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00	
7.00	Physi cal Therapy	0	0	0	0	0	7. 00	
8.00	Occupational Therapy	0	0	0	0	0	8. 00	
9.00	Speech/ Language Pathology	0	0	0	0	0		
10.00	Medical Social Services	119, 147	0	0	0	0		
11. 00	Spiritual Counseling	0	0	0	0	0	11. 00	
12.00	Di etary Counseling	0	0	0	0	0	12.00	
13.00	Counseling - Other	0	0	0	0	0	13. 00	
14.00	Home Health Aide and Homemaker	196, 468	0	0	0	0	14. 00	
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0		
16. 00	Other	49, 777	0	0	0	0	16. 00	
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00	
18.00	Anal gesi cs	0	0	0	0	0	18. 00	
19.00	Sedatives / Hypnotics	0	0	0	0	0	19. 00	
20.00	Other - Specify	0	0	0	0	0	20. 00	
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00	
22. 00	Patient Transportation	0	0	0	0	0	22. 00	
23.00	I maging Services	0	0	0	0	0	23. 00	
24.00	Labs and Diagnostics	0	0	0	0	0	24. 00	
25.00	Medical Supplies	0	0	0	0	0	25. 00	
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00	
27. 00	Radi ati on Therapy	0	0	0	0	0	27. 00	
28.00	Chemotherapy	0	0	0	0	0	28. 00	
29.00	Other	0	0	0	0	0	29. 00	
30.00	Bereavement Program Costs	0	0	0	0	0	30.00	
31.00	Volunteer Program Costs	0	0	0	0	0	31.00	
32.00	Fundrai si ng	0	0	0	0	0	32. 00	
33.00	Other Program Costs	0	0	0	0	0	33. 00	
34.00	Total (sum of lines 1 thru 33) (2)	986, 289	0	0	0	0	34.00	
35.00	Unit Cost Multiplier (see instructions)						35. 00	

 Y HOSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 151329
 Period: From 01/01/2015 Part I

 Hospice CCN: 151551
 To 12/31/2015 Date/Time Prepared: 5/26/2016 11: 49 am

						37 207 2010 11.	17 4111
					Hospi ce I		
	Cost Center Description	EMPLOYEE	Subtotal	ADMI NI STRATI VE		OPERATION OF	
		BENEFITS		& GENERAL	PLANT	PLANT -OFFSITE	
		DEPARTMENT	4.0	F 00	7.00	7.01	
1 00	Administrative and Consent	4.00	4A	5.00	7. 00	7. 01	1 00
1.00	Administrative and General	230, 409	230, 409	44, 471	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	
4.00	Physi ci an Servi ces	0	(00.007	0	0	0	
5.00	Nursing Care	0	620, 897	119, 837	0	0	
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathol ogy	0	0	0	0	0	
10.00	Medical Social Services	0	119, 147	22, 996	0	0	
11. 00	Spiritual Counseling	0	0	0	0	0	
12. 00	Di etary Counsel i ng	0	0	0	0	0	12. 00
13. 00	Counseling - Other	0	0	0	0	0	13. 00
14.00	Home Health Aide and Homemaker	0	196, 468	37, 920	0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15. 00
16. 00	Other	0	49, 777	9, 607	0	0	
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	
18. 00	Anal gesi cs	0	0	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	0	0	0	1 . ,
20.00	Other - Specify	0	0	0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22. 00	Pati ent Transportation	0	0	0	0	0	
23. 00	I maging Services	0	0	0	0	0	
24. 00	Labs and Diagnostics	0	0	0	0	0	24. 00
25. 00	Medi cal Supplies	0	0	0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27. 00	Radi ati on Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	
30.00	Bereavement Program Costs	0	0	0	0	0	
31. 00	Volunteer Program Costs	0	0	0	0	0	31. 00
32. 00	Fundrai si ng	0	0	0	0	0	32. 00
33. 00	Other Program Costs	0	0	0	0	0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	230, 409	1, 216, 698		0	0	34. 00
35. 00	Unit Cost Multiplier (see instructions)		0. 000000	1		l	35. 00

Health Financial Systems MARGARET MA
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provi der CCN: 151329 Hospi ce CCN:

						5/26/2016 11:	<u>49 am</u>
					Hospi ce I		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
			LINEN SERVICE				
		HOSPITAL &					
		0FFS					
	I a construction of the co	7. 02	8. 00	9. 00	10. 00	11. 00	
1.00	Administrative and General	0	0		0	_	
2.00	Inpatient - General Care	0	0		0	0	1
3.00	Inpatient - Respite Care	0	0		0	0	
4.00	Physi ci an Servi ces	0	0		0	0	
5.00	Nursing Care	0	0		0	0	
6.00	Nursing Care-Continuous Home Care	0	0		0	0	
7.00	Physical Therapy	0	0		0	0	
8.00	Occupational Therapy	0	0		0	0	
9.00	Speech/ Language Pathology	0	0		0	0	
10.00	Medical Social Services	0	0		0	0	10. 00
11. 00	Spiritual Counseling	0	0		0 0	0	11. 00
12.00	Di etary Counsel i ng	0	0		0 0	0	12. 00
13.00	Counseling - Other	0	0		0 0	0	
14.00	Home Health Aide and Homemaker	0	0		0 0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	
16.00	Other	0	0		0 0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17. 00
18.00	Anal gesi cs	0	0		0 0	0	18. 00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19. 00
20.00	Other - Specify	0	0		0 0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21. 00
22.00	Pati ent Transportation	0	0		0 0	0	22. 00
23.00	I maging Services	0	0		0 0	0	23. 00
24.00	Labs and Diagnostics	0	0		0 0	0	24. 00
25.00	Medical Supplies	0	0		0 0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26. 00
27.00	Radiation Therapy	0	0		o o	0	27. 00
28.00	Chemotherapy	0	0		o o	0	28. 00
29.00	Other	0	0		o o	0	29. 00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0		0 0	0	31.00
32.00	Fundrai si ng	o	0		0 0	0	32. 00
33.00	Other Program Costs	o	0		0 0	0	1
34.00	Total (sum of lines 1 thru 33) (2)	0	0		0 0	0	34.00
	Unit Cost Multiplier (see instructions)						35. 00
				•	"	•	

 Heal th Financial
 Systems
 MARGARET
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						5/26/2016 11:	49 am_
					Hospi ce I		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	(cols. 4A-23)	
			SUPPLY		LI BRARY		
		13. 00	14. 00	15. 00	16.00	24. 00	
1.00	Administrative and General	0	14		0 0	274, 894	1. 00
2.00	Inpatient - General Care	0	0		0 0	0	2. 00
3.00	Inpatient - Respite Care	0	0		0 0	0	3. 00
4.00	Physi ci an Servi ces	0	0	)	0 0	0	4. 00
5.00	Nursing Care	0	0		0 0	740, 734	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6. 00
7.00	Physi cal Therapy	0	0	)	0 0	0	7. 00
8.00	Occupational Therapy	0	0		0 0	0	8. 00
9.00	Speech/ Language Pathology	0	0		0 0	0	9. 00
10.00	Medical Social Services	0	0		0 0	142, 143	10.00
11.00	Spiritual Counseling	0	0		0 0	0	11. 00
12.00	Di etary Counseling	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	234, 388	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15. 00
16.00	Other	0	0	)	0 0	59, 384	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	)	0 0	0	17. 00
18. 00	Anal gesi cs	0	0	)	0 0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	)	0 0	0	19. 00
20.00	Other - Specify	0	0		0 0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21. 00
22. 00	Patient Transportation	0	0		0 0	0	22. 00
23.00	I maging Services	0	0		0 0	0	23. 00
24.00	Labs and Diagnostics	0	0		0 0	0	24. 00
25.00	Medical Supplies	0	0		0 0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0		0	0	26. 00
27.00	Radi ati on Therapy	0	0		0	0	27. 00
28. 00	Chemotherapy	0	0		0	0	28. 00
29.00	Other	0	0		0 0	0	29. 00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0		0 0	0	31. 00
32.00	Fundrai si ng	0	0		0 0	0	32. 00
33.00	Other Program Costs	0	0		0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	14		0 0	1, 451, 543	34.00
35.00	Unit Cost Multiplier (see instructions)						35. 00

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

						5/26/2016 11:49 am
					Hospi ce I	
	Cost Center Description	Intern &	Subtotal	Allocated	Total Hospice	
		Residents Cost	(cols. 24 ±	Hospi ce A&G	Costs (cols.	
		& Post	25)	(See Part II)	26 ± 27)	
		Stepdown				
		Adjustments				
	T	25. 00	26. 00	27. 00	28. 00	
1.00	Administrative and General					1.00
2.00	Inpatient - General Care	0	0	C	0	2. 00
3.00	Inpatient - Respite Care	0	0	) C	0	3.00
4.00	Physi ci an Servi ces	0	0	) C	0	4. 00
5.00	Nursing Care	0	740, 734	173, 053	913, 787	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	C	0	6. 00
7.00	Physi cal Therapy	0	0	C	0	7. 00
8.00	Occupational Therapy	0	0	) c	0	8. 00
9.00	Speech/ Language Pathology	0	0	) c	0	9. 00
10.00	Medical Social Services	0	142, 143	33, 208	175, 351	10.00
11.00	Spiritual Counseling	0	0	) c	0	11. 00
12.00	Di etary Counsel i ng	0	0	C	0	12. 00
13.00	Counseling - Other	0	0	) c	0	13. 00
14.00	Home Health Aide and Homemaker	0	234, 388	54, 759	289, 147	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	O	l c	o	15. 00
16.00	Other	0	59, 384	13, 874	73, 258	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	O	d	o	17. 00
18.00	Anal gesi cs	0	O	l c	o	18. 00
19.00	Sedatives / Hypnotics	0	O	ol c	o	19. 00
20.00	Other - Specify	0	O	ol c	o	20.00
21.00	Durable Medical Equipment/Oxygen	0	O	ol c	o	21. 00
22. 00	Patient Transportation	0	O	ol c	o	22. 00
23.00	I maging Services	0	O	ol c	o	23. 00
24.00	Labs and Diagnostics	0	O	ol c	o	24. 00
25.00	Medical Supplies	0	O	ol c	o	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	O	ol c	o	26. 00
27.00	Radi ati on Therapy	0	O	ol c	o	27. 00
28. 00	Chemotherapy	0	0		ol	28. 00
29.00	Other	0	O	ol c	o	29. 00
30.00	Bereavement Program Costs	o	0	ol c	ol	30.00
31.00	Volunteer Program Costs	0	O		ol	31.00
32.00	Fundrai si ng	0	O		ol	32. 00
33. 00	Other Program Costs		0		ol	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	1, 451, 543		1, 451, 543	34.00
	Unit Cost Multiplier (see instructions)			0. 233624		35. 00
						1

Hospi ce I								
	·		CAPITAL RELATED COSTS					
	Cost Center Description	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE	EMPLOYEE		
		FLXT	BLDG	EQUI P	EQUIP OFFSIT	BENEFI TS		
		(SQUARE	(SQUARE	(SQUARE	(SQUARE	DEPARTMENT		
		FEET)	FEET)	FEET)	FEET)	(GROSS		
						SALARI ES)		
		1.00	1. 01	2. 00	2. 01	4. 00		
1.00	Administrative and General	0	3, 750	0	0	634, 181	1. 00	
2.00	Inpatient - General Care	0	0	0	0	0	2.00	
3.00	Inpatient - Respite Care	0	o	0	o	0	3.00	
4.00	Physi ci an Servi ces	0	o	0	o	0	4. 00	
5.00	Nursing Care	0	o	0	o	0	5. 00	
6.00	Nursing Care-Continuous Home Care	0	o	0	o	0	6. 00	
7.00	Physical Therapy	0	o	0	o	0	7. 00	
8. 00	Occupational Therapy	0	0	0	0	0	8. 00	
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00	
10. 00	Medical Social Services	0	0	0	0	0	10.00	
11. 00	Spiritual Counseling	0	0	0	0	0	11. 00	
12. 00	Di etary Counsel i ng	0	0	0		0	12. 00	
13. 00	Counseling - Other	0	0	0		0	13. 00	
14. 00	Home Health Aide and Homemaker	0	Ö	0		0	14. 00	
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	0		0	15. 00	
16. 00	Other	0	Ö	0		0	16. 00	
17. 00	Drugs, Biological and Infusion Therapy	0	0	0		0	17. 00	
18. 00	Anal gesi cs	0	0	0		0	18. 00	
19. 00	Sedatives / Hypnotics	0	0	0		0	19. 00	
20. 00	Other - Specify	0	0	0		0	20. 00	
21. 00	Durable Medical Equipment/Oxygen	0	0	0		0	21. 00	
22. 00	Patient Transportation	0	0	0		0	22. 00	
23. 00	I maging Services	0	0	0	0	0	23. 00	
24. 00	Labs and Diagnostics	0	0	0		0	24. 00	
25. 00	Medical Supplies	0	0	0		0	25. 00	
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00	
27. 00	Radi ati on Therapy	0	0	0	- 1	0	27. 00	
28. 00	Chemotherapy	0	Ö	0		0	28. 00	
29. 00	Other	0	0	0		0	29. 00	
30. 00	Bereavement Program Costs	0	0	0	0	0	30.00	
31. 00	Volunteer Program Costs	0	0	0	0	0	31. 00	
32. 00	Fundrai si ng	0	0	0	0	0	32. 00	
33. 00	Other Program Costs			0		0	33. 00	
34. 00	Total (sum of lines 1 thru 33) (2)		3, 750	0		634, 181	34. 00	
35. 00	Total cost to be allocated		3, 730	0		230, 409	35. 00	
	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0. 000000	0. 000000	0. 363317		
30.00	Tomic oost multiplier (see instructions)	0.00000	0.000000	0.00000	0.000000	0. 303317	30.00	

STATISTICAL BASIS

							5/26/2016 11:	<u>49 am</u>
						Hospi ce I		
	Cost Center Description	Reconciliation	ADMI NI STRATI	VE OPERATION	0F	OPERATION OF	OPERATION OF	
	The state of the s		& GENERAL			PLANT -OFFSITE	PLANT -	
			(ACCUM.	(SQUARE			HOSPITAL &	
			COST)	FEET)	_	(SQUARE	0FFS	
			0001)	''בביי		FEET)	(SQUARE	
						ILLI)	FEET)	
		5A	5. 00	7.00		7. 01	7. 02	
1.00	Administrative and General	0 O	230. 4		0	7.01	7.02	1. 00
2.00	Inpatient - General Care	0	230, 4	109	0	0		2.00
3.00	Inpatient - Respite Care				0	0		3.00
4.00	Physician Services				0	0		4.00
		0	(20.	207	0	0		
5.00	Nursing Care	0	620, 8	397	0	0		5. 00
6.00	Nursing Care-Continuous Home Care	0		0	0	0	0	6. 00
7.00	Physi cal Therapy	0		o	0	0	0	7. 00
8.00	Occupational Therapy	0		0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0		0	0	0	0	9. 00
10.00	Medical Social Services	0	119,	147	0	0	0	10. 00
11.00	Spiritual Counseling	0		0	0	0	0	11. 00
12.00	Di etary Counsel i ng	0		0	0	0	0	12.00
13.00	Counseling - Other	o		o	0	0	0	13.00
14.00	Home Health Aide and Homemaker	o	196,	468	0	0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	l ol	•	ol	0	0	ol	15. 00
16. 00	Other	أم	49,	777	0	0	Ö	16. 00
17. 00	Drugs, Biological and Infusion Therapy	أم		0	0	0	0	17. 00
18. 00	Anal gesi cs				0	0	o o	18. 00
19. 00	Sedatives / Hypnotics				0	0	Ö	19.00
20. 00	Other - Specify				0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen				0	0		21.00
21.00		0			0	0		21.00
	Patient Transportation	0			0	0	0	
23. 00	I maging Services	0		0	0	0	-	23. 00
24. 00	Labs and Diagnostics	0		0	0	0	0	24. 00
25. 00	Medi cal Supplies	0		0	0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0		O	0	0	0	26. 00
27. 00	Radiation Therapy	0		0	0	0	0	27. 00
28. 00	Chemotherapy	0		0	0	0	0	28. 00
29. 00	Other	0		0	0	0	0	29. 00
30.00	Bereavement Program Costs	0		0	0	0	0	30.00
31.00	Volunteer Program Costs	0		0	0	0	0	31.00
32.00	Fundrai si ng	0		O	0	0	0	32.00
33.00	Other Program Costs	o		o	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)		1, 216, 6	598	0	0	0	34.00
35. 00	Total cost to be allocated		234, 8	1	0	o.	Ö	35. 00
36. 00			0. 1930		ດດດດ	0. 000000	-	
55.50	1 1 1 (		3. 170	3.00		3. 333000		, 50. 00

						5/26/2016 11:	49 am
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS OF SERVI CE)	NURSI NG ADMI NI STRATI ON	
		LAUNDRY)	ŕ			(HOURS OF	
						SERVICE)	
		8. 00	9. 00	10.00	11. 00	13. 00	
1.00	Administrative and General	0		0	0	0 0	
2.00	Inpatient - General Care	0		0	0	0 0	
3.00	Inpatient - Respite Care	0		0	0	0 0	
4.00	Physician Services	0		0	0	0 0	
5.00	Nursing Care	0		O	0	0 0	
6.00	Nursing Care-Continuous Home Care	0		O	0	0 0	
7.00	Physi cal Therapy	0		0	0	0 0	
8.00	Occupational Therapy	0		0	0	0 0	1
9.00	Speech/ Language Pathology	0		0	0	0 0	
10.00	Medical Social Services	0		0	0	0 0	
11.00	Spiritual Counseling	0		0	0	0 0	
12.00	Di etary Counsel i ng	0		0	0	0 0	
13.00	Counseling - Other	0		0	0	0 0	
14.00	Home Health Aide and Homemaker	0		0	0	0 0	1
15. 00	HH Aide & Homemaker - Cont. Home Care	0		0	0	0 0	
16. 00	Other	0		0	0	0 0	
17. 00	Drugs, Biological and Infusion Therapy	0		0	0	0 0	
18.00	Anal gesi cs	0		0	0	0 0	
19.00	Sedatives / Hypnotics	0		0	0	0 0	
20.00	Other - Specify	0			0	0 0	
21. 00	Durable Medical Equipment/Oxygen	0			0	0 0	
22. 00 23. 00	Pati ent Transportation	0			0	0 0	
24. 00	Imaging Services Labs and Diagnostics	0			0		
25. 00	Medical Supplies	0			0		1
26. 00	Outpatient Services (including E/R Dept.)	0			0		
27. 00	Radiation Therapy	0			0		
28. 00	Chemotherapy	0			0		
29. 00	Other				0		1
30. 00	Bereavement Program Costs				0		1
31. 00	Volunteer Program Costs				0		1
32. 00	Fundrai si ng				0		1
33. 00	Other Program Costs				0		
34. 00	Total (sum of lines 1 thru 33) (2)			ol	0		1
35. 00	Total cost to be allocated			ol	0		1
36. 00		0. 000000	0. 00000	0.0000	0.0000		
	(222 1.021 2.06)	1 2: 2: 2000		2.0000	2.3000		1

					3/20/2010 11.	. 49 alli
					Hospi ce I	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL		
		SERVICES &	(100%	RECORDS &		
		SUPPLY	PHARMACY)	LI BRARY		
		(COSTED	ŕ	(TIME		
		REQUIS.)		SPENT)		
		14. 00	15. 00	16. 00		
1.00	Administrative and General	124, 567	0	0		1. 00
2.00	Inpatient - General Care	l ol	o	0		2. 00
3.00	Inpatient - Respite Care	o	0	0		3. 00
4. 00	Physi ci an Servi ces	أم	0	0		4. 00
5. 00	Nursing Care		0	0		5. 00
6. 00	Nursing Care-Continuous Home Care		0	0		6. 00
7. 00	Physical Therapy		0	0		7. 00
8. 00	Occupational Therapy		0	0		8. 00
9. 00	Speech/ Language Pathology		0	0		9. 00
10.00	Medical Social Services		0	0		10.00
11. 00	Spiritual Counseling		0	0		11. 00
12. 00			0	0		12.00
	Di etary Counseling	0	0			
13.00	Counseling - Other	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0		14.00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	0		15. 00
16. 00	Other	0	0	0		16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	0		17. 00
18. 00	Anal gesi cs	0	0	0		18. 00
19. 00	31	0	0	0		19. 00
20.00	1 3	0	0	0		20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0	0		21. 00
22. 00	Patient Transportation	0	0	0		22. 00
23.00	I maging Services	0	0	0		23. 00
24.00	Labs and Diagnostics	0	0	0		24. 00
25.00	Medical Supplies	l ol	o	0		25. 00
26.00	Outpatient Services (including E/R Dept.)	l ol	o	0		26. 00
27.00	Radi ati on Therapy	l ol	0	0		27. 00
28. 00	Chemotherapy	ol	o	0		28. 00
29. 00	Other	l ol	o	0		29. 00
30.00		o	0	0		30. 00
31. 00	Volunteer Program Costs		ol	0		31. 00
32. 00	Fundrai si ng	ام	n	n		32. 00
33. 00	Other Program Costs	ا	n	n		33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	124, 567	n	0		34. 00
35. 00	Total cost to be allocated	124, 307	0	0		35. 00
	Unit Cost Multiplier (see instructions)	0. 000112	0. 000000	0. 000000		36. 00
30. 00	John Coost Martiplier (See Histractions)	0.000112	0. 000000	0.000000	I	1 30.00

Heal th	Financial Systems MARC	GARET MARY COMMUNI	TY HOSPITA	.L	In Lieu of Form CMS-2552-10			
COMPUT	TATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 151329	Period: From 01/01/2015	Worksheet K-5 Part III		
			Hospi ce CCN: 151551		To 12/31/2015			
					Hospi ce I	072072010 11.	17 4111	
	Cost Center Description	Wks	t. C, Part	Cost to Char	ge Total Hospice	Hospi ce Shared		
		1,	col . 11	Ratio	Charges	Ancillary		
			line		•	Costs (cols. 1		
					Records)	x 2)		
			0	1.00	2. 00	3. 00		
	ANCILLARY SERVICE COST CENTERS							
1. 00	PHYSI CAL THERAPY		66.00	•		0	1. 00	
2.00	OCCUPATI ONAL THERAPY		67.00	•		0	2. 00	
3.00	SPEECH PATHOLOGY		68. 00	•	24 0	0	3. 00	
4.00	DRUGS CHARGED TO PATIENTS		73.00	0. 32758	36 0	0	4. 00	
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00	)			5. 00	
6.00	LABORATORY		60.00	0. 2134	51 0	0	6. 00	
6. 01	BLOOD LABORATORY		60. 01	0.0000	00	0	6. 01	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0. 4276	51 0	0	7. 00	
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00	)			8. 00	
9.00	RADI OLOGY-THERAPEUTI C		55.00				9. 00	
10.00	OTHER ANCILLARY SERVICE COST CENTERS		76. 00				10.00	
11.00	Totals (sum of lines 1-10)					0	11. 00	
	•	·		•	•		-	

Heal th	Financial Systems MARGARET MARY COM	MMUNI T	ΓΥ HOSPI TA	L	In Li∈	eu of Form CMS-2	2552-10
CALCUL	ATION OF HOSPICE PER DIEM COST		Provi der	CCN: 151329	Peri od:	Worksheet K-6	
			Hospi ce (	CCN: 151551	From 01/01/2015 To 12/31/2015		
		_			Hospi ce I		
		Ti t	le XVIII	Title XIX	0ther	Total	
			1. 00	2.00	3. 00	4. 00	
1.00	Total cost (see instructions)					1, 451, 543	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)					11, 832	2.00
3.00	Average cost per diem (line 1 divided by line 2)					122. 68	3.00
4. 00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)		10, 949				4. 00
5.00	Aggregate Medicare cost (line 3 time line 4)		1, 343, 223				5. 00
6. 00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line				84		6. 00

10, 305

0

799

98, 021

5, 507

675, 599

7.00

8.00

9.00

10. 00 11. 00

12.00

13.00

5)

7.00

8.00

9.00

Aggregate Medicaid cost (line 3 time line 60)
Upduplicated SNF Days (Worksheet S-9, column 3, line 5)

Aggregate SNF cost (line 3 time line 8)

10.00 Unduplicated NF Days (Worksheet S-9, column 4, line 5)
11.00 Aggregate NF cost (line 3 times line 10)

13.00 Aggregate cost for other days (line 3 times line 12)

12.00 Other Unduplicated days (Worksheet S-9, column 5, line 5)

Health Financial Systems	MARGARET	MARY COMMUNIT	Y HOSPITAL			In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RURA	AL HEALTH CLINIC/FEDERALLY	QUALIFIED	Provi der CC	N: 151329	Period:	: 1/01/2015	Worksheet M-1
HEALTH CENTER COSTS			Component C	CCN: 158511			Date/Time Prepared: 5/26/2016 11:49 am
					Rural	Heal th	Cost

						3/20/2010 11.	49 alli
					Rural Health Clinic (RHC) I	Cost	
		Compensation	Other Costs		Reclassi fi cati	Reclassi fi ed	
		Compensation	011101 00313	+ col . 2)	ons	Trial Balance	
				1 (01. 2)	0113	(col. 3 + col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	170, 519	0	170, 51	9 0	170, 519	1.00
2.00	Physi ci an Assi stant	118, 132	0	118, 13:	2 0	118, 132	2. 00
3.00	Nurse Practitioner	O	0	)	0	0	3. 00
4.00	Visiting Nurse	o	O	)	0	0	4. 00
5.00	Other Nurse	16, 062	0	16, 06	2 0	16, 062	5. 00
6. 00	Clinical Psychologist	0	0	,	0	0	6.00
7. 00	Clinical Social Worker	0	0			Ö	7. 00
8. 00	Laboratory Techni ci an	0	0			0	8.00
9. 00		59, 480		59, 480		_	•
	Other Facility Health Care Staff Costs		0			59, 480	
10.00		364, 193	U	364, 19		364, 193	1
11. 00		0	U	1	0	0	11. 00
12. 00		0	0	1	0	0	12. 00
13. 00	3	0	0	)	0	0	13. 00
14.00	, ,	0	0	)	0	0	14. 00
15. 00	Medical Supplies	0	0	)	0	0	15. 00
16.00	Transportation (Health Care Staff)	0	0	)	0	0	16. 00
17.00	Depreciation-Medical Equipment	0	0	)	0	0	17. 00
18.00	Professional Liability Insurance	o	0	)	0	0	18. 00
19. 00	Other Health Care Costs	o	O	)	0	0	19. 00
20.00	Allowable GME Costs	o	0	)	0	0	20.00
21. 00		0	0	,	0	0	21.00
22. 00		364, 193	Ô	364, 19	3 0	_	1
22.00	lines 10, 14, and 21)	304, 173		304, 17.		304, 173	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23. 00		0	0		0	0	23. 00
24. 00		0	0	1	0	0	24. 00
25. 00		0	Ô			Ö	25. 00
26. 00	1 .	0	0	]		0	26. 00
27. 00		0	0	]		0	27. 00
28. 00		0	0			0	28.00
28.00		U	U	'	U U	0	28.00
	through 27)						ļ
00.0	FACILITY OVERHEAD		7/ 0/0	7. 04		7/ 0/0	00.00
29. 00		0	76, 240			,	•
30. 00		139, 523	0	1 .07,02		,	30. 00
31.00		139, 523	76, 240	215, 76	0	215, 763	31. 00
	30)			[			
32. 00		503, 716	76, 240	579, 95	6 0	579, 956	32. 00
	and 31)						

Health Financial Systems	MARGARET	MARY COMMUNIT	TY HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RURAL	HEALTH CLINIC/FEDERALLY	QUALIFIED	Provider CCN: 151329		Worksheet M-1
HEALTH CENTER COSTS			Component CCN: 150511	From 01/01/2015	
			Component CCN: 158511	10 12/31/2015	5/26/2016 11: 49 am
				Rural Health	Cost

				Clinic (RHC) I	
		Adjustments	Net Expenses	CITILE (MIC) 1	
			for Allocation		
			(col . 5 + col .		
			6)		
		6. 00	7.00		
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00		
1.00	Physi ci an	0	170, 519		1.00
2.00	Physici an Assistant	0	118, 132		2.00
3.00	Nurse Practitioner	0	0		3. 00
4.00	Visiting Nurse	0	0	l .	4. 00
5. 00	Other Nurse	0	16, 062	l .	5. 00
6.00	Clinical Psychologist	0	0		6.00
7. 00	Clinical Social Worker	0	0		7. 00
8. 00	Laboratory Techni ci an	0	0		8. 00
9. 00	Other Facility Health Care Staff Costs	0	59, 480		9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	364, 193		10.00
11. 00	Physician Services Under Agreement	0	0 304, 193		11.00
12. 00	Physician Supervision Under Agreement	0		l .	12.00
13. 00	Other Costs Under Agreement	0		l .	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0			14. 00
		0			15. 00
15.00	Medical Supplies	0	1		
16.00	Transportation (Health Care Staff)	0	0		16.00
17. 00	Depreciation-Medical Equipment	0	0		17. 00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21. 00
22. 00	Total Cost of Health Care Services (sum of	0	364, 193		22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICS				
23. 00	Pharmacy	0	0		23. 00
24. 00	Dental	0		l .	24. 00
25. 00	Optometry	0			25. 00
26. 00	All other nonreimbursable costs	0	0		26. 00
27. 00	Nonallowable GME costs	0	0		27. 00
28. 00	i i	0			28.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	U	0		28.00
	FACILITY OVERHEAD				-
29. 00	Facility Costs	0	76, 240		29. 00
30.00	Admi ni strati ve Costs	0	139, 523		30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	215, 763		31.00
31.00	30)	U	210, 703		31.00
32. 00	Total facility costs (sum of lines 22, 28	0	579, 956		32. 00
52.00	and 31)		3,7,730		32.00
	aa 5./	l	ı	I	1

LLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES			Provi der		Peri od:	Worksheet M-2	
				Component	CCN: 158511	From 01/01/2015 To 12/31/2015	Date/Time Pre 5/26/2016 11:	
						Rural Health	Cost	
		Number of FTE	Total	Vi si ts	Producti vi tv	Clinic (RHC) I Minimum Visits	Greater of	
		Personnel	Total	VI 31 L3		(col. 1 x col. 3)		
		1.00	2	2. 00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY							
	Posi ti ons							
00	Physi ci an	0. 62		2, 766				1.
00	Physici an Assistant	0. 86		1, 343				2.
00	Nurse Practitioner	0. 00		0	_,			3.
00	Subtotal (sum of lines 1 through 3)	1. 48		4, 109		4, 410		
00	Visiting Nurse	0. 00		0			0	
00	Clinical Psychologist	0. 00		0			0	
00	Clinical Social Worker	0. 00		0			0	
01	Medical Nutrition Therapist (FQHC only)	0. 00	1	0			0	
02	Diabetes Self Management Training (FQHC	0. 00		0			0	7.
00	only)	4 40		4 400			4 440	
00	Total FTEs and Visits (sum of lines 4	1. 48		4, 109			4, 410	8.
00	through 7) Physician Services Under Agreements			0			0	9.
00	Friysi ci air Sei vi ces Under Agreements			0			U	7.
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O RHC/FQHC SERV	/I CES					
. 00				22)			364, 193	10.
. 00	Total nonreimbursable costs (from Wkst. M-1,			ŕ			0	11.
00	Cost of all services (excluding overhead) (si	um of lines 10	and 1	1)			364, 193	12.
00	Ratio of RHC/FQHC services (line 10 divided	by line 12)					1.000000	13.
00	Total facility overhead - (from Wkst. M-1, co	ol. 7, line 31)	)				215, 763	14.
00	Parent provider overhead allocated to facili	ty (see instruc	ctions)	)			460, 672	15.
00	Total overhead (sum of lines 14 and 15)						676, 435	
00	Allowable GME overhead (see instructions)						0	1
	Subtotal (see instructions)						676, 435	
	Overhead applicable to RHC/FQHC services (li						676, 435	
	Total allowable cost of RHC/FQHC services (si	um of lines 10	and 10	2)			1, 040, 628	1 20

	<del>_</del>	NITY HOSPITAL	•	u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 151329  Component CCN: 158511	Peri od: From 01/01/2015 To 12/31/2015	Worksheet M-3 Date/Time Pre	
		Component Colv. 136311	10 12/31/2013	5/26/2016 11:	
		Title XVIII	Rural Health Clinic (RHC) I	Cost	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			1. 00	
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, li	ne 20)		1, 040, 628	1.00
2. 00	Cost of vaccines and their administration (from Wkst. M-4, li			110, 071	2. 00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	,		930, 557	3. 00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4, 410	
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5. 00
6.00	Total adjusted visits (line 4 plus line 5)			4, 410	
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	211.01	7. 00
			Carcuration	51 LI III ( ( I )	
			Prior to	On on After	
			January 1	January 1	
0.00	D		1. 00	2. 00	
8. 00 9. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	80. 44 211. 01	80. 44	8. 00 9. 00
9.00	Rate for Program covered visits (see instructions)  CALCULATION OF SETTLEMENT		211.01	211. 01	9.00
10. 00	Program covered visits excluding mental health services (from	contractor records)	O	1, 277	10.00
11. 00			o	269, 460	
12.00	11.00 Program cost excluding costs for mental health services (line 9 x line 10)  12.00 Program covered visits for mental health services (from contractor records)  0		0	12. 00	
13. 00	Program covered cost from mental health services (line 9 x li		0	0	13. 00
14.00	Limit adjustment for mental health services (see instructions		0	0	
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			0 269, 460	15.00
16. 00	Total program charges (see instructions) (from contractor's re	,		165, 291	
16. 02	Total program preventive charges (see instructions)(from prov			2, 770	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			4, 516	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		197, 981	16. 04
16. 05	Total program cost (see instructions)			202, 497	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records) $ \\$	·		17, 468	
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records) $ \begin{tabular}{ll} \hline \end{tabular}  \begin{tabular}{ll} \end{tabular} $	ns) (from contractor		29, 011	
20. 00	Net Medicare cost excluding vaccines (see instructions)			202, 497	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		64, 008	
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			266, 505 0	22. 00 23. 00
23. 00	Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	25. 50
26. 00	Net reimbursable amount (see instructions)			266, 505	
26. 01	Sequestration adjustment (see instructions)			5, 330	
27. 00 28. 00	Interim payments  Tentative settlement (for contractor use only)			187, 117 0	27. 00 28. 00
28.00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 27,	and 28)		74, 058	
30.00	Protested amounts (nonallowable cost report items) in accorda			74,030	30.00
	the state of the s		1	-	

Heal th	Financial Systems MARGARET MARY COMMUNI	TY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 151329	Peri od:	Worksheet M-4	
		Component CCN: 158511	From 01/01/2015 To 12/31/2015	Date/Time Prep 5/26/2016 11:4	
		Title XVIII	Rural Health	Cost	
			Clinic (RHC) I		
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		364, 193	364, 193	
2.00	Ratio of pneumococcal and influenza vaccine staff time to total			0. 013813	2. 00
3.00	Pneumococcal and influenza vaccine health care staff cost (line		2, 477	5, 031	3. 00
	4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records)		19, 982	11, 032	4. 00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	,	22, 459	· ·	5. 00
6.00	6.00 Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)		364, 193		
7.00	Total overhead (from Wkst. M-2, line 16)		676, 435	676, 435	7. 00
8. 00	Ratio of pneumococcal and influenza vaccine direct cost to total divided by line 6)	I direct cost (line 5	0. 061668	0. 044106	8. 00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x li	ne 8)	41, 714	29, 835	9. 00
10. 00	Total pneumococcal and influenza vaccine cost and its (their) a lines 5 and 9)	dministration (sum of	64, 173	45, 898	10. 00
11.00	Total number of pneumococcal and influenza vaccine injections (	from your records)	97	197	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/	line 11)	661. 58	232. 98	12.00
13. 00	Number of pneumococcal and influenza vaccine injections adminis beneficiaries	tered to Program	64	93	13. 00
14. 00	Program cost of pneumococcal and influenza vaccine and its (the (line 12 x line 13)	ir) administration	42, 341	21, 667	14. 00
15. 00	Total cost of pneumococcal and influenza vaccine and its (their of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,			110, 071	15. 00
16. 00	Total Program cost of pneumococcal and influenza vaccine and it administration (sum of cols. 1 and 2, line 14) (transfer this a line 21)			64, 008	16. 00

Health Financial Systems	MARGARET MARY COMMUNI	TY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC	PROVIDER FOR SERVICES	Provider CCN: 151329	Period: From 01/01/2015	Worksheet M-5
RENDERED TO PROGRAM BENEFICIARIES		Component CCN: 158511		
			Rural Health	Cost

			Rural Health Clinic (RHC) I	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to provider			187, 117	1.
	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
	List separately each retroactive lump sum adjustment amount				3
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
-	Program to Provider			_	_
)1				0	3
)2				0	3
03				0	3
04				0	3
	Provider to Program			U	3
50	Provider to Program			0	3
51				0	3
52				0	3
3				0	3
54				o o	3
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		o o	3
	Total interim payments (sum of lines 1, 2, and 3.99) (trans			187, 117	4
	27)			,	
Ī	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	k review. Also show date of	,		5
	each payment. If none, write "NONE" or enter a zero. (1)				
F	Program to Provider				
01				0	5
02				0	5
03				0	5
	Provider to Program				_
50				0	5
51				0	5
52 99	Subtatal (aum of lines E O1 E 40 minus aum of lines E E0 E	00)		0	5
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. Determined net settlement amount (balance due) based on the				5 6
	SETTLEMENT TO PROVIDER	cost report. (1)		74, 058	6
	SETTLEMENT TO PROGRAM			74,058	6
	Total Medicare program liability (see instructions)			261, 175	7
00	Total medicale program frability (see mistractions)		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
	Name of Contractor			2.00	8