In Lieu of Form CMS-2552-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED

payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1329 Worksheet S Peri od. From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: То 8/31/2020 7:54 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 8/31/2020 Time: 7:54 am Manually prepared cost report use only 2. []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4 [6. Date Received: 7. Contractor No. Contractor 10. NPR Date: 5.]Cost Report Status Γ

 (1) As Submitted
 7. Contractor No.
 11. Contractor's Vendor Code:
 4

 (2) Settled without Audit 8.
 [N] Initial Report for this Provider CCN
 11. Contractor's Contractor's Vendor Code:
 4

 (3) Settled with Audit 9.
 [N] Final Report for this Provider CCN
 number of times reopened = 0-9.

 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL 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 (15-1329) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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. [X] have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Si gned) BRI AN DAEGER

Officer or Administrator of Provider(s)

C00

Title

(Dated when report is electronically signed.)

Date

		Title XVIII				
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY			_			
1.00 Hospital	0	-496, 762	-431, 646	0	100, 307	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - 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		16, 235		0	10.00
200. 00 Total	0	-496, 762	-415, 410	0	100, 307	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 Please note that any correspondence not pertaining to the information collection burden approved Reports Clearance Office. 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.

	AL AND HOSPITAL HEALTH CARE COMPLEX	I DENTI FI C.	ATION DATA	Provid	SPITAL der CCN:	: 15-1329	Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti	me Pre	epared:
	1.00		2.00		3.00		/	1.00	8/31/20)20 7:5	4 am
	Hospital and Hospital Health Care Co	molex Add			5.00			+. 00			
. 00	Street: 321 MITCHELL		PO Box:								1.00
. 00	City: BATESVILLE		State: IN	Zip Cod	le: 4700	6- Coun	ty: RIPLEY				2.00
			onent Name	CCN	CBSA			Payme	ent Syst	em (P	2.00
				Number	Numbe		Certified		, 0, or		
						J		V	XVIII	XIX	1
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	Hospital and Hospital-Based Componer	ht Identif			1 0.00				1		
. 00	Hospi tal		MARY COMMUNITY	151329	99915	5 1	01/07/1966	Ν	0	0	3.00
		HOSPI TAL									
. 00	Subprovider - IPF				1						4.00
. 00	Subprovider - IRF				1						5.00
. 00	Subprovider - (Other)										6.00
. 00	Swing Beds - SNF										7.00
. 00	Swing Beds - NF										8.00
. 00	Hospital -Based SNF										9.00
0.00	Hospital -Based NF										10.00
1.00	Hospital -Based OLTC										11.00
2.00	Hospital -Based HHA	MARCARET	MARY COMMUNITY	157143	99915	-	03/01/1985	N	Р	N	12.0
2.00		HOSPI TAL		137143	7771		03/01/1903	IN	1 '		12.00
3.00	Separately Certified ASC	I USI I IAL									13.00
4.00	Hospital -Based Hospice	MARCAPET	MARY COMMUNITY	151551	99915	5	12/31/2003				14.00
4.00	hospi tai -based hospi ce	HOSPI TAL		131331	7771		12/ 51/ 2005				14.0
5.00	Hospital-Based Health Clinic - RHC		MARY COMMUNITY	158511	99915	-	09/03/2013	N	0	N	15.0
5.00	nospital-based hearth cirnic - kic	HOSPI TAL	WART CONNUNT I	130311	7771		07/03/2013	IN			15.0
6.00	Hospital-Based Health Clinic - FQHC	HUSPITAL									16.0
7.00											
	Hospital-Based (CMHC) I										17.0
8.00	Renal Dialysis										18.00
9.00	Other										19.00
							From: 1.00		To 2. (-
0 00	Cost Reporting Period (mm/dd/yyyy)										00.00
							01/01/20	<u>110</u>	12/21	/2010	
							01/01/20	019	12/31/	/2019	20.00
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1.00 2.00 2.01 2.02 2.02 2.03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is in disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aff Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aff Does this hospital contain at least counted in accordance with 42 CFR 4	ustment, i or yes or §412.106(c) or yes or compensat umn 1, "Y" eriod occu u" for no ter Octobe ter requires port sett " for no, ber 1. Ent he cost re nic reclas column 1, ng period no for the 100 but n 12.105)? E	n accordance wi "N" for no. Is)(2)(Pickle ame "N" for no. ed care payment for yes or "N" rring prior to for the portior final uncomper lement? (see ir for the portic er in column 2, porting period sification from lineating stati "Y" for yes or prior to Octobe e portion of th r 1. (see instr ot more than 49 nter in column	th 42 CF this endment s for the for no October of the uctions) isstruction in of the "Y" for on or af urban t stical a "N" for er 1. Ent ie cost 90 beds (3, "Y" f	R is for 1. cost re ns) ter o reas no er as for	N	2 2.00 N N	019	3. (00	21.0
1. 00 2. 00 2. 01 2. 02 2. 02 2. 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or af- Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aff Does this hospital contain at least counted in accordance with 42 CFR 47 yes or "N" for no.	ustment, i or yes or 5412.106(c or yes or acompensat umn 1, "Y" eriod occu u" for no ter Octobe t requires oport sett " for no, ber 1. Ent he cost re hic reclas rds for de column 1, ng period no for the 100 but n 12.105)? E edicaid da	n accordance wi "N" for no. Is)(2) (Pickle ame "N" for no. ed care payment for yes or "N" rring prior to for the portior r 1. (see instr final uncomper lement? (see ir for the portic er in column 2, porting period sification from lineating stati "Y" for yes or prior to Octobe e portion of th r 1. (see instr ot more than 49 nter in column ys on lines 24	th 42 CF this endment is for the for no October of the uctions) usated ca istruction on of the "Y" for on or af nurban t stical a "N" for er 1. Ent uctions) 09 beds (3, "Y" f and/or 2	R is for 1. cost re ms) ter o reas no er as cor	N	2 2.00 N N	019	3. (00	21.0 22.0 22.0 22.0
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	ARY COMMUNI	TY HOSPITAI	L		In Lieu	of For	m CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	DATA I	Provider CC	CN: 15-1329	Period: From 01/C To 12/3		Workshe Part I Date/Ti 8/31/20	ime Pre	epared:
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ys Med	ther di cai d days	
24.00 If this provider is an IPPS hospital, enter the	1.00	2.00	3.00	4.00	5.00	0	5.00 C	24.00
 25.00 If this provider is an information of the provider in the medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible but unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. 	n n e	0		0		0		25.00
				Urban/R	ural S	Date of 2.0	U	-
26.00 Enter your standard geographic classification (not w		at the be	ginning of		2	Ζ.	00	26.00
 cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not wreporting period. Enter in column 1, "1" for urban center the effective date of the geographic reclassification 	wage) status or "2" for r fication in	rural. If a column 2.	ppl i cabl e,		2			27.00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	ne number of	periods S	CH status i	n Begi ni		Endi	na	35.00
				1. (2.0		
36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		script line	36 for num	ber				36.00
37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		·		us	0			37.00
37.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f instructions)								37.01
38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of enter subsequent dates.							Z 1	38.00
				Y/ 1.0		Y/ 2.0		-
39.00 Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)	i), (ii), or the mileage	r (iii)? En e requireme	ter in colu nts in	mn		Ν	1	39.00
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octor no in column 2, for discharges on or after October 1	ober 1. Ente	er "Y" for				Ν	I	40.00
					V 1.00	XVIII	XIX	
Prospective Payment System (PPS)-Capital						1	3.00	
45.00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	ent for disp	proporti ona	te share in	accordance	e N	N	N	45.00
46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymer Teaching Hospitals					N N	N N	N N	47.00 48.00
56.00 Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you	impacted by	/ CR 11642						56.00
GME payment reduction? Enter "Y" for yes or "N" for 57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor for yes or "N" for no in column 2. If column 2 is "	period duri or yes or "M nth of this "Y", complet	ng which r I" for no i cost repor e Workshee	n column 1. ting period	וֹל column ר Enter אינייייייייייייייייייייייייייייייייייי				57.00
"N", complete Wkst. D, Parts III & IV and D-2, Pt. I 58.00 f line 56 is yes, did this facility elect cost reim	mbursement f	°or physici	ans' servic	es as	N			58.00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 59.00 Are costs claimed on line 100 of Worksheet A? If ye			Pt I		N			59.00
and price costs of an incur on time too of moresticet A: If ye	ss, somprete		, . .			I	1	1 07.00

	ΑΤΑ	Provider C	011.10.1027	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Pre 8/31/2020 7:5	pared:
			NAHE 413.85 Y/N	5 Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	1
OO Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col	3.85? (s olumn 1. CR) NAHE	see lf column 1	N			60.00
	Y/N	I ME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 01 Enter the average number of unweighted primary care 				0.00	0. 00	61.0
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 02 Enter the current year total unweighted primary care	à					61.0
 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) O3 Enter the base line FTE count for primary care 						61.0
and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						
 04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 05 Enter the difference between the baseline primary 						61.C
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)	9					01.0
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)		nan Nana	Durana Cad			61. C
	Pro	gram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.1
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. Enter in column 4, the direct GME FTE unweighted count.	ו			0. 00	0. 00	61.2
The arrest owner file anwerghted count.	1		l		1.00	
ACA Provisions Affecting the Health Resources and Se 00 Enter the number of FTE residents that your hospital				eriod for which		62.0
your hospital received HRSA PCRE funding (see instru 01 Enter the number of FTE residents that rotated from	uctions)					62.0
during in this cost reporting period of HRSA THC pro Teaching Hospitals that Claim Residents in Nonprovid	ogram. (s	see instructio		3 , 1		

OSPI TAL	nancial Systems AND HOSPITAL HEALTH CARE COMP		ARY COMMUNITY HOSPIT ATA Provider (eri od:	Worksheet S-2	
					rom 01/01/2019 o 12/31/2019	Part I Date/Time Pre 8/31/2020 7:5	pared: 4 am
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	1
	tion 5504 of the ACA Base Yea			-This base yea	r is your cost	reporti ng	
.00 Ent in res set res	iod that begins on or after J er in column 1, if line 63 is the base year period, the num ident FTEs attributable to ro tings. Enter in column 2 the ident FTEs that trained in yo (column 1 divided by (column	yes, or your facili ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratic		0.00	0. 000000	64. OC
101		Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
		J		FTËs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
	-			Site	1.00		4
. 00 Ent	erin column 1, ifline 63	1.00	2.00	3.00	4.00 0.00	5.00 0.000000	65.00
is tra yea ass FTE pro res the col unw res rot non col unw res you 5, div	yes, or your facility ined residents in the base r period, the program name ociated with primary care s for each primary care gram in which you trained idents. Enter in column 2, program code. Enter in umn 3, the number of eighted primary care FTE idents attributable to ations occurring in all -provider settings. Enter in umn 4, the number of eighted primary care ident FTEs that trained in r hospital. Enter in column the ratio of (column 3 ided by (column 3 + column . (see instructions)			Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	tion 5504 of the ACA Current inning on or after July 1, 20		n Nonprovider Settir	ngsEffective	for cost report	ing periods	
. 00 Ent FTE Ent FTE	er in column 1 the number of s attributable to rotations o er in column 2 the number of s that trained in your hospit lumn 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.00
(00		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	-	1.00	2.00	3.00	4.00	5.00	1
nam you whi Ent cod num car to non col unw res you 5,	er in column 1, the program le associated with each of r primary care programs in ch you trained residents. er in column 2, the program le. Enter in column 3, the ber of unweighted primary e FTE residents attributable rotations occurring in all -provider settings. Enter in umn 4, the number of reighted primary care ident FTEs that trained in r hospital. Enter in column the ratio of (column 3 ided by (column 3 + column			0.0		0. 000000	67.00

Heal th	Financial Systems MARGARET MARY COMMUNITY HOSPITAL	In Lieu	of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1329 Pe	eriod: com 01/01/2019	Worksheet S-2 Part I Date/Time Pre 8/31/2020 7:5	2 epared:
		1.00	2.00 3.00	_
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub	orovider? N		70.00
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teach program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reporting	no. (see ni ng no.	0	71.00
75 00	(see instructions) Inpatient Rehabilitation Facility PPS			
	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N		75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes on no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y indicate which program year began during this cost reporting period. (see instructions)	r "N" for with 42	0	76.00
			1.00	-
	Long Term Care Hospital PPS			
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? Enter	N N	80.00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes o Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section		N	85.00 86.00
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		Ν	87.00
		V 1.00	XI X 2. 00	_
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Y	90.00
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N	Y	91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. 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 column.		Ν	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	Ν	Ν	93.00
94.00	applicable column.	Ν	Ν	94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N	0.00 N	95.00 96.00
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	0. 00 Y	0.00 Y	97.00 98.00
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	Ν	Ν	98.03
98. 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Ν	Ν	98.04
98. 05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	Y	Y	98.05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
105.00	Rural Providers Does this hospital qualify as a CAH?	Y		105.00
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an	Ν		107.00
	approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			

Health Financial Systems MARGARET MARY COMM	L	In Lieu of Form CMS-2552-10			
				Worksheet S-2 Part I Date/Time Pre 8/31/2020 7:5	epared:
			V 1.00	XI X 2. 00	-
108.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	edul e? See 42	Ν		108.00
Physical Occupat			Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3.00 N	4.00 N	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
110.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	F yes,	1.00 N	110.00		
			1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting Dumn 1 is Y, rticipating ir	period? Enter enter the column 2.	Ν		111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Health Model N 112.00 Did this hospital participate in the Pennsylvania Rural Health Model N demonstration for any portion of the current cost reporting period? N Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter If column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.					112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.				C	0115.00
116.00 s this facility classified as a referral center? Enter "Y" for yes or N "N" for no.					116.00
117.00 Is this facility legally-required to carry malpractice insur	ance? Enter	Ν			117.00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr		1			118.00
		Premi ums	Losses	l nsurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00 401,290	2.00	3.00	0118.01
		101,270	5		
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			<u>1.00</u> N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions)				Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Y	5.00	122.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" fo	or ves and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below.	•				
126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2	2.				126.00
127.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2		ication date			127.00
128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2	er the certif	fication date			128.00
129.00 If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2.		cation date in			129.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLE		COMMUNITY HOSPITAL Provider CC		Peri od		u of Form CMS Worksheet S-		
				From O	1/01/2019 2/31/2019	Part I	repared	
		L.			1.00		_	
0.00 f this is a Medicare certified p	ancreas transplant cent	ter enter the cert	tification	1	1.00	2.00	130.0	
date in column 1 and termination of 1.00 If this is a Medicare certified in	date, if applicable, ir	n column 2.					131.0	
date in column 1 and termination of 2.00 If this is a Medicare certified is	slet transplant center,	enter the certifi	ication da	ite			132. (
in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. All Providers								
Ail Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, N chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 1.00 1.00								
If this facility is part of a cha		on lines 141 thro	ugh 143 th	ne name ar		of the home		
office and enter the home office	contractor name and con Contractor's Name		Contro	actor's Nu	mbor.		141.0	
1.00Name: 2.00Street: 3.00City:	PO Box: State:	2.					141.0	
3. 00 01 ty.	jstate.		Zip Co	Jue.			143.0	
4.00 Are provider based physicians' co	ata inaludad in Warkaha	aat 42				1.00 Y	144. (
4. OUALE PLOVI del based physicialis co	Sts Therudeu Th Workshe	Bet A?				T	144.	
	Laimad an What A Line	74	- 6		1.00	2.00	1.45	
 5.00 f costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 5.00 Has the cost allocation methodological 	" for yes or "N" for no clude Medicare utilizat for no in column 2.	o in column 1. If a tion for this cost	column 1 i reporting		N		145.	
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/		ub. 15-2, chapter 4	40, §4020)	lf				
7.00 Was there a change in the statist	ical basis? Enter "Y" f	for yes or "N" for	no.			1.00 N	147.	
3.00Was there a change in the order o	f allocation? Enter "Y"	' for yes or "N" fo	or no.	for no		N N	148.	
7.00Was there a change in the statist 3.00Was there a change in the order o 9.00Was there a change to the simplif	f allocation? Enter "Y"	' for yes or "N" fo	or no. <u>es or "N"</u> Part E		ītle V	N N Title XIX	147. 148. 149.	
3.00Was there a change in the order o 9.00Was there a change to the simplif	f allocation? Enter "Y" ied cost finding method	' for yes or "N" fo d? Enter "Y" for ye Part A 1.00	or no. <u>es or "N"</u> Part E 2.00	В Т	3.00	N N TitleXIX 4.00	148.	
B. 00Was there a change in the order or D. 00Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or	f allocation? Enter "Y" ied cost finding methoc ider that qualifies for	for yes or "N" for <u>Part A</u> 1.00 r an exemption fro mponent for Part A	or no. es or "N" Part E 2.00 m the appl and Part	B T lication (3.00 of the low 42 CFR §41	N N TitleXIX 4.00 er of costs 3.13)	148. 149.	
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 B. 00 Was there a change in the order of 0.00 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or 5.00 Hospital D. 00 Subprovider - IPF D. 00 Subprovider - IRF D. 00 SUBPROVI DER D. 00 SUBPROVI DER D. 00 SUBPROVI DER D. 00 HOME HEALTH AGENCY D. 00 CMHC Multicampus 5.00 Is this hospital part of a Multication of the system of th	f allocation? Enter "Y" ied cost finding method ider that qualifies for "N" for no for each cor ampus hospital that has Name	' for yes or "N" for d? Enter "Y" for yes Part A 1.00 mponent for Part A N N N N N S one or more camput County	or no. es or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	B T ication (B. (See 4) fferent (Zip Code	3.00 of the low 42 CFR §41 N N N N N SBSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N T.00 FTE/Campus 5.00	148. 149. 155. 156. 157. 158. 159. 160. 161. 165.	
 3. 00 Was there a change in the order of 2. 00 Was there a change to the simplif Does this facility contain a provor or charges? Enter "Y" for yes or 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 9. 00 SNF 9. 00 HOME HEALTH AGENCY 1. 00 CMHC Multicampus 5. 00 If line 165 is yes, for each campus enter the name in column 3, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7. 00 Is this provider a meaningful use 	f allocation? Enter "Y" ied cost finding method ider that qualifies for "N" for no for each cor "N" bospital that has Name 0 1) incentive in the Amer r under §1886(n)? Enter	' for yes or "N" for d? Enter "Y" for yes Part A 1.00 r an exemption from mponent for Part A N N N N N S one or more camputation county 1.00 eri can Recovery an er "Y" for yes or '	or no. es or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	B T i cation (B. (See 4) fferent (Zip Code 3.00 tment Act).	3.00 of the Iow 42 CFR §41 N N N N N N N N N N N N N	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 157. 160. 161. 165. 00 166. 00 166.	
3. 00 Was there a change in the order o 4. 00 Was there a change to the simplif 5. 00 Was there a change to the simplif 5. 00 Hospital 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 7. 00 SUBPROVIDER 7. 00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 5. 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) Heal th Information Technology (HI 7. 00 Is this provider a meaningful use 3. 00 If this provider is a CAH (line 11)	f allocation? Enter "Y" ied cost finding method ider that qualifies for "N" for no for each cor "N" for no for each cor ampus hospital that has Name 0 1) incentive in the Amer r under §1886(n)? Ente 05 is "Y") and is a mea HIT assets (see instruct	' for yes or "N" for d? Enter "Y" for yes Part A 1.00 r an exemption from mponent for Part A N N N N N N N N N N N N N	or no. es or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	B T i cation of B. (See A See A Fferent O Zip Code 3.00 tment Act Y"), ente	3.00 of the low 42 CFR §41 N N N N N EBSAs? CBSA 4.00 er the	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166. 00 166.	
 B. 00 Was there a change in the order of 2. 00 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or 5. 00 Hospital D. 00 Subprovider - IPF D. 00 Subprovider - IRF D. 00 SUBPROVI DER D. 00 SUBPROVI DER D. 00 SNF D. 00 HOME HEALTH AGENCY D. 00 CMHC Multicampus 5. 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) Health Information Technology (HI 7. 00 Is this provider a meaningful use 3. 00 If this provider is a CAH (line 10)	f allocation? Enter "Y" ied cost finding method ider that qualifies for "N" for no for each cor "N" for no for each cor "N" for each cor "N" for each cor "N" for no for each cor "N" fo	for yes or "N" for for yes or "N" for Part A 1.00 r an exemption from mponent for Part A N N N N N N N N N N N N N	or no. es or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	B T ication o B. (See A B. (See A Control of the second B. (See A Control of the second B. (See A Control of the second Control	3.00 of the Iow 42 CFR §41 N N N N N N N N N N N N N	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166. 00 166.	

Health Financial Systems	In Lie	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COM	PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1329 Per			Worksheet S-2	2
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre 8/31/2020 7:5	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this p	N	(0171.00		
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter					
"Y" for yes and "N" for no in o	column 1. If column 1 is yes,	enter the number of section	n		
1876 Medicare days in column 2.	(see instructions)				

	Financial Systems MARGARET MARY COM AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			In Lie Period:	u of Form CMS Worksheet S-	
				From 01/01/2019 To 12/31/2019		
		I		Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter I	V for all NO r	asnonsas Ent	1.00	2.00	
	COMPLETED BY ALL HOSPITALS		esponses. Litte		the	_
	Provider Organization and Operation					_
. 00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in o	column 2. (see	Y/N) Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colum		N			2.0
. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includi contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
ł. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date ava	for Compiled,	Y	A		4.0
. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit re-		N			5. C
	Those on the fired financial statements? If yes, submit fer			Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is t	he provider i	s N		6.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7. C 8. C
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	ns.		Ν		9.0
	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.			N		10.0
1.00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N		11.0
					Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection			ost reporting	Y N	12. (13. (
	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paym Bed Complement	ents waived? I	fyes, see in:	structions.	N	14.0
5.00	Did total beds available change from the prior cost report	<u> </u>			N	15.0
		Par Y/N	rt A Date	Par Y/N	t B Date	_
		1.00	2.00	3.00	4.00	-
	PS&R Data					
6.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/10/2020	Y	01/10/2020	16.0
7.00	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	Ν		Ν		17.0
8.00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.0
9.00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19. (

Health Financial Systems

MARGARET MARY COMMUNITY HOSPITAL

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE		Provi der C	CN: 15-1329 F	Period: From 01/01/2019	Worksheet S-2 Part II	2
		То		To 12/31/2019	Date/Time Pre 8/31/2020 7:5	
		Descr	iption	Y/N	Y/N	
00.00			0	1.00	3.00	00.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
21 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.00
	records? If yes, see instructions.	14				21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS	HOSPI TALS)		1.00	
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, se			ng the cost	N N	22.00
23.00	3.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					
24.00	0 Were new leases and/or amendments to existing leases entered into during this cost reporting period?					
25.00						
26.00						
27.00	instructions. Has the provider's capitalization policy changed during th	Ν	27.00			
	сору.					
28.00	Interest Expense Were new Loans, mortgage agreements or Letters of credit e	N	28.00			
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29.00			
	treated as a funded depreciation account? If yes, see inst					
30.00	Has existing debt been replaced prior to its scheduled mat instructions.	N	30.00			
31.00	.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ed through con	tractual	Ν	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competit	ive bidding? If	N	33.00
	no, see instructions. Provider Pased Physicians					-
34.00	Provider-Based Physicians Are services furnished at the provider facility under an a	arrangement wit	h provider-bas	ed physicians?	Y	34.00
	If yes, see instructions.	Ū.	•			
35.00	If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i		nts with the p		Y	35.00
				Y/N 1.00	Date 2.00	
	Home Office Costs			1.00	2.00	
	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	prepared by the	home office?	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home of			N		38.00
39.00	the provider? If yes, enter in column 2 the fiscal year er If line 36 is yes, did the provider render services to oth			N		39.00
40.00	see instructions. If line 36 is yes, did the provider render services to the	e home office?	lfyes, see	N		40.00
	instructions.					
		1.	00	2.	00	
41 00	Cost Report Preparer Contact Information			CMI TH		41.00
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	KYLE		SMI TH		41.00
42.00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LL	_C			42.00
43.00	preparer. Enter the telephone number and email address of the cost	317-713-7957		KCSMI TH@BLUEANI	DCO. COM	43.00
	report preparer in columns 1 and 2, respectively.					

Health Financial Syste	ms	MARGARET MARY CO	OMMUN	NI TY HOSPI TAL		-	In Lieu	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL	HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provider CCN	: 15-1329	Peri Erom	od: 01/01/2019	Worksheet S- Part II	2
						То		Date/Time Pr 8/31/2020 7:	epared: 54 am
				3.00)				
Cost Report Pre	parer Contact Information								
41.00 Enter the first	name, last name and the	title/position	SEN	VIOR MANAGER					41.00
held by the cos	t report preparer in colu	mns 1, 2, and 3,							
respectively.									
42.00 Enter the emplo	yer/company name of the c	ost report							42.00
preparer.									
43.00 Enter the telep	hone number and email add	ress of the cost							43.00
report preparer	in columns 1 and 2, resp	ecti vel y.							

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	F	Period: From 01/01/2019 Fo 12/31/2019		pared
Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
	1.00	2.00	3.00	4.00	5.00	
.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	18			0	
 .00 HMO and other (see instructions) .00 HMO IPF Subprovider .00 HMO IRF Subprovider .00 Hospital Adults & Peds. Swing Bed SNF 					0	2. 3. 4. 5.
 Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) 		18	6, 570	90, 168. 00	0	6. 7.
.00INTENSIVE CARE UNIT.00CORONARY CARE UNIT0.00BURN INTENSIVE CARE UNIT1.00SURGICAL INTENSIVE CARE UNIT2.00OTHER SPECIAL CARE (SPECIFY)	31.00	7	2, 555	6, 648. 00	0	8. 9. 10. 11. 12.
 3. 00 NURSERY 4. 00 Total (see instructions) 5. 00 CAH visits 5. 00 SUBPROVIDER - IPF 7. 00 SUBPROVIDER - IRF 3. 00 SUBPROVIDER 9. 00 SKILLED NURSING FACILITY 5. 00 NURSING FACILITY 	43.00	25	9, 125	96, 816. 00	0 0 0	13. 14. 15. 16. 17. 18. 19. 20.
 O OTHER LONG TERM CARE OO HOME HEALTH AGENCY OO AMBULATORY SURGICAL CENTER (D. P.) OO HOSPICE IO HOSPICE (non-distinct part) OO CMHC - CMHC 	101. 00 116. 00 30. 00	0	C		0	21.
 6.00 RURAL HEALTH CLINIC 5.25 FEDERALLY QUALIFIED HEALTH CENTER 7.00 Total (sum of lines 14-26) 3.00 Observation Bed Days 9.00 Ambulance Trips 	88. 00 89. 00	25			0 0 0	26. 26. 27.
 0.00 Employee discount days (see instruction) .00 Employee discount days - IRF 2.00 Labor & delivery days (see instructions) 2.01 Total ancillary labor & delivery room outpatient days (see instructions) 		0	C			30. 31. 32. 32.
3.00 LTCH non-covered days 3.01 LTCH site neutral days and discharges						33. 33.

iospi t <i>a</i>	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	F	Period: From 01/01/2019 To 12/31/2019		pare
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1, 572	88	3, 757	7		1.
. 00	HMO and other (see instructions)	550	117				2.
	HMO I PF Subprovi der	0	0				3.
	HMO IRF Subprovider	0	0	(4. 5.
	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	U	0				6
	Total Adults and Peds. (exclude observation	1, 572	88	3, 75	7		7
	beds) (see instructions)						
	INTENSIVE CARE UNIT	152	7	27	7		8
	CORONARY CARE UNIT						9
	BURN INTENSIVE CARE UNIT						10
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						11 12
	NURSERY		0	945			13
	Total (see instructions)	1, 724	95	4, 979		544.98	
	CAH visits	0	0	(, , , ,	0.00	011.70	15
	SUBPROVIDER - IPF	-	-				16
. 00	SUBPROVIDER – IRF						17
. 00	SUBPROVI DER						18
	SKILLED NURSING FACILITY						19
	NURSING FACILITY						20
	OTHER LONG TERM CARE	6 500	10/	10.10		10.00	21
	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	6, 522	436	10, 435	0.00	19.83	22
	HOSPICE	0	0	(0. 00	12.37	
	HOSPICE (non-distinct part)	0	0			12. 37	24
	CMHC - CMHC						25
	RURAL HEALTH CLINIC	1, 958	1, 992	9, 399	0.00	15. 18	
5. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	26
7.00	Total (sum of lines 14-26)				0.00	592.36	27
	Observation Bed Days		24	1, 235	ō		28
	Ambul ance Trips	0					29
	Employee discount days (see instruction)			(30
	Employee discount days - IRF		~				31
	Labor & delivery days (see instructions) Total ancillary labor & delivery room	0	0				32
	outpatient days (see instructions)						32
	LTCH non-covered days	0					33
	LTCH site neutral days and discharges	o					33

HOSPI T	Financial Systems MAR AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	GARET MARY COMMU AL DATA	Provider C		Peri od:	u of Form CMS-2 Worksheet S-3	
105111	AL AND HOST THE HEALTH OAKE COMPLEX STATISTIC			GN. 10 1027	From 01/01/2019 To 12/31/2019	Part I Date/Time Pre 8/31/2020 7:5	pared:
		Full Time Equivalents		Di s	charges	0,01,2020 ,10	
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	component	Workers				Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	5	63 33	1, 517	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)			1	64 42		2.00
3.00	HMO I PF Subprovi der				0		3.00
4.00	HMO I RF Subprovider				0		4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation						6.00 7.00
7.00	beds) (see instructions)						7.00
8.00	I NTENSI VE CARE UNI T						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN I NTENSI VE CARE UNI T						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	5	63 33	1, 517	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER – IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						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.)	0.00					23.00
24.00 24.10	HOSPICE	0.00					24.00 24.10
24.10	HOSPICE (non-distinct part) CMHC - CMHC						24.10
26.00	RURAL HEALTH CLINIC	0.00					25.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.2
27.00	Total (sum of lines 14-26)	0.00					27.0
28.00	Observation Bed Days	0.00					28.0
29.00	Ambul ance Trips						29.0
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				0		33.00
33.01	LTCH site neutral days and discharges				0		33. 0 ⁻

	Financial Systems MAF	RGARET MARY COMM	Provider C	AL CN: 15-1329 CCN: 15-7143	Peri od: From 01/01/2019 To 12/31/2019 Home Heal th	u of Form CMS- Worksheet S-4 Date/Time Pre 8/31/2020 7:5 PPS	epared:
					Agency I		
0.00	County				1.	00	0.00
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	0.00	1.00	0.00	
1.00	Home Health Aide Hours	0	0)	0 0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	273.00			0.00	2.00
				Number of Em	ployees (Full Ti	me Equivalent)	
				Ctaff	Contract	Tatal	
		Enter the numbe your normal		n Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0		1.00	2.00	5.00	
3.00	Administrator and Assistant Administrator(s)		40.00	0. (0. 00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.0		0.00	•
5.00	Other Administrative Personnel			5.		5.58	•
6.00	Direct Nursing Service			7.1		7.20	
7.00 8.00	Nursing Supervisor Physical Therapy Service			0.0		0.00 4.10	
9.00	Physical Therapy Supervisor			0.0		0.00	
10.00	Occupational Therapy Service			1.	76 0. 00	1.76	10.00
11.00	Occupational Therapy Supervisor			0.0		0.00	
12.00	Speech Pathology Service			0.0		0.04	
13.00 14.00	Speech Pathology Supervisor Medical Social Service			0.0		0. 00 0. 19	
14.00	Medical Social Service Supervisor			0.0		0. 19	
16.00	Home Health Aide			0.0		0.94	
17.00	Home Health Aide Supervisor			0. (0.00	
18.00	Other (specify)			0.0	0.00	0.00	18.00
10.00	HOME HEALTH AGENCY CBSA CODES	1		1			1 10 00
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost				2		19.00
	reporting period.						
20.00	List those CBSA code(s) in column 1 serviced	I		17140			20.00
	during this cost reporting period (line 20						
00.01	contains the first code).			00015			00.01
20.01		Full Ep	i sodos	99915			20.01
			With Outliers	LUPA Epi sode	s PEP Only	Total (cols.	
		Outliers			Epi sodes	1-4)	
		1.00	2.00	3.00	4.00	5.00	
21.00	PPS ACTIVITY DATA Skilled Nursing Visits	1, 892	1 047	/	54 31	3, 034	21 00
21.00	Skilled Nursing Visit Charges	317, 856	1, 047 175, 896	1		3, 034 509, 712	
23.00	Physical Therapy Visits	1, 333	623		37 26	2, 019	
24.00	Physical Therapy Visit Charges	269, 266	125, 846	7,4		407, 838	24.00
25.00	Occupational Therapy Visits	589	419	1	1 3	1, 012	
26.00	Occupational Therapy Visit Charges	127, 224	90, 504		16 648	218, 592	
27.00 28.00	Speech Pathology Visits Speech Pathology Visit Charges	17 3, 488	22 4, 578	1	1 0 18 0	40 8, 284	
28.00	Medical Social Service Visits	3,400	4, 576		0 0	0, 204 10	1
30.00	Medical Social Service Visit Charges	2, 240	960		0 0	3, 200	
31.00	Home Health Aide Visits	130	276	1	1 0	407	
32.00	Home Health Aide Visit Charges	12, 870	27, 324		99 0	40, 293	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3, 968	2, 390	/ ¹⁽	60	6, 522	33.00
34.00	Other Charges	0	C		0 0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28,	732, 944	425, 108		-	1, 187, 919	
	30, 32, and 34)		-,				
o (Total Number of Episodes (standard/non	261		:	34 6	301	36.00
36.00	outlion)						
36.00 37.00	outlier) Total Number of Outlier Episodes		73	3	0	72	37.00

Heal th	Financial Systems MAR	GARET MARY COM	MUNITY HOSPITA	\L	In Lie	eu of Form CMS-2	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	;
			Component		rom 01/01/2019 o 12/31/2019		
					RHC I	Cost	
					1	. 00	-
	Clinic Address and Identification	<u> </u>			<u> </u>	00	
1.00	Street				112 N. BUCKEYE		1.00
		-		ty	State	ZIP Code	
2.00	City, State, ZIP Code, County		I. DSGOOD	00	2.00	3.00 \\47037	2.00
2.00	Torty, otato, 211 obao, obarty	I`					2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for		Award	Date 0	3.00
					00	2.00	
	Source of Federal Funds					1	
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00 6.00	Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34)						5.00 6.00
7.00	Appal achi an Regi onal Commi ssi on	O(U), FIIS ACT)					7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h	ospital-based F	RHC or FQHC? E	nter "Y" for	N	0	10.00
	yes or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type o	ate number of c	other operatio	ns in column			
	hours.)	Sup		Mor	dav	Tuesday	
		Sund	to	from	nday to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)					1	
11.00	CLINIC			08: 00	16: 30	08: 00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception	on to the produ	uctivity stand	ard?	N		12.00
13.00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col				Ν	0	13.00
	number of providers included in this report. numbers below.	List the names	s of all provi				
					er name 00	CCN number 2.00	
14.00	RHC/FQHC name, CCN number			1.	00	2.00	14.00
		Y/N	V	XVIII	XI X	Total Visits	
15 00		1.00	2.00	3.00	4.00	5.00	15.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)						
				inty			
2.00	City, State, ZIP Code, County		4.	00			2.00
2.00	Toriy, State, ZIP Code, County	Tuesday	Wedn	esday	Thu	rsday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1)	14.20	08.00	14.20	08.00	14. 20	11 00
11.00	CLINIC	16: 30	08: 00	16: 30	08: 00	16: 30	11.00

Health Financial Systems MAR	RGARET MARY CON	MUNITY HOSPITA	AL.	In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	
		Component		From 01/01/2019 To 12/31/2019	Date/Time Pre 8/31/2020 7:5	pared: 4 am
	_			RHC I	Cost	
	Fri	day	Sat	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	07: 00	06: 00	08: 00	12:00		11.00

HOSPI T	TAL-BASED HOSPICE IDENTIFICATION	I DATA		Provider CO Hospice CCI	CN: 15-1329 N: 15-1551	Period: From 01/01/2019 To 12/31/2019		GH IV pared:
						Hospi ce I		_
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00 2.00 3.00 4.00 5.00	PART I - ENROLLMENT DAYS FOR CO Hospice Continuous Home Care Hospice Routine Home Care Hospice Inpatient Respite Care Hospice General Inpatient Care Total Hospice Days							1.00 2.00 3.00 4.00 5.00
	Part II - CENSUS DATA FOR COST	REPORTING PER	ODS BEGINNING	BEFORE OCTOBER	R 1, 2015			
6.00 7.00 8.00	Number of patients receiving hospice care Total number of unduplicated Continuous Care hours billable to Medicare Average Length of Stay (line 5							6.00 7.00 8.00
	/line 6)							
9.00	Unduplicated census count							9.00
OTE:	Parts I and II, columns 1 and 2	al so include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
				1.00	2.00	3.00	4.00	
10 00	PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERIODS BEGI	NNING ON OR AF	ER OCTOBER 1	·		10.00
	Hospice Routine Home Care Hospice Inpatient Respite Care Hospice General Inpatient Care			0 11, 775 5 0		0 0 39 1,679 0 0 0 2	0 14, 393 5 2	11.00 12.00 13.00
14.00	Total Hospice Days PART IV - CONTRACTED STATISTIC	AL DATA FOR COS	ST REPORTING P	11,780 ERIODS BEGINNIN		39 1,681 R OCTOBER 1, 201	<u>14, 400</u> 5	14.00
15.00	Hospice Inpatient Respite Care			0		0 0	0	15.00
1 / 00	Hospice General Inpatient Care			0		0 0	0	16.0

	Financial Systems MARGARET MARY COMMUNITY			In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovider CC	N: 15-1329	Period:	Worksheet S-1	0
				From 01/01/2019 To 12/31/2019		
					1.00	
1 00	Uncompensated and indigent care cost computation	1. 1.1. 1.1	000		0.055000	1 1 00
1.00	Cost to charge ratio (Worksheet C, Part line 202 column 3 divi	ded by II	ne 202 colum	18)	0. 355828	1.00
2.00	Medicaid (see instructions for each line) Net revenue from Medicaid				5, 063, 068	2.00
2.00	Did you receive DSH or supplemental payments from Medicaid?				N 5,003,008	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplementa	l navment	s from Medic	ai d?	IN IN	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fro				0	5.00
6.00	Medi cai d charges				18, 267, 390	
7.00	Medicaid cost (line 1 times line 6)				6, 500, 049	7.00
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of li	nes 2 and 5; if	1, 436, 981	8.00
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions for	each lin	e)			
9.00	Net revenue from stand-al one CHIP				0	
	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10.00
	Difference between net revenue and costs for stand-alone CHIP (I	ing 11 mi	nus lino 0.	f < zero then		12.00
12.00	enter zero)		nus rine 7,	I < Zero then	0	12.00
	Other state or local government indigent care program (see instr	uctions f	or each line)		
	Net revenue from state or local indigent care program (Not inclu				0	13.00
14.00	Charges for patients covered under state or local indigent care	program (Not included	in lines 6 or	0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line 14)		<i>.</i>		0	15.00
16.00	Difference between net revenue and costs for state or local indi	gent care	program (li	ne 15 minus line	• 0	16.00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP	and stat	e/local indi	nent care progra	ame (see	-
	instructions for each line)	unu stat		gent care progra		
17.00	Private grants, donations, or endowment income restricted to fun	ding char	ity care		0	17.00
18.00	Government grants, appropriations or transfers for support of ho	spital op	erations		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local	i ndi gent	care program	s (sum of lines	1, 436, 981	19.00
	8, 12 and 16)		Line: an excerne of	L maxima al	Tatal (asl 1	
			Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)	
		-	1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire faci	lity	741, 22	4 1, 340, 174	2, 081, 398	20.00
	(see instructions)					
21.00	Cost of patients approved for charity care and uninsured discoun	ts (see	263, 74	8 1, 340, 174	1, 603, 922	21.00
22.00	instructions)	ff oo		0	0	22.00
22.00	Payments received from patients for amounts previously written or charity care	in as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		263, 74	8 1, 340, 174	1, 603, 922	23 00
20100			200771	1/010/1/1	170007722	20100
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patient		ond a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care p					
25.00	If line 24 is yes, enter the charges for patient days beyond the	indigent	care progra	n's length of	0	25.00
24 00	stay limit	ructions)			4 010 0E4	24 00
26.00 27.00	Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex		ructions)		6, 840, 856 609, 557	
27.00	Medicare allowable bad debts for the entire hospital complex (se				937, 779	
28.00	Non-Medicare bad debt expense (see instructions)				5, 903, 077	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	nse (see	instructions)	2, 428, 702	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				4, 032, 624	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus lin	ie 30)			5, 469, 605	31.00

	MARGARET MARY COMM				u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANC	E OF EXPENSES	Provider CC		eriod: rom 01/01/2019	Worksheet A	
			To		Date/Time Pre 8/31/2020 7:5	
Cost Center Description	Sal ari es	Other	Total (col. 1		Recl assi fi ed	
			+ col. 2)	ions (See A-6)	Trial Balance (col. 3 +-	
				A-0)	col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 1.01 00101 NEW CAP REL COSTS-OFFSLTE BLDG		3, 155, 649	3, 155, 649	0	3, 155, 649	1.00 1.01
2.00 00200 NEW CAP REL COSTS-OFFSITE BLDG		853, 630 5, 419, 931	853, 630 5, 419, 931	-574, 151	853, 630 4, 845, 780	2.00
2.01 00201 NEW CAP REL COSTS MVBLE EQUIP OFFSIT		0,417,731	0,417,751	574, 151	574, 151	2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	202, 578	15, 271, 092	15, 473, 670	0	15, 473, 670	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	7, 054, 451	12, 248, 850	19, 303, 301	387, 328	19, 690, 629	5.00
7.00 00700 OPERATION OF PLANT	0	1, 486, 167	1, 486, 167	-170	1, 485, 997	7.00
7.01 00701 OPERATION OF PLANT -OFFSITE 7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS	0 5 549, 167	260, 578 14, 759	260, 578	0	260, 578 563, 926	7.01 7.02
8.00 00800 LAUNDRY & LINEN SERVICE	125, 727	87, 791	563, 926 213, 518	-15, 290	198, 228	7.02 8.00
9. 00 00900 HOUSEKEEPI NG	974, 563	361, 281	1, 335, 844	-1, 780	1, 334, 064	9.00
10. 00 01000 DI ETARY	796, 763	547, 868	1, 344, 631	-1, 240, 298	104, 333	10.00
11. 00 01100 CAFETERI A	0	0	0	1, 206, 277	1, 206, 277	11.00
13. 00 01300 NURSING ADMINISTRATION	550, 276	2, 226	552, 502	0	552, 502	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0 778, 313	0 3, 021, 782	0 3, 800, 095	0 -27, 207	0 3, 772, 888	14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1, 293, 486	260, 771	3, 800, 095 1, 554, 257	-27, 207 -163	3, 772, 000 1, 554, 094	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	172707100	200,771	1,001,207	100	1,001,071	10100
30. 00 03000 ADULTS & PEDIATRICS	1, 748, 976	1,047,745	2, 796, 721	475, 607	3, 272, 328	30.00
31.00 03100 INTENSIVE CARE UNIT	317, 201	30, 222	347, 423	-21, 290	326, 133	31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	9, 218	9, 218	642, 640	651, 858	43.00
50. 00 05000 OPERATING ROOM	1, 556, 661	2, 781, 038	4, 337, 699	-2, 347, 217	1, 990, 482	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 318, 567	237,878	1, 556, 445	-1, 436, 940	119, 505	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 172, 643	9, 059, 360	12, 232, 003	-296, 841	11, 935, 162	54.00
60. 00 06000 LABORATORY	1, 638, 871	2, 537, 445	4, 176, 316	-54, 429	4, 121, 887	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	555, 864 1, 107, 879	172, 116 70, 131	727, 980 1, 178, 010	-38, 752	689, 228 1, 161, 936	65.00 66.00
67. 00 06700 OCCUPATIONAL THERAPY	359, 599	16, 048	375, 647	-16, 074 -11, 196	364, 451	67.00
68. 00 06800 SPEECH PATHOLOGY	193, 316	2, 863	196, 179	-751	195, 428	68.00
69. 00 06900 ELECTROCARDI OLOGY	619, 601	336, 775	956, 376	-32, 352	924, 024	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	2, 836, 632	2, 836, 632	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 73. 00 07300 DRUGS CHARGED TO PATI ENTS	0	0	0	999, 210	999, 210	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	73.00
88.00 08800 RURAL HEALTH CLINIC	1, 094, 995	122, 858	1, 217, 853	0	1, 217, 853	88.00
90. 00 09000 CLINIC	1, 765, 075	999, 963	2, 765, 038	-206, 546	2, 558, 492	90.00
90. 01 09001 WOUND CLINC	341, 761	231, 815	573, 576	-219, 593	353, 983	90.01
90. 02 09002 BEHAVI ORAL HEALTH	505, 452	77, 523	582, 975	-3	582, 972	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 281, 683	2, 668, 169	4, 949, 852	-169, 735	4, 780, 117	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	1, 613, 304	198, 346	1, 811, 650	0	1, 811, 650	101.00
SPECIAL PURPOSE COST CENTERS				1		
113.00 11300 INTEREST EXPENSE	704 474	0	0	0		113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 11	721, 174 7) 33, 237, 946	428, 418 64, 020, 306	1, 149, 592 97, 258, 252	0 411, 067	1, 149, 592 97, 669, 319	
NONREI MBURSABLE COST CENTERS	7) 33,237,740	04, 020, 300	77,230,232	411,007	77,007,317	110.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	10, 427, 461	2, 642, 918	13, 070, 379	0	13, 070, 379	192.00
192. 01 19201 PEDI ATRI CS	689, 560	45, 723		0	735, 283	
192. 02 19202 BROOKVI LLE	1, 275, 222	95, 643	1, 370, 865	0	1, 370, 865	
192. 03 19203 RADI OLOGY – OSGOOD 192. 04 19204 ENT	92,051	0 12 617	92, 051 284, 327	0	92, 051 284, 327	
192. 04 19204 ENT 194. 00 07950 COMMUNITY RELATIONS	270, 710 393, 286	13, 617 843, 846	284, 327 1, 237, 132	-411,067	284, 327 826, 065	
194. 01 07951 COMMUNITY BENEFITS	460, 234	323, 052	783, 286	0	783, 286	
194.0207952 OTHER NON-REIMBURSABLE	0	0	0	0		194.02
194. 03 07953 EMS	48, 853	43, 263	92, 116	0	92, 116	
194. 04 07954 BATESVILLE TOOL & DIE CLINIC	166, 247	26, 186	192, 433	0	192, 433	
194.05 07955 MMHCB RHC 200.00 TOTAL (SUM OF LINES 118 through 199)	585, 714 47, 647, 284	59, 899 68, 114, 453	645, 613 115, 761, 737	0	645, 613 115, 761, 737	
200.00 TOTAL (SUM OF LINES FIG LIFUUUUI 199)	47,047,204	00, 114, 403	113,701,737	U	113,701,737	200.00

		GARET MARY COM				u of Form CM	
ECLASSI FI	ICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provider C	CN: 15-1329	Period: From 01/01/2019	Worksheet	A
					To 12/31/2019	Date/Time	Prepare
	Cost Center Description	Adjustments	Net Expenses			8/31/2020	<u>7:54 an</u>
		(See A-8)	For				
			Allocation				
		6.00	7.00				
	ERAL SERVICE COST CENTERS	050,400	0.005.044	1			
	00 NEW CAP REL COSTS-BLDG & FIXT 01 NEW CAP REL COSTS-OFFSITE BLDG	-850, 408 0	2, 305, 241 853, 630	1			1
	00 NEW CAP REL COSTS-OFFSITE BLDG	-121, 451	4, 724, 329	1			2
	01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	-121, 431	574, 151	1			2
	00 EMPLOYEE BENEFITS DEPARTMENT	0	15, 473, 670	1			4
00 005	00 ADMI NI STRATI VE & GENERAL	-4, 462, 492	15, 228, 137				5
	OO OPERATION OF PLANT	-17,075	1, 468, 922				7
	01 OPERATION OF PLANT -OFFSITE	0	260, 578				7
	02 OPERATION OF PLANT - HOSPITAL & OFFS	0	563, 926	1			7
	00 LAUNDRY & LINEN SERVICE	-1, 791	196, 437	1			8
	00 HOUSEKEEPI NG 00 DI ETARY	0	1, 334, 064				9
	00 CAFETERI A	-66, 310 -357, 848					11
	00 NURSI NG ADMI NI STRATI ON	-337, 848	552, 502	1			13
	00 CENTRAL SERVICES & SUPPLY	0	552, 502	1			14
	00 PHARMACY	-66, 688	3, 706, 200				15
	00 MEDI CAL RECORDS & LI BRARY	-15, 691	1, 538, 403				16
	ATIENT ROUTINE SERVICE COST CENTERS						
	00 ADULTS & PEDIATRICS	-695, 226					30
	00 INTENSIVE CARE UNIT	0	326, 133	1			31
	00 NURSERY	0	651, 858				43
	I LLARY SERVICE COST CENTERS	E2 222	1 027 140				
	00 OPERATING ROOM 00 DELIVERY ROOM & LABOR ROOM	-53, 333 0	1, 937, 149 119, 505	1			50 52
	00 RADI OLOGY-DI AGNOSTI C	-1, 229, 524	10, 705, 638	1			54
	00 LABORATORY	1, 227, 324	4, 121, 887	1			60
	01 BLOOD LABORATORY	0	C	1			60
00 065	00 RESPI RATORY THERAPY	0	689, 228				65
	00 PHYSI CAL THERAPY	-65, 649	1, 096, 287				66
	00 OCCUPATI ONAL THERAPY	-1, 725	362, 726	1			67
	00 SPEECH PATHOLOGY	0	195, 428	1			68
		-172,068	751, 956				69
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS 00 IMPL. DEV. CHARGED TO PATIENT	0	2, 836, 632 999, 210				71
	00 DRUGS CHARGED TO PATIENTS	0	999,210				73
	PATIENT SERVICE COST CENTERS	0		1			/`
	00 RURAL HEALTH CLINIC	0	1, 217, 853				88
	00 CLINIC	-1, 181, 534					90
	01 WOUND CLINC	0	353, 983	1			90
	02 BEHAVI ORAL HEALTH	-156, 116					90
	00 EMERGENCY	-1, 937, 079	2, 843, 038				91
	00 OBSERVATION BEDS (NON-DISTINCT PART)						92
	ER REIMBURSABLE COST CENTERS		1 011 (50				
	00 HOME HEALTH AGENCY CIAL PURPOSE COST CENTERS	0	1, 811, 650	1			101
	00 INTEREST EXPENSE	0	C				113
	00 HOSPI CE	0		•			116
3.00	SUBTOTALS (SUM OF LINES 1 through 117)	-11, 452, 008					118
	REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	·			
	00 PHYSICIANS' PRIVATE OFFICES	0		1			192
1	01 PEDI ATRI CS	0	735, 283	1			192
	02 BROOKVILLE	0	1, 370, 865				192
	03 RADI OLOGY - OSGOOD	0	92, 051	1			192
2.04 192		0	284, 327	1			192
	50 COMMUNI TY RELATI ONS 51 COMMUNI TY BENEFI TS	0	826,065	1			194 194
	51 COMMONITY BENEFITS 52 OTHER NON-REIMBURSABLE	0	783, 286 C				194
4.02079		0	92, 116				194
	54 BATESVILLE TOOL & DIE CLINIC	0	192, 433	1			194
	55 MMHCB RHC	0	645, 613				194
	TOTAL (SUM OF LINES 118 through 199)	-11, 452, 008					200

ECLASSI FI CATI (al Systems DNS			Provi der C	CN: 15-1329	Period: From 01/01/2019	Worksheet A-6
						To 12/31/2019	Date/Time Prepare 8/31/2020 7:54 am
		Increases				-1	0/01/2020 /101 am
	Cost Center	Line #	Sal ary	Other			
	2.00	3.00	4.00	5.00			
A – CAFI							
. 00 <u>CAF</u> E <u>TERI</u>	A	<u>11.</u> 00	71 <u>4, 7</u> 81	<u>491, 4</u> 96			1.
0			714, 781	491, 496			
B - OB F							
	3 PEDI ATRI CS	30.00	600, 344	42, 459			1.
. 00 <u>NUR</u> S <u>ERY</u>		43.00	600, 344	42, 459			2.
0			1, 200, 688	84, 918			
	MUNITY RELATIONS	5 00	107 (50	070 417			1
. 00 ADMI NI S	TRATIVE & GENERAL		137,650	<u>273, 417</u> 273, 417			1.
	SITE BUILDING DEPR REG		137, 650	273,417			
	REL COSTS-MVBLE	2, 01	0	574, 151			1.
EQUIP OF		2.01	U	574, 131			''
	<u> </u>	+		574, 151			
E - IMPI	ANTABLE SUPPLIES RECI	224	Ч	574, 151			
	EV. CHARGED TO	72.00	0	999, 210			1.
PATI ENT	V. CHARGED TO	72.00	Ŭ	777,210			1.
. 00		0.00	0	0			2.
. 00		0.00	0	0			3.
. 00		0.00	0	0			4.
. 00		0.00	0	0			5.
. 00		0.00	0	0			6.
. 00		0.00	o	0			7.
0			0	999, 210			
G - CEN	TRAL SUPPLY RECLASS						
. 00 MEDI CAL	SUPPLIES CHARGED TO	71.00	0	2, 836, 632			1.
PATI ENTS	8						
. 00		0.00	0	0			2.
. 00		0.00	0	0			3.
. 00		0.00	0	0			4.
. 00		0.00	0	0			5.
. 00		0.00	0	0			6.
. 00		0.00	0	0			7.
. 00		0.00	0	0			8.
. 00 D. 00		0.00	0	0			9.
1.00		0.00 0.00	0	0			10.
2.00		0.00	0	0			11.
3.00		0.00	0	0			12.
4.00		0.00	0	0			13.
5.00		0.00	0	0			14.
5.00		0.00	0	0			16.
7.00		0.00	0	0			10.
8.00		0.00	0	0			17.
9.00		0.00	0	0			19.
0.00		0.00	0	0			20.
1.00		0.00	0	0			20.
2.00		0.00	0	0			21.
3.00		0.00	0	0			23.
			— — — ö	2, 836, 632			20.
	otal: Increases		2,053,119	5, 259, 824			500.

Heal th	Financial Systems	MAR	GARET MARY COMM	UNITY HOSPIT	AL	In Lieu	u of Form CMS	6-2552-10
	SIFICATIONS				CCN: 15-1329	Peri od:	Worksheet A	
						From 01/01/2019		
						To 12/31/2019	Date/Time Pr 8/31/2020 7:	
		Decreases					0/31/2020 /	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Re	f.		
	6.00	7.00	8.00	9.00	10.00	_		
	A - CAFETERIA		· · · ·					
1.00	DI ETARY	10.00	714, 781	491, 496		0		1.00
	0		714, 781	491, 496				
	B - OB RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 200, 688	84, 918		0		1.00
2.00		0.00	0	0	·	Q		2.00
	0		1, 200, 688	84, 918				
	C - COMMUNITY RELATIONS		1		1			_
1.00	COMMUNITY RELATIONS	194.00	<u>137,6</u> 50	<u>273, 4</u> 17		Q		1.00
	0		137, 650	273, 417				
	D - OFFSITE BUILDING DEPR REC							
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	574, 151		9		1.00
	EQUI P				<u> </u>	_		
		100	0	574, 151				-
1 00	E - IMPLANTABLE SUPPLIES RECL ADULTS & PEDIATRICS	30.00	0	17 ((0	1	0		1.00
1.00 2.00	INTENSIVE CARE UNIT	30.00	0	17, 668 2, 524		0		2.00
2.00	OPERATING ROOM	50.00	0	2, 524 906, 135		0		3.00
3.00 4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	42, 278		0		4.00
4.00 5.00		90.00	0	42, 278		0		5.00
6.00	WOUND CLINC	90.01	0	28, 711		0		6.00
7.00	EMERGENCY	91.00	0	1, 263		0		7.00
7.00			— — — d	999, 210				7.00
	G - CENTRAL SUPPLY RECLASS	I		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	23, 739		0		1.00
2.00	OPERATION OF PLANT	7.00	0	170		0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	15, 290		0		3.00
4.00	HOUSEKEEPI NG	9.00	0	1, 780		0		4.00
5.00	DI ETARY	10.00	0	34, 021		0		5.00
6.00	PHARMACY	15.00	0	27, 207		0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	163		0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	149, 528		0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	18, 766)	0		9.00
10.00	NURSERY	43.00	0	163		0		10.00
11.00	OPERATI NG ROOM	50.00	0	1, 441, 082		0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	109, 056		0		12.00
13.00	RADI OLOGY-DI AGNOSTI C	54.00	0	296, 841		0		13.00
14.00	LABORATORY	60.00	0	54, 429		0		14.00
15.00	RESPI RATORY THERAPY	65.00	0	38, 752		0		15.00
16.00	PHYSI CAL THERAPY	66.00	0	16, 074		0		16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	11, 196		0		17.00
18.00	SPEECH PATHOLOGY	68.00	0	751		0		18.00
19.00	ELECTROCARDI OLOGY	69.00	0	32, 352		0		19.00
20.00		90.00	0	205, 915		0		20.00
21.00	WOUND CLINC	90.01	0	190, 882		0		21.00
22.00	BEHAVIORAL HEALTH	90.02	U	140 470	1	0		22.00
23.00	EMERGENCY	<u>91.00</u>	¥_	_ <u>168, 472</u> 2, 836, 632		Ō		23.00
500 00	Grand Total: Decreases		2,053,119	2, 836, 632				500.00
550.00		I	2,000,117	5,257,024	I	I		1 000.00

Health Financial Systems MAR	GARET MARY COM	MUNITY HOSPITA	L	In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2019 To 12/31/2019	Worksheet A-7 Part I	
			Acqui si ti on	S		
	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	Bal ances				Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00 Land	2, 419, 583	3, 379, 101		0 3, 379, 101	0	1.00
2.00 Land Improvements	272, 044	0		0 0	0	2.00
3.00 Buildings and Fixtures	79, 896, 265	339, 816		0 339, 816	0	3.00
4.00 Building Improvements	0	0		0 0	0	4.00
5.00 Fixed Equipment	5, 245, 768	0		0 0	0	5.00
6.00 Movable Equipment	57, 327, 432	6, 541, 391		0 6, 541, 391	3, 718, 971	6.00
7.00 HIT designated Assets	0	0		0 0	0	7.00
8.00 Subtotal (sum of lines 1-7)	145, 161, 092	10, 260, 308		0 10, 260, 308	3, 718, 971	8,00
9.00 Reconciling Items	0	0		0 0	0	
10.00 Total (line 8 minus line 9)	145, 161, 092	10, 260, 308		0 10, 260, 308	-	
	Ending	Fully				
	Balance	Depreci ated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE			I			
1.00 Land	5, 798, 684	0				1.00
2.00 Land Improvements	272, 044					2.00
3.00 Buildings and Fixtures	80, 236, 081	0				3.00
4.00 Building Improvements	0	0				4.00
5.00 Fixed Equipment	5, 245, 768	0				5.00
6.00 Movable Equipment	60, 149, 852					6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	151, 702, 429	-				8.00
9.00 Reconciling Items	∩ 101, 702, 427	0				9.00
10.00 Total (line 8 minus line 9)	151, 702, 429	0				10.00
	101,702,427	0	I			10.00

Heal th	Financial Systems MA	RGARET MARY CON	MUNITY HOSPITA	L	In Lie	eu of Form CMS-:	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	I nsurance (see i nstructi ons)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2		1	
1.00	NEW CAP REL COSTS-BLDG & FIXT	3, 155, 649			0 0	0	
1.01	NEW CAP REL COSTS-OFFSITE BLDG	853, 630			0 0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	5, 419, 931	0		0 0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0		0 0	0	2.0.
3.00	Total (sum of lines 1-2)	9, 429, 210			0 (0 0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1)	1			
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)		-			
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLU					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3, 155, 649	•			1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	853, 630	•			1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	5, 419, 931				2.00
2.01 3.00	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0 420 210				2.01 3.00
3.00	Total (sum of lines 1-2)	0	9, 429, 210	1			J 3.00

Health Financial Systems M	ARGARET MARY CON	IMUNI TY HOSPI TA	L	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
	COM	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 -	Ratio (see instructions)	Insurance	
	1.00	2.00	<u>col. 2)</u> 3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS		2.00	0.00	1.00	0.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	63, 979, 729	0	63, 979, 72	9 0. 421745	0	1.00
1.01 NEW CAP REL COSTS-OFFSITE BLDG	20, 405, 844					1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	67, 316, 910					2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0			0. 000000		2.01
3.00 Total (sum of lines 1-2)	151, 702, 483	0	151, 702, 48			3.00
	ALLOCA	TION OF OTHER (F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capital-Relat ed Costs	cols.5 through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		3, 155, 649	0	1.00
1.01 NEW CAP REL COSTS-OFFSITE BLDG	0	0		0 853, 630	0	1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 4, 724, 329	0	2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0		574, 151	0	2.01
3.00 Total (sum of lines 1-2)	0	0		9, 307, 759	0	3.00
		SI	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)			
		instructions)	,	ed Costs (see		
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	-850, 408	0)	0 C	2, 305, 241	1.00
1.01 NEW CAP REL COSTS-OFFSITE BLDG	0	0		0 C	853, 630	1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0)	0 C	4, 724, 329	2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0		0 0	574, 151	2.01
3.00 Total (sum of lines 1-2)	-850, 408	0		0 C	8, 457, 351	3.00

Heal th	Financial Systems	MAR	GARET MARY CON	IMUNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUSTI	MENTS TO EXPENSES			F	Period: From 01/01/2019 Fo 12/31/2019	Worksheet A-8 Date/Time Prep 8/31/2020 7:54	pared:
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		0	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	1.00
1. 01	2) Investment income - NEW CAP REL COSTS-OFFSITE BLDG (chapter 2)		C	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2. 01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	2. 01
3.00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		C		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -5, 401, 957		0.00	0 0	
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	0			0	12.00
13.00	transactions (chapter 10) Laundry and linen service		0		0.00	0	
	Cafeteria-employees and guests Rental of quarters to employee		0 0		0.00 0.00	0 0	
16.00	and others Sale of medical and surgical supplies to other than		C		0.00	0	16.00
17.00	patients Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	о	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	
22.00	Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
26.01	Depreciation - NEW CAP REL			FIXT NEW CAP REL COSTS-OFFSITE BLDG	1. 01	0	26. 01

In Lieu of Form CMS-2552-10

ADJUSTMENTS TO EXPENSES	WAH	GARET MARY CON	Provider CCN: 15-1329	eriod:	Worksheet A-8	
			Fr Tc	om 01/01/2019 0 12/31/2019		pared:
			Expense Classification on To/From Which the Amount is t			
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
cost center bescription	(2) 1.00	2.00	3.00	4.00	Ref. 5. 00	
27.00 Depreciation - NEW CAP REL	1.00		NEW CAP REL COSTS-MVBLE	2.00		27.00
COSTS-MVBLE EQUIP		0	EQUI P	2.00	0	27.00
27.01 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2. 01	0	27.01
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
80.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDI ATRI CS	30. 00		30. 99
31.00 Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest	А	-121, 451	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33. 00 OTHEROPERATING OTHOP - INTERNAL SALE	В	-6, 223	ADMI NI STRATI VE & GENERAL	5.00	0	33.00
34.00 MMCH OTHER OPERATING COMMBENEFITS SC	В		ADMI NI STRATI VE & GENERAL	5.00		
35. 00 OTHEROPERATING DIABETES PROGRAM	В		ADMINISTRATIVE & GENERAL	5.00		
36.00 OTHEROPERATING OTHOP - MISC REVENUE 37.00 MMCH NON-OPERATING R NONOP -	B		OPERATION OF PLANT OPERATION OF PLANT	7.00 7.00		
MI SCELL 38. 00 OTHEROPERATI NG OTHOP - LAUNDRY	В		LAUNDRY & LINEN SERVICE	8.00		
40. 00 OTHEROPERATING OTHOP - VENDING	В	-5, 429	CAFETERI A	11.00	0	40.00
SALES	D	252 410		11 00	0	41 00
 41.00 CAFETERIA OFFSET 43.00 OTHEROPERATING OTHOP - MEDICAL RECOR 	B B		CAFETERIA MEDICAL RECORDS & LIBRARY	11. 00 16. 00		
14. 00 OTHEROPERATI NG OTHOP - MEDRED TRANSC	В	-15, 575	MEDI CAL RECORDS & LI BRARY	16. 00	0	44. OC
15.00 OTHEROPERATI NG OTHOP-PHYSI CAL THERAP	В	-65, 649	PHYSI CAL THERAPY	66.00	0	45.00
5. 01 OTHEROPERATING OTHOP- OCCUPATIONAL T	В		OCCUPATI ONAL THERAPY	67.00		
IS. 02 OTHEROPERATING OTHOP - OUTPATIENT CL	В	-17, 443		90.00		
45. 03 340B OFFSET 45. 04 INTEREST OFFSET	A A		PHARMACY NEW CAP REL COSTS-BLDG & FLXT	15. 00 1. 00		
15. 05 LOBBYING EXPENSE	А	-5, 728	ADMINISTRATIVE & GENERAL	5.00	0	45.05
5.06 MEDICAL STAFF RETENTION COST	А	-71, 551	ADMINISTRATIVE & GENERAL	5.00		
5.07 MEDICAL STAFF PLACEMENT FEE	A	-130, 552	ADMI NI STRATI VE & GENERAL	5.00	0	45.07
5.08 DI ETARY REVENUE	В		DI ETARY	10.00		
5. 09 HAF	А	-4, 244, 769	ADMI NI STRATI VE & GENERAL	5.00		
5.10 TELEPHONE & TV OFFSET	А		ADMI NI STRATI VE & GENERAL	5.00	0	
5. 11 BOUTIQUE OFFSET	А		RADI OLOGY-DI AGNOSTI C	54.00		
 15. 12 HOSPITALIST OFFSET 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 	A	-4, 068 -11, 452, 008	ADULTS & PEDI ATRI CS	30.00	0	45. 12 50. 00
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

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

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

Heal th	Fi nanci a	l Systems	

MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provi der	CCN: 15-1329	Period: From 01/01/2019	Worksheet A-8	3-2
						To 12/31/2019	Date/Time Pre 8/31/2020 7:5	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	849, 258				0	
2.00		OPERATING ROOM	108, 333			0	0	2.00
3.00		RADI OLOGY-DI AGNOSTI C	1, 286, 112	1, 228, 112	2 58,000	0	0	3.00
4.00		LABORATORY	71, 460		71, 460	0 0	0	4.00
5.00		ELECTROCARDI OLOGY	212, 068		40, 000	0	0	5.00
6.00		CLINIC	1, 164, 091			0	0	6.00
7.00	91.00	EMERGENCY	2, 386, 182	1, 937, 079	449, 103	0	0	7.00
8.00	90. 02	BEHAVI ORAL HEALTH	156, 116	156, 116	6 C	0	0	8.00
9.00	0. 00		0	() (0	0	9.00
10.00	0. 00		0	0) (0	0	10.00
200.00			6, 233, 620	5, 401, 957	831,663	8	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	(0 0	0	1.00
2.00	50.00	OPERATING ROOM	0	0) (0	0	2.00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	0			0 0	0	3.00
4.00	60.00	LABORATORY	0			0	0	4.00
5.00	69.00	ELECTROCARDI OLOGY	0			0 0	0	5.00
6.00	90, 00	CLINIC	0	(o o	0	6.00
7.00		EMERGENCY	0	l c		0	0	7.00
8.00		BEHAVI ORAL HEALTH	0	l c		0	0	8.00
9.00	0.00		0	(0	0	9.00
10.00	0.00		0				0	10.00
200.00			0				0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	() (691, 158		1.00
2.00	50.00	OPERATING ROOM	0	0) (53, 333		2.00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	0	(1, 228, 112		3.00
4.00	60.00	LABORATORY	0	(0		4.00
5.00	69.00	ELECTROCARDI OLOGY	0	(172,068		5.00
6.00		CLINIC	0	C) (6.00
7.00		EMERGENCY	0					7.00
8.00		BEHAVI ORAL HEALTH	0		-			8.00
9.00	0.00		0					9.00
10.00	0.00		0			-		10.00
200.00	0.00		0					200.00
					1		•	

MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

Health Financial System		RGARET MARY COMM				U OT FORM CMS-2	2552-10
COST ALLOCATION - GENE	RAL SERVI CE COSTS		Provider CC		riod: om 01/01/2019 12/31/2019	Worksheet B Part I Date/Time Pre 8/31/2020 7:5	
				CAPI TAL REL	ATED COSTS	0/31/2020 7.3	4 ani
	5						
Cost Cente	r Description	Net Expenses	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE	
		for Cost	FLXT	BLDG	EQUI P	EQUIP OFFSIT	
		Allocation (from Wkst A					
		col. 7)					
		0	1.00	1.01	2.00	2.01	
GENERAL SERVICE	COST CENTERS		1100		2100	2.01	
	L COSTS-BLDG & FIXT	2, 305, 241	2, 305, 241				1.00
1.01 00101 NEW CAP RE	L COSTS-OFFSITE BLDG	853, 630	0	853, 630			1.01
	L COSTS-MVBLE EQUIP	4, 724, 329			4, 724, 329		2.00
	L COSTS-MVBLE EQUIP OFFSIT	574, 151			0	574, 151	2.01
	ENEFI TS DEPARTMENT	15, 473, 670	9, 647	0	19, 771	0	4.00
5.00 00500 ADMI NI STRA		15, 228, 137	353, 478	0	724, 414	0	5.00
7. 00 00700 OPERATI ON 7. 01 00701 OPERATI ON	OF PLANT OF PLANT -OFFSITE	1, 468, 922	381, 853 0	0	782, 559 0	0	7.00 7.01
	OF PLANT - HOSPITAL & OFFS	260, 578 563, 926	0	0	0	0	7.01
8.00 00800 LAUNDRY &		196, 437	25, 608	0	52, 480	0	8.00
9.00 00900 HOUSEKEEPI		1, 334, 064	29, 199	0	59, 840	0	9.00
10.00 01000 DI ETARY		38, 023	8, 906	0	18, 253	0	10.00
11.00 01100 CAFETERI A		848, 429	77, 593	0	159, 018	0	11.00
13.00 01300 NURSING AD	MI NI STRATI ON	552, 502	869	0	1, 781	0	13.00
14.00 01400 CENTRAL SE	RVICES & SUPPLY	0	10, 787	0	22, 108	0	14.00
15.00 01500 PHARMACY		3, 706, 200	12, 013	0	24, 619	0	15.00
16.00 01600 MEDI CAL RE		1, 538, 403	39, 986	0	81, 947	0	16.00
	E SERVICE COST CENTERS	0 577 400	011 0/0		400.450		00.00
30.00 03000 ADULTS & P		2, 577, 102	211, 360 19, 794	0	433, 159	0	30.00 31.00
31.00 03100 I NTENSI VE 43.00 04300 NURSERY	CARE UNI I	326, 133 651, 858	19, 794 10, 502	0	40, 565 21, 524	0	43.00
ANCI LLARY SERVIC	E COST CENTERS	031,030	10, 302	0	21, 324	0	45.00
50.00 05000 OPERATING		1, 937, 149	69, 655	0	142, 751	0	50.00
52.00 05200 DELIVERY R		119, 505	18, 027	0	36, 944	0	52.00
54.00 05400 RADI OLOGY-	DI AGNOSTI C	10, 705, 638	272, 651	0	558, 767	0	54.00
60.00 06000 LABORATORY		4, 121, 887	49, 591	0	101, 631	0	60.00
60.01 06001 BLOOD LABO		0	0	0	0	0	60.01
65.00 06500 RESPI RATOR		689, 228	37, 920	0	77, 713	0	65.00
66.00 06600 PHYSI CAL T		1,096,287	79, 403	0	162, 727	0	66.00
67.00 06700 0CCUPATION 68.00 06800 SPEECH PAT		362, 726 195, 428	16, 659 15, 219	0	34, 140 31, 190	0	67.00 68.00
69.00 06900 ELECTROCAR		751, 956	34, 343	0	70, 382	0	69.00
	PPLIES CHARGED TO PATIENTS	2, 836, 632	01,010	0	, 0, 002	0	71.00
	CHARGED TO PATIENT	999, 210	33, 673	0	69, 010	0	72.00
73.00 07300 DRUGS CHAR		0	0	0	0	0	73.00
OUTPATIENT SERVI							
88.00 08800 RURAL HEAL	TH CLINIC	1, 217, 853	0	52, 445	0	35, 274	88.00
90.00 09000 CLINIC		1, 376, 958	201, 314	21, 782	412, 570	14, 651	90.00
90. 01 09001 WOUND CLIN		353, 983	9,619	0	19, 713	0	90.01
90. 02 09002 BEHAVI ORAL 91. 00 09100 EMERGENCY	HEALTH	426, 856 2, 843, 038	19, 893 127, 398	0	40, 769 261, 087	0	90. 02 91. 00
	N BEDS (NON-DISTINCT PART)	2, 043, 030	127, 370	0	201,007	0	91.00
OTHER REI MBURSAB	· · · · · · · · · · · · · · · · · · ·	I I					72.00
101.00 10100 HOME HEALT		1, 811, 650	48, 665	1, 540	99, 733	1, 036	101.00
SPECIAL PURPOSE	COST CENTERS					· · · ·	
113.00 11300 INTEREST E	XPENSE						113.00
116. 00 11600 HOSPI CE		1, 149, 592	0	0	0	0	116.00
118.00 SUBTOTALS	(SUM OF LINES 1 through 117)	86, 217, 311	2, 225, 625	75, 767	4, 561, 165	50, 961	118.00
NONREIMBURSABLE							
192. 00 19200 PHYSI CI ANS		13, 070, 379	25,807	607, 803	52, 889	408, 808	
192. 01 19201 PEDI ATRI CS 192. 02 19202 BROOKVI LLE		735, 283 1, 370, 865	32, 305	0 136, 896	66, 206	92,076	192.01
192. 03 19203 RADI OLOGY		92, 051	0	3, 287	0		192.02
192. 04 19204 ENT	000000	284, 327	0	0,207	0		192.03
194.0007950 COMMUNI TY	RELATIONS	826, 065	4, 318	0	8, 849		194.00
194. 01 07951 COMMUNI TY		783, 286	17, 186	0	35, 220		194.01
194.0207952 OTHER NON-		0	0	0	0		194.02
194. 03 07953 EMS		92, 116	0	0	0		194.03
194. 04 07954 BATESVI LLE	TOOL & DIE CLINIC	192, 433	0	0	0		194.04
194.0507955 MMHCB RHC		645, 613	0	29, 877	0	20, 095	
	Adjustments					-	200.00
	ost Centers	104 200 700	2 205 241	0 952 420	0		201.00
202.00 TOTAL (sum	lines 118 through 201)	104, 309, 729	2, 305, 241	853, 630	4, 724, 329	574, 151	202.00

ACCT ALLOGATION	OFNERAL	0.55
Heal th Financial	Systems	

In Lieu of Form CMS-2552-10

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	F T		8/31/2020 7:5	pared: 4 am
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	PLANT	OPERATION OF PLANT -OFFSITE	
		4.00	4A	5.00	7.00	7.01	
1.00 1.01 2.00 2.01 4.00	GENERAL SERVICE COST CENTERS 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	15, 503, 088					1.00 1.01 2.00 2.01 4.00
5.00 7.00 7.01 7.02	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT -OFFSITE 00702 OPERATION OF PLANT - HOSPITAL & OFFS	2, 350, 098 0 179, 446	18, 656, 127 2, 633, 334 260, 578 743, 372	573, 564 56, 756	3, 206, 898 0	317, 334 0	5.00 7.00 7.01 7.02
8.00 9.00 10.00 11.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A	41, 083 318, 449 26, 789 233, 563	315, 608 1, 741, 552 91, 971 1, 318, 603	68, 742 379, 326 20, 032	52, 633 60, 014 18, 306	0 0 0 0	1
13.00 14.00 15.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	179, 809 0 254, 322	734, 961 32, 895 3, 997, 154	160, 081 7, 165 870, 616	1, 787 22, 172 24, 691	0 0 0	13.00 14.00 15.00
	01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	422, 661	2, 082, 997			0	16.00 30.00
31. 00 43. 00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	103, 649 196, 169	490, 141 880, 053			0	31.00 43.00
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM	508, 656 38, 518	2, 658, 211 212, 994	46, 392	37, 051	0	50.00 52.00
54.00 60.00 60.01	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06001 BLOOD LABORATORY	1, 036, 696 535, 519 0	12, 573, 752 4, 808, 628 0		101, 927	0 0 0	54.00 60.00 60.01
65.00 66.00 67.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	181, 635 362, 012 117, 503	986, 496 1, 700, 429 531, 028	370, 369	163, 201	0 0 0	65.00 66.00 67.00
68.00 69.00 71.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	63, 168 202, 461 0	305, 005 1, 059, 142 2, 836, 632	230, 691	70, 587	0 0 0	68.00 69.00 71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	1, 101, 893 0			0	72.00 73.00
88.00	08800 RURAL HEALTH CLINIC	357, 802	1, 663, 374	362, 298	0	19, 496	88.00
	09000 CLI NI C	576, 758	2,604,033	567, 182	413, 772	8, 097	90.00
	09001 WOUND CLINC	111,674	494, 989			0	90.01
90. 02 91. 00 92. 00	09002 BEHAVI ORAL HEALTH 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	165, 162 745, 565	652, 680 3, 977, 088 0	866, 246		0	90.02 91.00 92.00
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	527, 165	2, 489, 789	542, 298	100, 023	573	101.00
	11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	235, 652 10, 839, 650	1, 385, 244 80, 010, 040	13, 363, 435			113.00 116.00 118.00
192.01	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 PEDI ATRI CS	3, 407, 295 225, 321	17, 572, 981 1, 059, 115	230, 685	66, 399		192.01
192.03 192.04	19202 BROOKVI LLE 19203 RADI OLOGY - OSGOOD 19204 ENT	416, 693 30, 079 88, 457	2, 016, 530 127, 628 372, 784	27, 799 81, 196	0	1, 222 0	192.02 192.03 192.04
194.01 194.02	07950 COMMUNITY RELATIONS 07951 COMMUNITY BENEFITS 07952 OTHER NON-REIMBURSABLE	83, 532 150, 387 0	922, 764 986, 079 0	214, 777	35, 323	0	194.00 194.01 194.02
194. 03 194. 04 194. 05	07953 EMS 07954 BATESVILLE TOOL & DIE CLINIC 07955 MMHCB RHC	15, 963 54, 323 191, 388	108, 079 246, 756 886, 973	53, 746 193, 191	0	0	194.03 194.04 194.05
200.00 201.00 202.00	Negative Cost Centers	0 15, 503, 088	0 0 104, 309, 729	0			200.00 201.00 202.00

In Lieu of Form CMS-2552-10

COSTA	LLOCATION - GENERAL SERVICE COSTS		Provider C	F	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Pre 8/31/2020 7:5	epared: 54 am
	Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	
	1	7.02	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						1
1.00 1.01 2.00 2.01 4.00 5.00 7.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-OFFSITE BLDG 00200 NEW CAP REL COSTS-OFFSITE BLDG 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00700 DEPATION OF PLANT						1.00 1.01 2.00 2.01 4.00 5.00 7.00
7.01 7.02	00701 OPERATION OF PLANT -OFFSITE 00702 OPERATION OF PLANT - HOSPITAL & OFFS	905, 285					7.01
8.00	00800 LAUNDRY & LINEN SERVICE	9, 423					8.00
9.00	00900 HOUSEKEEPI NG	10, 745)		9.00
10.00	01000 DI ETARY	3, 277	355				10.00
11.00	01100 CAFETERI A	28, 553				1, 906, 598	11.00
13.00	01300 NURSING ADMINISTRATION	320	0	1, 229	9 0	47, 384	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 970				0	
15.00	01500 PHARMACY	4, 421	0			61, 547	
16.00	01600 MEDI CAL RECORDS & LI BRARY	14, 715	0	56, 516	b 0	157, 774	16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	77, 794	66, 757	298, 794	139, 833	266, 448	30.00
30.00	03100 I NTENSI VE CARE UNI T	7, 284				37, 341	
43.00	04300 NURSERY	3, 865				61, 204	
	ANCILLARY SERVICE COST CENTERS					.,	1
50.00	05000 OPERATING ROOM	25, 632	40, 480	98, 450	0 0	177, 861	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6, 618	2, 547	25, 418	3 0	12, 018	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	100, 333				154, 083	
60.00	06000 LABORATORY	18, 249				217, 348	
60.01	06001 BLOOD LABORATORY	0			-	0	
65.00		13, 954				60, 346	1
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	29, 219 6, 130			-	0	
68.00	06800 SPEECH PATHOLOGY	5, 601	4, 262			0	
69.00	06900 ELECTROCARDI OLOGY	12, 638			-	62, 406	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	12, 391	10, 193	47, 594		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS	-		-		-	
	08800 RURAL HEALTH CLINIC	0				0	
90.00 90.01	09000 CLINIC 09001 WOUND CLINC	85, 125 3, 540				0	
90.01	09002 BEHAVI ORAL HEALTH	7, 321	, 3, 431 0			45, 409	
	09100 EMERGENCY	46, 881				246, 104	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	18, 689	0	71, 783	3 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 556, 688					116.00
110.00	NONREIMBURSABLE COST CENTERS	550,000	421,009	2,010,207	140, 329	1,007,273	110.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	244, 201	9, 693	223, 950	0 0	170, 565	192.00
	19201 PEDI ATRI CS	11, 888					192.01
192.02	19202 BROOKVI LLE	69, 440					192.02
	19203 RADI OLOGY – OSGOOD	0			0 0		192.03
	19204 ENT	0	0		-		192.04
	07950 COMMUNITY RELATIONS	1, 589	0	6, 103			194.00
	07951 COMMUNITY BENEFITS	6, 324	0	24, 290			194.01
104 00	07952 OTHER NON-REI MBURSABLE	0	0				194.02 194.03
	07053 FMS		. 0	, U	, U		
194.03	07953 EMS			r		∩	194 04
194.03 194.04	07954 BATESVILLE TOOL & DIE CLINIC	0	5		-		194.04 194.05
194. 03 194. 04 194. 05	07954 BATESVILLE TOOL & DIE CLINIC 07955 MMHCB RHC		5		-	0	194.05 200.00
194.03 194.04	07954 BATESVILLE TOOL & DIE CLINIC 07955 MMHCB RHC Cross Foot Adjustments	0	5 7, 180	C	-	0	194.05 200.00 201.00

		RGARET MARY COM				u of Form CMS-	2552-10
COST ALLOCAT	TION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1329	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Pre 8/31/2020 7:5	
	Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
	AL SERVICE COST CENTERS	1					1
	NEW CAP REL COSTS-BLDG & FIXT						1.00
	NEW CAP REL COSTS-OFFSITE BLDG						1.01
	NEW CAP REL COSTS-MVBLE EQUIP						2.00
	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT EMPLOYEE BENEFITS DEPARTMENT						2.01 4.00
	ADMI NI STRATI VE & GENERAL						5.00
	OPERATION OF PLANT						7.00
	OPERATION OF PLANT -OFFSITE						7.01
	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
	LAUNDRY & LINEN SERVICE						8.00
9.00 00900	HOUSEKEEPING						9.00
	DI ETARY						10.00
	CAFETERIA						11.00
	NURSING ADMINISTRATION	945, 762					13.00
	CENTRAL SERVICES & SUPPLY	0	81, 449				14.00
		50, 164 0	0	5, 025, 57			15.00
	MEDICAL RECORDS & LIBRARY	0			0 2, 847, 883		16.00
	ADULTS & PEDIATRICS	217, 272	0		0 1, 873, 608	8, 233, 117	30.00
	INTENSIVE CARE UNIT	30, 417	0		0 0	749, 973	31.00
43.00 04300	NURSERY	49, 922	0		0 0	1, 240, 360	43.00
ANCI L	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0	0		0 209, 844	3, 932, 627	50.00
	DELIVERY ROOM & LABOR ROOM	9, 803	0		0 0	352, 841	52.00
	RADI OLOGY-DI AGNOSTI C	125, 620	0		0 382, 216	17,074,202	54.00
	LABORATORY BLOOD LABORATORY	177, 204	0		0 0	6, 440, 809 0	60.00 60.01
	RESPIRATORY THERAPY	49, 232	0			1, 458, 908	65.00
	PHYSI CAL THERAPY	47, 232	0		0 0	2, 403, 919	66.00
	OCCUPATI ONAL THERAPY	0	0		0 0	713, 911	67.00
68.00 06800	SPEECH PATHOLOGY	0	0		0 0	434, 093	68.00
	ELECTROCARDI OLOGY	35, 452	0		0 22, 483	1, 551, 304	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	81, 449		0 0	3, 535, 925	
	IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	1, 481, 284	72.00
	DRUGS CHARGED TO PATIENTS TIENT SERVICE COST CENTERS	0	0	5, 025, 57	2 0	5, 025, 572	73.00
	RURAL HEALTH CLINIC	0	0		0 0	2,046,394	88.00
	CLINIC	0	0		0 104, 922	4, 083, 820	
90.01 09001	WOUND CLINC	0	0		0 0	643, 138	90.01
	BEHAVI ORAL HEALTH	0	0		0 0	916, 575	90.02
	EMERGENCY	200, 676	0		0 232, 327	6, 039, 845	
	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	REIMBURSABLE COST CENTERS HOME HEALTH AGENCY	ol	0		0 0	3, 223, 155	101 00
	AL PURPOSE COST CENTERS		0		<u> </u>	0,220,100	101.00
	INTEREST EXPENSE						113.00
116.0011600		0	0		0 0	1, 686, 963	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	945, 762	81, 449	5, 025, 57	2, 825, 400	73, 268, 735	118.00
	I MBURSABLE COST CENTERS		0		0 22 402	22.250.417	100.00
192.0019200	PHYSICIANS' PRIVATE OFFICES	0	0		0 22, 483 0 0	22, 350, 417 1, 463, 291	1
192.02 19202		0	0			2, 584, 240	
	RADI OLOGY - OSGOOD	0	0		0 0	156, 649	
192.04 19204		0	0		0 0	453, 980	
194.0007950	COMMUNITY RELATIONS	0	0		0 0	1, 164, 009	194.00
	COMMUNITY BENEFITS	0	0		0 0	1, 315, 207	
	OTHER NON-REI MBURSABLE	0	0		0 0		194.02
194.0307953		0	0		0 0	139, 088	
194. 04 07954 194. 05 07955	BATESVILLE TOOL & DIE CLINIC	0	0		0 0	300, 507 1, 113, 606	
200.00	Cross Foot Adjustments		0				200.00
201.00	Negative Cost Centers	0	о		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	945, 762	81, 449	5, 025, 57	2 2, 847, 883	104, 309, 729	

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	ALLOCATION - GENERAL SERVICE COSTS	GARET MARY COMM	Provider CCN:	15-1329	Period: From 01/01/2019 To 12/31/2019 Date/Time	В
					8/31/2020	
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			
		25.00	26.00			
	GENERAL SERVICE COST CENTERS					
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	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINI 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					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A					10.00
13.00	01300 NURSI NG ADMI NI STRATI ON					11.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
14.00						15.00
	01600 MEDICAL RECORDS & LIBRARY					16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS					10.00
30.00	03000 ADULTS & PEDIATRICS	0	8, 233, 117			30.00
	03100 I NTENSI VE CARE UNI T	0	749, 973			31.00
43.00		0	1, 240, 360			43.00
	ANCI LLARY SERVICE COST CENTERS	-	.,			
50.00		0	3, 932, 627			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	352, 841			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	17, 074, 202			54.00
60.00	06000 LABORATORY	0	6, 440, 809			60.00
60. 01	06001 BLOOD LABORATORY	0	0			60.01
65.00	06500 RESPI RATORY THERAPY	0	1, 458, 908			65.00
66.00	06600 PHYSI CAL THERAPY	0	2, 403, 919			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	713, 911			67.00
68.00	06800 SPEECH PATHOLOGY	0	434, 093			68.00
69.00	06900 ELECTROCARDI OLOGY	0	1,551,304			69.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	3, 535, 925			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	1, 481, 284			72.00
73.00	07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	5,025,572			73.00
88.00		0	2,046,394			88.00
90.00		0	4,083,820			90.00
90.01	09001 WOUND CLINC	0	643, 138			90.01
90.02	09002 BEHAVI ORAL HEALTH	0	916, 575			90.02
	09100 EMERGENCY	0	6,039,845			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY	0	3, 223, 155			101.00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · ·				
	11300 INTEREST EXPENSE					113.00
	11600 HOSPI CE	0	1, 686, 963			116.00
118.00		0	73, 268, 735			118.00
100.00	NONREI MBURSABLE COST CENTERS		00.050.447			
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	22, 350, 417			192.00
	19201 PEDI ATRI CS	0	1, 463, 291			192.01
	2 19202 BROOKVI LLE 3 19203 RADI OLOGY - OSGOOD	0	2, 584, 240			192.02 192.03
	19203 RADIOLOGY - OSGOOD		156, 649 453, 980			192.03
	07950 COMMUNITY RELATIONS	0	453, 980			192.04
	07951 COMMUNITY BENEFITS	0	1, 315, 207			194.00
	207952 OTHER NON-REI MBURSABLE		1, 313, 207			194.01
	07953 EMS	0	139, 088			194.02
	07954 BATESVILLE TOOL & DIE CLINIC	0	300, 507			194.04
	07955 MMHCB RHC	0	1, 113, 606			194.05
200.00		0	0			200.00
201.00		0	Ō			201.00
202.00		0	104, 309, 729			202.00
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		OF	C A		DEL	ATED	0

In Lieu of Form CMS-2552-10

Heal th	Fi nar	ncial Systems MAF	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-	2552-10
ALLOCA	ATION	OF CAPITAL RELATED COSTS		Provider C	CN: 15-1329 Pe Fi Te	eriod: rom 01/01/2019 o 12/31/2019	Worksheet B Part II Date/Time Pre 8/31/2020 7:5	epared: 54 am
					CAPI TAL REL	ATED COSTS		
		Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUI P	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
	GENER	AL SERVICE COST CENTERS						
1.00		NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01		NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	1	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01		NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	0	9,647		19, 771	0	
5.00		ADMINISTRATIVE & GENERAL	0	353, 478		724, 414	0	
7.00 7.01		OPERATION OF PLANT OPERATION OF PLANT -OFFSITE	0	381, 853 0		782, 559 0	0	
7.01		OPERATION OF PLANT - HOSPITAL & OFFS	0	0		0	0	
8.00		LAUNDRY & LI NEN SERVICE	0	25, 608	-	52, 480	0	
9.00		HOUSEKEEPING	0	29, 199		59, 840	-	
10.00		DIETARY	0	8, 906		18, 253	0	
11.00	01100	CAFETERIA	0	77, 593	0	159, 018	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	869	0	1, 781	0	13.00
	-	CENTRAL SERVICES & SUPPLY	0	10, 787	0	22, 108		
		PHARMACY	0	12, 013		24, 619		
16.00		MEDICAL RECORDS & LIBRARY	0	39, 986	0	81, 947	0	16.00
20.00		I ENT ROUTINE SERVICE COST CENTERS		211 240	0	422 150	0	20.00
30.00 31.00		ADULTS & PEDIATRICS	0	211, 360 19, 794		433, 159 40, 565		
		NURSERY	0	19, 794	0	40, 585 21, 524	0	
45.00		LARY SERVICE COST CENTERS	0	10, 302	0	21, 524	0	45.00
50.00		OPERATING ROOM	0	69, 655	0	142, 751	0	50.00
52.00		DELIVERY ROOM & LABOR ROOM	0	18, 027	0	36, 944	0	
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	272, 651	0	558, 767	0	54.00
60.00		LABORATORY	0	49, 591	0	101, 631	0	
60.01		BLOOD LABORATORY	0	0	-	0	0	
65.00	1	RESPI RATORY THERAPY	0	37, 920		77, 713	0	
66.00		PHYSICAL THERAPY	0	79, 403		162, 727	0	
67.00		OCCUPATIONAL THERAPY	0	16, 659 15, 219		34, 140 31, 190		
		ELECTROCARDI OLOGY	0	34, 343		70, 382	0	
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	01,010		,0,002	0	
		IMPL. DEV. CHARGED TO PATIENT	0	33, 673	0	69, 010	0	
		DRUGS CHARGED TO PATIENTS	0	0		0	0	
		TI ENT SERVICE COST CENTERS						
		RURAL HEALTH CLINIC	0	0			00/2/1	
			0	201, 314		412, 570		
		WOUND CLINC	0	9, 619		19, 713	0	
		BEHAVIORAL HEALTH	0	19,893		40, 769 261, 087		
		OBSERVATION BEDS (NON-DISTINCT PART)	0	127, 398	0	201, 007	0	91.00
72.00	OTHER	REIMBURSABLE COST CENTERS	1 1					72.00
101.00		HOME HEALTH AGENCY	0	48, 665	1, 540	99, 733	1, 036	101.00
		AL PURPOSE COST CENTERS						
		INTEREST EXPENSE						113.00
		HOSPICE	0	0		0	-	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 225, 625	75, 767	4, 561, 165	50, 961	118.00
100.00		IMBURSABLE COST CENTERS PHYSICIANS' PRIVATE OFFICES		25.007	(07.000	F2 000	408, 808	100.00
		PEDIATRICS	0	25, 807 32, 305		52, 889 66, 206		192.00
		BROOKVILLE	0	52, 505		00, 200		192.02
		RADIOLOGY - OSGOOD	0	0	3, 287	0		192.03
192.04			0	0	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	0	4, 318	0	8, 849		194.00
		COMMUNITY BENEFITS	0	17, 186		35, 220		194.01
		OTHER NON-REI MBURSABLE	0	0	-	0		194.02
194.03			0	0	0	0		194.03
		BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
		MMHCB RHC	0	0	29, 877	0	20, 095	194.05
200.00		Cross Foot Adjustments Negative Cost Centers		<u>^</u>		~	_	200.00 201.00
201.00		TOTAL (sum lines 118 through 201)	0	0 2, 305, 241	853, 630	0 4, 724, 329		
202.00	- 1		, v	2,000,241	1 000,000	1, 127, 527	1 077,101	1-02.00

Heal th	Financial Systems MAR	GARET MARY COM	MUNITY HOSPITA	\L	In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		eri od:	Worksheet B	
					rom 01/01/2019 o 12/31/2019	Date/Time Pre	
	Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	8/31/2020 7:5 OPERATION OF PLANT -OFFSITE	54 am
		2A	4.00	5.00	7.00	7.01	
	GENERAL SERVICE COST CENTERS			1	T		
1.00 1.01 2.00 2.01	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						1.00 1.01 2.00 2.01
4.00 5.00 7.00 7.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT -OFFSITE	29, 418 1, 077, 892 1, 164, 412 0	29,418 4,459 0 0	1, 082, 351 33, 275 3, 293	1, 197, 687 0	3, 293	
7.02 8.00 9.00	00702 OPERATION OF PLANT - HOSPITAL & OFFS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0 78, 088 89, 039	340 78 604	3, 988	19, 657	0 0 0	8.00
10.00	01000 DI ETARY	27, 159	51			0	
11.00	01100 CAFETERI A	236, 611	443			0	
13.00	01300 NURSI NG ADMI NI STRATI ON	2,650	341			0	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	32, 895 36, 632	0 483			0	
16.00	01600 MEDICAL RECORDS & LIBRARY	121, 933	802			0	
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · ·					
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	644, 519 60, 359	1, 457 197			0	
43.00	04300 NURSERY	32, 026	372			0	•
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	212, 406	965			0	•
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	54, 971 831, 418	73 1, 967			0	
60.00	06000 LABORATORY	151, 222	1, 016			0	
60.01	06001 BLOOD LABORATORY	0	0			0	60.01
65.00		115, 633	345			0	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	242, 130 50, 799	687 223			0	
68.00	06800 SPEECH PATHOLOGY	46, 409	120			0	
69.00	06900 ELECTROCARDI OLOGY	104, 725	384			0	
71.00 72.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	102 (02	0			0	
73.00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	102, 683 0	0			0	
88.00	08800 RURAL HEALTH CLINIC	87, 719	679			202	88.00
90.00	09000 CLINIC	650, 317	1, 094			84	
90. 01 90. 02	09001 WOUND CLINC 09002 BEHAVI ORAL HEALTH	29, 332 60, 662	212 313			0	
91.02	09100 EMERGENCY	388, 485	1, 415			0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
101 00	OTHER REIMBURSABLE COST CENTERS	450.074	1 000	01.4(1	07.05/		101 00
101.00	SPECIAL PURPOSE COST CENTERS	150, 974	1,000	31, 461	37, 356	0	101.00
113.00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	0	447				116.00
118.00	NONREI MBURSABLE COST CENTERS	6, 913, 518	20, 567				118.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 PEDI ATRI CS	1,095,307	6, 468				192.00
	19201 PEDIATRICS 19202 BROOKVI LLE	98, 511 228, 972	428 791				192.01 192.02
	19203 RADI OLOGY - OSGOOD	5, 498	57				192.03
	19204 ENT	0	168				192.04
	07950 COMMUNITY RELATIONS	13, 167	158				194.00
	07951 COMMUNITY BENEFITS 207952 OTHER NON-REIMBURSABLE	52, 406 0	285 0				194.01 194.02
194.03	07953 EMS	0	30		-		194.02
194.04	07954 BATESVILLE TOOL & DIE CLINIC	О	103	3, 118	0		194.04
	07955 MMHCB RHC	49, 972	363	11, 208	0	115	194.05
200.00 201.00		0	0	0	n	n	200.00 201.00
202.00		8, 457, 351	29, 418				202.00

Health Financial Systems MAR ALLOCATION OF CAPITAL RELATED COSTS	RGARET MARY COM	MUNITY HOSPITA Provider C	CN: 15-1329 Pe	eriod: com 01/01/2019	of Form CMS-: Worksheet B Part II Date/Time Pre 8/31/2020 7:5	pared:
Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	
	7.02	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-DFSITE BLDG 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP 5.00 00500 ADMINI STRATI VE & GENERAL F 7.01 00701 OPERATION OF PLANT - HOSPITAL & OFFS 8.00 00800 LAUNDRY & LI NEN SERVICE SERVICE SERVICE SERVICE	9, 733 101 116 35 307 3 43 43 48 158	101, 912 28, 911 81 705 0 0 0 0	163, 090 886 7, 715 86 1, 073 1, 194	36, 211 0 0 0 0 0	322, 005 8, 003 0 10, 395 26, 646	13.00 14.00 15.00
30. 00 03000 ADULTS & PEDIATRICS	836	15, 240	21, 020	34, 556	45,000	30.00
31. 00 03100 I NTENSI VE CARE UNI T	78			1, 655	6, 306	•
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	42	3, 927	1, 044	0	10, 337	43.00
50.00 05000 0PERATI NG ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 60.00 06000 LABORATORY 60.01 06001 BLOOD 65.00 06500 RESPI RATORY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY	276 71 1,079 196 0 150 314 66 60 136	581 12, 274 0 565 6, 501 755 973	1, 788 27, 113 4, 931 0 3, 770 7, 895 1, 656 1, 513	0 0 0 0 0 0 0 0 0 0 0	30, 039 2, 030 26, 023 36, 708 0 10, 192 0 0 0 10, 540	52.00 54.00 60.00 60.01 65.00 66.00 67.00 68.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		-	0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	133			0	0	72.00
OUTPATIENT SERVICE COST CENTERS	0	0		UU	0	/3.00
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC 90. 01 09001 WOUND CLINC 90. 02 09002 BEHAVI ORAL HEALTH 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 915 38 79 504	3, 688 783 0	20, 017 956 1, 978	0 0 0 0 0	0 0 7, 669 41, 564	
OTHER REIMBURSABLE COST CENTERS	201	0	5, 050	0	0	101.00
SPECIAL PURPOSE COST CENTERS	201			0	0	
113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 5, 985			0 36, 211	0 271, 452	113.00 116.00 118.00
Instruct Instruct Instruct 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 192.01 19200 PEDI ATRI CS Instruct Instruct 192.02 19202 BROKVI LLE Instruct Instruct Instruct 192.03 19203 RADI OLOGY - OSGOOD Instruct Instruct Instruct 192.04 19204 ENT Instruct Instruct	2, 625 128 747 0 0 17 68 0 0 0 0 163 0 9, 733	82 1, 863 0 0 0 0 0 0 1 1, 639	3, 212 0 0 429 1, 709 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 307 0 0 4, 001 8, 177 0 1, 261 0 0	192.00 192.01 192.02 192.03 192.04 194.00 194.01 194.03 194.03 194.04 194.05 200.00 201.00
					• • • • •	

LOCATI	ON OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1329	Period: From 01/01/2019 To 12/31/2019		epared
	Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	<u>8/31/2020 7:5</u> Subtotal	54 am
		13.00	14.00	15.00	16.00	24.00	
	ENERAL SERVICE COST CENTERS	1					
	0100 NEW CAP REL COSTS-BLDG & FIXT 0101 NEW CAP REL COSTS-OFFSITE BLDG						1.0
	D200 NEW CAP REL COSTS-MVBLE EQUIP						2.0
	0201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.0
00 00	0400 EMPLOYEE BENEFITS DEPARTMENT						4.0
	0500 ADMI NI STRATI VE & GENERAL						5.0
	0700 OPERATION OF PLANT						7.0
	0701 OPERATION OF PLANT -OFFSITE 0702 OPERATION OF PLANT - HOSPITAL & OFFS						7.0
	0800 LAUNDRY & LINEN SERVICE						8.0
	0900 HOUSEKEEPING						9.0
	1000 DI ETARY						10.0
	1100 CAFETERI A						11. (
	1300 NURSING ADMINISTRATION	21, 037					13. (
	1400 CENTRAL SERVICES & SUPPLY	0	42, 708				14. (
	1500 PHARMACY 1600 MEDICAL RECORDS & LIBRARY	1, 116 0	0 0				15.0
	NPATIENT ROUTINE SERVICE COST CENTERS	0	0		0 210, 530		1 10. (
	3000 ADULTS & PEDIATRICS	4, 832	0		0 138, 507	1, 118, 620	30. (
	3100 I NTENSI VE CARE UNI T	677	0		0 0	93, 238	1
	4300 NURSERY	1, 110	0		0 0	68, 040	43.0
	VCI LLARY SERVICE COST CENTERS	-1	-				
	5000 OPERATING ROOM	0	0		0 15, 513	362, 424	
	5200 DELIVERY ROOM & LABOR ROOM 5400 RADIOLOGY-DIAGNOSTIC	218 2, 794	0		0 0 0 28, 255	76, 261 1, 299, 096	
	6000 LABORATORY	3, 942	0		0 20, 255	296, 844	
	6001 BLOOD LABORATORY	0	0		0 0	0	1
	6500 RESPI RATORY THERAPY	1, 095	0		0 0	173, 323	
	6600 PHYSI CAL THERAPY	0	0		0 0	339, 965	66.0
	6700 OCCUPATI ONAL THERAPY	0	0		0 0	72, 996	
		0	0		0 0	64, 612	1
	6900 ELECTROCARDI OLOGY 7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	789 0	0 42, 708		0 1,662 0 0	163, 534 78, 552	
	7200 I MPL. DEV. CHARGED TO PATIENT	0	42,700		0 0	148, 263	
	7300 DRUGS CHARGED TO PATIENTS	0	0			109, 597	
οι	JTPATIENT SERVICE COST CENTERS						
	8800 RURAL HEALTH CLINIC	0	0		0 0	109, 898	
	9000 CLINIC	0	0		0 7,756	871, 308	
	9001 WOUND CLINC	0	0		0 0	44, 960	
	9002 BEHAVI ORAL HEALTH 9100 EMERGENCY	4, 464	0		0 0 0 17, 175	94, 219 620, 854	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	-, +0+	0		0 17,175	020, 034	92.
	THER REIMBURSABLE COST CENTERS	1					
	D100 HOME HEALTH AGENCY	0	0		0 0	226, 048	101.
	PECIAL PURPOSE COST CENTERS	1 1					1
	1300 INTEREST EXPENSE	0	0		0	17 051	113.0
18.00	1600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 21, 037	0 42, 708		0 0 97 208, 868	17, 951 6, 450, 603	
	DNREIMBURSABLE COST CENTERS	21,037	42,700	107, 3	200,000	0, 430, 003	1110.1
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 1,662	1, 397, 076	192.
	9201 PEDI ATRI CS	0	0		0 0	148, 849	192.
	9202 BROOKVI LLE	0	0		0 0	258, 382	
	9203 RADI OLOGY - OSGOOD	0	0		0 0	7, 181	
		0	0		0 0	4,878	
	7950 COMMUNITY RELATIONS 7951 COMMUNITY BENEFITS	0	0		0 0	32, 746 88, 297	
	7951 COMMONITY BENEFITS 7952 OTHER NON-REI MBURSABLE	0	0		0 0		194.
	7953 EMS	0	0		0 0	2,657	
	7954 BATESVILLE TOOL & DIE CLINIC	0	0		0 0	3, 222	
4.050	7955 MMHCB RHC	0	0		0 0	63, 460	194.
0. 00	Cross Foot Adjustments						200.
01.00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0	0		0 0		201.
02.00		21,037	42, 708	109, 5	97 210, 530	8, 457, 351	1202

	ncial Systems MAR DF CAPITAL RELATED COSTS	GARET MARY COMM	Provider CC	Peri od:		of Form CMS-2552-10 orksheet B
				 From 01/0)1/2019 P	art II ate/Time Prepared:
				 10 12/3		/31/2020 7:54 am
	Cost Center Description	Intern & Residents	Total			
		Cost & Post				
		Stepdown				
		Adjustments				
GENER	AL SERVICE COST CENTERS	25.00	26.00			
	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
	NEW CAP REL COSTS-MVBLE EQUIP					2.00
	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL					4.00
	OPERATION OF PLANT					7.00
	OPERATION OF PLANT -OFFSITE					7.01
	OPERATION OF PLANT - HOSPITAL & OFFS					7.02
	LAUNDRY & LINEN SERVICE					8.00
	HOUSEKEEPING					9.00
						10.00
	CAFETERIA NURSI NG ADMI NI STRATI ON					11.00
	CENTRAL SERVICES & SUPPLY					14.00
	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
	IENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS	0	1, 118, 620			30.00
	INTENSIVE CARE UNIT	0	93, 238			31.00
	NURSERY LARY SERVICE COST CENTERS	U	68, 040			43.00
	OPERATING ROOM	0	362, 424			50.00
	DELIVERY ROOM & LABOR ROOM	0	76, 261			52.00
	RADI OLOGY-DI AGNOSTI C	0	1, 299, 096			54.00
	LABORATORY	0	296, 844			60.00
	BLOOD LABORATORY RESPI RATORY THERAPY	0	172 222			60.01
	PHYSICAL THERAPY	0	173, 323 339, 965			65.00 66.00
	OCCUPATI ONAL THERAPY	0	72, 996			67.00
	SPEECH PATHOLOGY	0	64, 612			68.00
	ELECTROCARDI OLOGY	0	163, 534			69.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	78, 552			71.00
	IMPL. DEV. CHARGED TO PATIENT	0	148, 263			72.00
	DRUGS CHARGED TO PATIENTS TIENT SERVICE COST CENTERS	0	109, 597			73.00
	RURAL HEALTH CLINIC	0	109, 898			88.00
	CLINIC	0	871, 308			90.00
90.01 09001	WOUND CLINC	0	44, 960			90.01
	BEHAVI ORAL HEALTH	0	94, 219			90.02
91.00 09100		0	620, 854			91.00
	OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS	0				92.00
	HOME HEALTH AGENCY	0	226, 048			101.00
	AL PURPOSE COST CENTERS	U				
113.0011300	INTEREST EXPENSE					113.00
116.0011600		0	17, 951			116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	6, 450, 603			118.00
	I MBURSABLE COST CENTERS PHYSI CI ANS' PRI VATE OFFI CES	0	1, 397, 076			192.00
192.00 19200 192.01 19201		0	1, 397, 076			192.00
92.02 19202		0	258, 382			192.02
92.03 19203	RADI OLOGY - OSGOOD	0	7, 181			192.03
192.04 19204		0	4, 878			192.04
	COMMUNITY RELATIONS	0	32, 746			194.00
	COMMUNITY BENEFITS	0	88, 297			194.01
194.0207952 194.0307953	OTHER NON-REIMBURSABLE	0	0 2,657			194. 02 194. 03
	BATESVILLE TOOL & DIE CLINIC	0	2, 657			194.03
194.0507955		o	63, 460			194.05
200. 00	Cross Foot Adjustments	Ö	0			200.00
201.00	Negative Cost Centers	0	0			201.00
202.00	TOTAL (sum lines 118 through 201)	0	8, 457, 351			202.00

COST AL	LOCATION - STATISTICAL BASIS		Provider CC		eriod: rom 01/01/2019	Worksheet B-1	
				T		Date/Time Pre 8/31/2020 7:5	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
G	GENERAL SERVICE COST CENTERS	1.00	1.01	2.00	2.01	4.00	
1.00 C 1.01 C 2.00 C 2.01 C 4.00 C 5.00 C	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	161, 768 0 677 24, 805	82, 572 0 0	161, 768 0 677 24, 805	82, 572 0 0	47, 444, 706 7, 192, 101	5.00
7.01 0 7.02 0 8.00 0 9.00 0 10.00 0 11.00 0 13.00 0 14.00 0	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT -OFFSITE 00702 OPERATION OF PLANT - HOSPITAL & OFFS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01100 CAFETERIA 01100 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	26, 796 0 1, 797 2, 049 625 5, 445 61 757 843	0 0 0 0 0 0 0 0 0	26, 796 0 1, 797 2, 049 625 5, 445 61 757 843	0 0 0 0 0 0 0 0 0 0	0 0 549, 167 125, 727 974, 563 81, 982 714, 781 550, 276 0 778, 313	7.01 7.02 8.00 9.00 10.00 11.00 13.00 14.00
	D1600 MEDICAL RECORDS & LIBRARY	2, 806	0	2, 806	0	1, 293, 486	1
30.00 0 31.00 0 43.00 0	NPATI ENT ROUTI NE SERVI CE COST CENTERS D3000 ADULTS & PEDI ATRI CS D3100 I NTENSI VE CARE UNI T D4300 NURSERY	14, 832 1, 389 737	0 0 0	14, 832 1, 389 737	0 0 0	2, 349, 320 317, 201 600, 344	31.00
50.00 C 52.00 C 54.00 C 60.01 C 65.00 C 65.00 C 66.00 C 67.00 C 68.00 C 69.00 C 71.00 C 71.00 C 72.00 C	ANCILLARY SERVICE COST CENTERS 55000 OPERATING ROOM 55200 DELIVERY ROOM & LABOR ROOM 55400 RADIOLOGY-DIAGNOSTIC 566001 BLOOD LABORATORY 566001 BLOOD LABORATORY 56600 PHYSICAL THERAPY 56600 PHYSICAL THERAPY 56700 OCCUPATIONAL THERAPY 56700 OCCUPATIONAL THERAPY 56800 SPEECH PATHOLOGY 56900 ELECTROCARDIOLOGY 57100 MEDICAL SUPPLIES CHARGED TO PATIENTS 57200 IMPL. DEV. CHARGED TO PATIENT 57300 DRUGS CHARGED TO PATIENTS 5000000000000000000000000000000000000	4, 888 1, 265 19, 133 3, 480 0 2, 661 5, 572 1, 169 1, 068 2, 410 0 2, 363 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4, 888 1, 265 19, 133 3, 480 0 2, 661 5, 572 1, 169 1, 068 2, 410 0 2, 363 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 556, 661 117, 879 3, 172, 643 1, 638, 871 0 555, 864 1, 107, 879 359, 599 193, 316 619, 601 0 0 0	52.00 54.00 60.01 65.00 66.00 67.00 68.00 69.00 71.00 72.00
88.00 (C 90.00 (C 90.01 (C 90.02 (C 91.00 (C 92.00 (C	08800 RURAL HEALTH CLINIC 09000 CLINIC 09001 WOUND CLINC 09002 BEHAVIORAL HEALTH 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 07HER REIMBURSABLE COST CENTERS	0 14, 127 675 1, 396 8, 940	2, 107 0 0	0 14, 127 675 1, 396 8, 940	2, 107 0 0	1, 094, 995 1, 765, 075 341, 761 505, 452 2, 281, 683	90.00 90.01 90.02
101.00	10100 HOME HEALTH AGENCY	3, 415	149	3, 415	149	1, 613, 304	101.00
113.001 116.001 118.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) IONRELMBURSABLE COST CENTERS	0 156, 181	0 7, 329	0 156, 181	0 7, 329	721, 174 33, 173, 018	118.00
192. 01 1 192. 02 1 192. 03 1 192. 04 1 194. 00 0	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 PEDI ATRI CS 19202 BROOKVI LLE 19203 RADI OLOGY - OSGOOD 19204 ENT 77950 COMMUNI TY RELATI ONS 07951 COMMUNI TY BENEFI TS	1, 811 2, 267 0 0 303 1, 206	58, 793 0 13, 242 318 0 0 0	1, 811 2, 267 0 0 0 303 1, 206	58, 793 0 13, 242 318 0 0 0	10, 427, 461 689, 560 1, 275, 222 92, 051 270, 710 255, 636 460, 234	192. 01 192. 02 192. 03 192. 04 194. 00
194. 02 0 194. 03 0 194. 04 0	77952 OTHER NON-REIMBURSABLE 07953 EMS 07954 BATESVILLE TOOL & DIE CLINIC 07955 MMHCB RHC Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0 0 0 0	0 0 2, 890 853 630	0 0 0 0	0 0 2, 890 574 151	0	194.02 194.03 194.04 194.05 200.00 201.00
202.00 203.00 204.00	Cost to be allocated (per WKST. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	2, 305, 241 14. 250291	853, 630 10. 338008	4, 724, 329 29. 204348	574, 151 6. 953338	0. 326761	

Health Financial Systems MAR	RGARET MARY CON	MUNITY HOSPITA	L	In Lieu of Form CMS-2552-10				
COST ALLOCATION - STATISTICAL BASIS				Period: From 01/01/2019	Worksheet B-1			
				To 12/31/2019		pared: 4 am		
	CAPI TAL RELATED COSTS							
Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)			
	1.00	1.01	2.00	2.01	4.00			
205.00 Unit cost multiplier (Wkst. B, Part					0. 000620	205.00		
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00		
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00		

ST ALLUCA	TION - STATISTICAL BASIS		Provider C	F	Period: From 01/01/2019 To 12/31/2019	Worksheet B-1 Date/Time Pre 8/31/2020 7:5	epare
	Cost Center Description	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	OPERATI ON OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
		5A	5.00	7.00	7.01	7.02	
	AL SERVICE COST CENTERS						1 1
01 00101 00 00200 01 00201 00 00400 00 00500 00 00700 01 00701 02 00702 00 00800 00 00900 00 01000 00 01300 00 01300 00 01400	NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-OFFSITE BLDG NEW CAP REL COSTS-OFFSITE BLDG NEW CAP REL COSTS-MVBLE EQUIP OFFSIT EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT OPERATION OF PLANT -OFFSITE OPERATION OF PLANT - HOSPITAL & OFFS LAUNDRY & LINEN SERVICE HOUSEKEEPING DI ETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	-18, 656, 127 0 0 0 0 0 0 0 0 0 0 0	85, 653, 602 2, 633, 334 260, 578 743, 372 315, 608 1, 741, 552 91, 971 1, 318, 603 734, 961 32, 895	109, 490 0 1, 797 2, 049 625 5, 445 61 757	82, 572 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	172, 634 1, 797 2, 049 625 5, 445 61 757	8. 9. 10. 11. 13. 14.
	PHARMACY MEDICAL RECORDS & LIBRARY	0	3, 997, 154 2, 082, 997	843 2, 806		843 2, 806	
	IENT ROUTINE SERVICE COST CENTERS	0	2,002,997	2,800	<u> </u>	2,000	10.
	ADULTS & PEDIATRICS	0	3, 989, 287	14, 832		14, 835	
	INTENSIVE CARE UNIT	0	490, 141 880, 053	1, 389 737		1, 389 737	
	LARY SERVICE COST CENTERS		000,000	, , ,		101	10.
	OPERATING ROOM	0	2, 658, 211	4, 888		4, 888	
	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	0	212, 994 12, 573, 752	1, 265 19, 133		1, 262 19, 133	
	LABORATORY	0	4, 808, 628			3, 480	
	BLOOD LABORATORY	0	0	0,100		0, 100	
	RESPI RATORY THERAPY	0	986, 496			2, 661	
	PHYSICAL THERAPY	0	1, 700, 429			5, 572	
	OCCUPATIONAL THERAPY	0	531, 028 305, 005	1, 169 1, 068		1, 169 1, 068	
	ELECTROCARDI OLOGY	0	1, 059, 142			2, 410	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 836, 632			0	
	IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	0	1, 101, 893 0	2, 363		2, 363 0	
	TI ENT SERVICE COST CENTERS	0	0		, 0	0	1 '3
	RURAL HEALTH CLINIC	0	1, 663, 374			0	
. 00 09000	VCLINIC WOUND CLINC	0	2, 604, 033 494, 989			16, 233 675	
	BEHAVI ORAL HEALTH	0	652, 680		, 0		
. 00 09100	EMERGENCY	0	3, 977, 088			8, 940	
	OBSERVATION BEDS (NON-DISTINCT PART)						92
	REIMBURSABLE COST CENTERS	0	2, 489, 789	3, 415	149	3, 564	101
	AL PURPOSE COST CENTERS	-				-,	
	INTEREST EXPENSE		4 005 044				113
6.0011600 8.00	SUBTOTALS (SUM OF LINES 1 through 117)	-18, 656, 127	1, 385, 244 61, 353, 913			106, 158	116
	IMBURSABLE COST CENTERS	10,030,127	01, 333, 713	103, 700	1,327	100, 100	
	PHYSICIANS' PRIVATE OFFICES	0	17, 572, 981	1, 811		46, 568	
	PEDI ATRI CS BROOKVI LLE	0	1,059,115			2, 267 13, 242	
	RADI OLOGY - OSGOOD	0	2, 016, 530 127, 628				192
2.04 19204	ENT	0	372, 784	C	0	C	192
	COMMUNITY RELATIONS	0	922, 764				194
	COMMUNITY BENEFITS OTHER NON-REIMBURSABLE	0	986, 079 0	1, 206		1, 206	194
4.0307953		0	108, 079	-	-		194
	BATESVILLE TOOL & DIE CLINIC	0	246, 756		0		194
	MMHCB RHC Cross Foot Adjustmonts	0	886, 973	C	2, 890	2, 890	
0.00	Cross Foot Adjustments Negative Cost Centers						200 201
2.00	Cost to be allocated (per Wkst. B,		18, 656, 127	3, 206, 898	3 317, 334	905, 285	
	Part I)						
3.00	Unit cost multiplier (Wkst. B, Part I)		0. 217809				
4.00	Cost to be allocated (per Wkst. B,		1, 082, 351	1, 197, 687	3, 293	9, 733	204.
	Part II)						

Health Financial Systems MAR	GARET MARY COM	MUNITY HOSPITA	L	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-1329			Worksheet B-1		
			From 01/01/2019 To 12/31/2019				
Cost Center Description	Reconciliatio	ADMI NI STRATI V	OPERATION OF	OPERATION OF	OPERATION OF		
	n	E & GENERAL	PLANT	PLANT	PLANT -		
		(ACCUM.	(SQUARE	-0FFSI TE	HOSPI TAL &		
		COST)	FEET)	(SQUARE	OFFS		
				FEET)	(SQUARE		
					FEET)		
	5A	5.00	7.00	7.01	7.02		
206.00 NAHE adjustment amount to be allocated						206.00	
(per Wkst. B-2)							
207.00 NAHE unit cost multiplier (Wkst. D,						207.00	
Parts III and IV)							

	LOCATION - STATISTICAL BASIS		Provider CC		eriod: rom 01/01/2019	Worksheet B-1	
					o 12/31/2019		
	Cost Center Description	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	8/31/2020 7:5 NURSI NG ADMI NI STRATI 0 N (HOURS OF SERVI CE)	
		8.00	9.00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS						1 1
. 01 . 00 . 01 . 00 . 00 . 00 . 00 . 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 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	286, 914 81, 390 228 1, 985 0 0 0 0	115, 101 625 5, 445 61 757 843 2, 806	12, 649 C C C C C C C C C C C C C C C C C C C	22, 211 552 0 717	281, 048 0 14, 907 0	14. 15.
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	42, 906 1, 721	14, 835 1, 389	12, 071 578	3, 104 435	64, 566 9, 039	
3. 00	04300 NURSERY	11, 057	737	0		14, 835	
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	26, 017	4, 888	C	2,072	0	50.
	05200 DELIVERY ROOM & LABOR ROOM	1, 637	4,000	C		2, 913	
4.00	05400 RADI OLOGY-DI AGNOSTI C	34, 556	19, 133	C		37, 330	
	06000 LABORATORY	0	3, 480	C	_,	52, 659	
	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0 1, 592	0 2, 661	0	-	0 14, 630	60
	06600 PHYSI CAL THERAPY	18, 301	5, 572	0		14,030	66
7.00	06700 OCCUPATI ONAL THERAPY	2, 125	1, 169	C	0	0	67
	06800 SPEECH PATHOLOGY	2,739	1,068	0	0	0	68
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	6, 019 0	2, 410	0		10, 535 0	69
	07200 IMPL. DEV. CHARGED TO PATIENT	6, 551	2, 363	0	-	0	72
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73
	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	788	0	C	0	0	88
	09000 CLINIC	10, 383	14, 127	C		0	90
	09001 WOUND CLINC	2, 205	675	C		0	
	09002 BEHAVI ORAL HEALTH	0	1, 396	0		0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	18, 391	8, 940	C	2, 867	59, 634	91
	OTHER REIMBURSABLE COST CENTERS						1
	10100 HOME HEALTH AGENCY	0	3, 564	C	0	0	101
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						1113
	11600 HOSPI CE	0	0	C			116
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	270, 591	100, 206	12, 649	18, 724	281, 048	118
	NONREI MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES	6, 230	11, 119	C	1, 987	0	192
	19200 PEDI ATRI CS	230	2, 267	0			192
	19202 BROOKVI LLE	5, 245	0	C	0	0	192
	19203 RADI OLOGY - OSGOOD	0	0	0	0		192
	19204 ENT 07950 COMMUNI TY RELATI ONS	0	0 303	0	276		192 194
	07951 COMMUNITY BENEFITS	0	1, 206	C	564		194
	07952 OTHER NON-REI MBURSABLE	0	0	C	0		194
	07953 EMS	0	0	0	87		194
	07954 BATESVILLE TOOL & DIE CLINIC 07955 MMHCB RHC	4, 615	0	C C			194 194
0.00	Cross Foot Adjustments	.,	_	-	_	_	200
1.00	Negative Cost Centers					o <i>i</i> = =	201
2.00	Cost to be allocated (per Wkst. B, Part I)	446, 406	2, 318, 270	146, 529	1, 906, 598	945, 762	202
03. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	1. 555888 101, 912	20. 141180 163, 090	11. 584236 36, 211		3. 365126 21, 037	
04.00	Part II)		I				1

Health Financial Systems MAR	RGARET MARY CON	MUNITY HOSPITA	L	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-1329	Period:	Worksheet B-1		
		_		From 01/01/2019 To 12/31/2019	Date/Time Pre 8/31/2020 7:5		
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	NURSI NG		
	LINEN SERVICE	x · - ·	(MEALS	(FTE'S)	ADMI NI STRATI O		
	(POUNDS OF	FEET)	SERVED)		N		
	LAUNDRY)				(HOURS OF		
					SERVICE)		
	8.00	9.00	10.00	11.00	13.00		
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	

OST ALLOCA	ncial Systems MAR TION - STATISTICAL BASIS		MUNITY HOSPITAL Provider CC		Peri od:	u of Form CMS-2552 Worksheet B-1
					From 01/01/2019 To 12/31/2019	
	Cost Center Description	CENTRAL SERVICES &	PHARMACY (100% TO	MEDI CAL RECORDS &		8/31/2020 7:54 a
		SUPPLY (100% MED SUPPLIES)	DRUGS)	LI BRARY (TI ME SPENT)		
		14.00	15.00	16.00		
	RAL SERVICE COST CENTERS					1
	NEW CAP REL COSTS-OFFSITE BLDG					1
	NEW CAP REL COSTS-MVBLE EQUIP					2
	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2
	DEMPLOYEE BENEFITS DEPARTMENT DADMINISTRATIVE & GENERAL					4
	OPERATION OF PLANT					7
	OPERATION OF PLANT -OFFSITE					7
	2 OPERATION OF PLANT - HOSPITAL & OFFS					7
	LAUNDRY & LINEN SERVICE					8
	D HOUSEKEEPI NG D DI ETARY					9
	CAFETERIA					11
	NURSING ADMINISTRATION					13
	CENTRAL SERVICES & SUPPLY	100				14
	PHARMACY	0		7	()	15
	MEDICAL RECORDS & LIBRARY	0	0	/ (50	16
	ADULTS & PEDIATRICS	0	0	50	00	30
	INTENSIVE CARE UNIT	0			0	31
	NURSERY	0	0		0	43
	LARY SERVICE COST CENTERS	0	0		56	50
	DELIVERY ROOM & LABOR ROOM	0			0	52
	RADI OLOGY-DI AGNOSTI C	0	0	1(02	54
00 0600	LABORATORY	0	0		0	60
	BLOOD LABORATORY	0	0		0	60
1		0	0		0	65
	D PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	0		0	66
	SPEECH PATHOLOGY	0	0		0	68
	ELECTROCARDI OLOGY	0	0		6	69
	MEDICAL SUPPLIES CHARGED TO PATIENTS	100	0		0	71
	IMPL. DEV. CHARGED TO PATIENT	0			0	72
	D DRUGS CHARGED TO PATIENTS	0	100		0	73
	RURAL HEALTH CLINIC	0	0		0	88
	CLINIC	0		:	28	90
. 01 0900	WOUND CLINC	0	0		0	90
	2 BEHAVI ORAL HEALTH EMERGENCY	0	0		0 52	90
	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92
	R REIMBURSABLE COST CENTERS					
	HOME HEALTH AGENCY	0	0		0	101
	AL PURPOSE COST CENTERS					113
6.001160		0	О		0	116
8. 00	SUBTOTALS (SUM OF LINES 1 through 117)	100		7!	54	118
	I MBURSABLE COST CENTERS	-				
	PHYSICIANS' PRIVATE OFFICES	0	1		6 0	192 192
	2 BROOKVI LLE	0	0		0	192
	RADI OLOGY - OSGOOD	0	0		0	192
2.04 1920	4 ENT	0	0		0	192
		0	0		0	194
	COMMUNITY BENEFITS 2 OTHER NON-REIMBURSABLE	0	0		0	194 194
4. 03 0795		0	0		õ	194
	BATESVILLE TOOL & DIE CLINIC	0	0		0	194
4. 05 0795	5 MMHCB RHC	0	0		0	194
0.00	Cross Foot Adjustments					200
1.00 2.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	81, 449	5, 025, 572	2, 847, 8	33	201 202
2.00	Part I)	01, 449	5,025,572	2,047,00		202
03.00	Unit cost multiplier (Wkst. B, Part I)		50, 255. 720000			203
04.00	Cost to be allocated (per Wkst. B,	42, 708	109, 597	210, 53	30	204
5.00	Part II)	127 00000	1 005 070000	777 0101	50	0.01
	Unit cost multiplier (Wkst. B, Part	427.080000	1,095.970000	277.0131	00	205

Health Financial Systems MAR	RGARET MARY COM	MUNITY HOSPITA	L	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS				Period: From 01/01/2019	Worksheet B-	1	
					Date/Time Pro 8/31/2020 7:1	epared: 54 am	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL				
	SERVICES & SUPPLY	(100% TO DRUGS)	RECORDS &				
	(100% MED	DRUGS)	(TIME				
	SUPPLIES)		SPENT)				
	14.00	15.00	16.00				
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	

MARGARET MARY COMMUNITY HOSPITAL

Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Therapy Limit Adj. Therapy Limit Adj. Total Costs Total Costs RCE Disal owance Total Costs 30.00 03000 ADULTS & PEDIATRICS 8.233,117 0	COMPUTATION OF RATIO OF COSTS TO CHARGES	WARGARET WART COM	Provider C	CN: 15-1329	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 8/31/2020 7:5	pared:
Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Therapy Limit Adj. Total Costs Disal Iowance Total Costs Disal Iowance INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 0.00 03000 ADULTS & PEDIATRICS 8.233,117 0 0 0 31.00 03100 INTENSIVE CARE UNIT 749,973 749,973 0 0 43.00 043000 NURSERY 1.240,360 1.240,360 0 0 0 50.00 05000 DELIVERY ROM & LABOR ROM 352,841 3,932,627 0 0 0 0 52.00 05400 RADI LARY SERVICE COST CENTERS			Title	XVIII	Hospi tal	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS Ádj. Disal I owance 30.00 03000 ADULTS & PEDIATRICS 8, 233, 117 0 0.00 0.00 03000 INTENSINE CARE UNIT 749, 973 749, 973 0 0 43.00 043.00 INPATIENT ROUTINE SERVICE COST CENTERS 0.00							
Impart ENT ROUTI NE SERVICE COST CENTERS Impart ENT ROUTI NE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS 8, 233, 117 8, 233, 117 0 0 0.01 03000 ADULTS & PEDIATRICS 8, 233, 117 8, 233, 117 0 0 0.01 03000 ADULTS & PEDIATRICS 8, 233, 117 8, 233, 117 0 0 0.01 000 ONURSERY 1, 240, 360 1, 240, 360 0 0 0.02000 DELIVERY ROM & LABOR ROOM 3, 932, 627 3, 932, 627 0 0 0.00 05000 DELIVERY ROM & LABOR ROOM 352, 841 0 0 0 0.01 054.00 DAGNOTI ELOUSTIC 17, 074, 202 17, 074, 202 0 0 0.01 0.001 BLOD LABORATORY 0	Cost Center Description		Therapy Limit	Total Costs		Total Costs	
col. 26) col. 2.00 3.00 4.00 5.00 INPATI ENT ROUTI NE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 30.00 03000 ADULTS & PEDI ATRICS 8.233.117 8.233.117 0 0 31.00 03000 INTENSIVE CARE UNI T 749,973 749,973 0 0 31.00 04300 INTENSIVE CARE UNI T 749,973 0 0 0 ANCILLARY SERVICE COST CENTERS 1.240,360 1.240,360 0 0 0 52.00 05200 DELI VERY ROOM & LABOR ROOM 3.932,627 3.932,627 0 0 54.00 05400 RADI LOGY-DI AGNOSTI C 17,074,202 17,074,202 0 0 66.00 06600 RESPI RATORY THERAPY 0 0 0 0 0 67.00 06500 SPECH PATHERAPY 2.403,919 0 2.403,919 0 0 68.00 6600 SPECH PATHOLOGY 434,093 0 434,093 0 0 69.00 06900 ELECTROCARDI OLOGY 1,551,30			Adj.		Di sal I owance		
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 Q3000 ADULTS & PEDIATRI CS 8, 233, 117 8, 233, 117 0 0 31.00 Q3000 ADULTS & PEDIATRI CS 8, 233, 117 749, 973 749, 973 0 0 31.00 Q3000 NURSERY 1, 240, 360 1, 240, 360 0 0 0 ANCILLARY SERVICE COST CENTERS 3, 932, 627 3, 932, 627 0 0 0 50.00 OS000 DERLITERY ROOM & LABOR ROOM 352, 841 352, 841 0 0 51.00 OS000 LDGY DI AGNOSTI C 17, 074, 202 17, 074, 202 0 0 60.00 O6000 LABORATORY 6, 440, 809 0 <							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 8, 233, 117 8, 233, 117 0 0 31. 00 03100 INTENSI VE CARE UNI T 749, 973 0 0 0 43. 00 04300 NURSERY 1, 240, 360 1, 240, 360 0 0 50. 00 05000 OPERATI NG ROM 352, 841 352, 841 0 0 54. 00 05200 DELI VERY ROM & LABOR ROM 352, 841 352, 841 0 0 54. 00 05400 RADI CLOGY-DI AGNOSTI C 17, 074, 202 17, 074, 202 0 0 0 65. 00 05600 RESPI RATORY THERAPY 1, 458, 908 0 1, 458, 908 0							
30.00 03000 ADULTS & PEDIATRICS 8, 233, 117 749, 973 0 0 31.00 03100 INTENSIVE CARE UNIT 749, 973 749, 973 0 0 30.00 04300 INTENSIVE CARE UNIT 749, 973 0 0 0 ANCILLARY SERVICE COST CENTERS 1, 240, 360 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 352, 841 352, 841 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 17, 074, 202 17, 074, 202 0 0 60.01 06001 LABORATORY 6, 440, 809 0 0 0 0 0 0 66.00 06000 PHYSI CAL THERAPY 1, 458, 908 0 1, 458, 908 0 0 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 713, 911 0 713, 911 0		1.00	2.00	3.00	4.00	5.00	
31.00 03100 INTENSIVE CARE UNIT 749,973 749,973 0 0 43.00 04300 NURSERY 1,240,360 0 0 ANCILLARY SERVICE COST CENTERS					-1		
43.00 04300 NURSERY 1, 240, 360 1, 240, 360 0 0 ANCILLARY SERVICE COST CENTERS						0	30.00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM 3,932,627 0 0 52.00 OS200 DELIVERY ROOM & LABOR ROOM 352,841 352,841 0 54.00 OS400, RADIOLOGY-DIAGNOSTIC 17,074,202 17,074,202 0 0 60.00 O6600 LABORATORY 6,440,809 6,440,809 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>0</td><td>31.00</td></t<>						0	31.00
50.00 05000 0PERATI NG ROM 3, 932, 627 3, 932, 627 0 0 52.00 05200 DELI VERY ROM & LABOR ROM 352, 841 352, 841 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 17, 074, 202 0 0 0 60.00 06000 LABORATORY 6, 440, 809 6, 440, 809 0 0 0 60.01 06001 BLODD LABORATORY 0		1, 240, 360		1, 240, 36	0 0	0	43.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 352, 841 352, 841 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 17, 074, 202 17, 074, 202 0 0 60.00 06000 LABORATORY 6, 440, 809 0 <							
54.00 05400 RADI OLOGY-DI AGNOSTI C 17, 074, 202 17, 074, 202 0 0 60.00 06000 LABORATORY 6, 440, 809 0		3, 932, 627		3, 932, 62	7 0	0	50.00
60.00 06000 LABORATORY 6, 440, 809 6, 440, 809 0 0 60.01 06001 BLODD LABORATORY 0 <t< td=""><td>52.00 05200 DELIVERY ROOM & LABOR ROOM</td><td>352, 841</td><td></td><td>352, 84</td><td>1 0</td><td>0</td><td>52.00</td></t<>	52.00 05200 DELIVERY ROOM & LABOR ROOM	352, 841		352, 84	1 0	0	52.00
60. 01 06001 BLOOD LABORATORY 0 0 0 65. 00 06500 RESPI RATORY THERAPY 1,458,908 0 1,458,908 0 0 66. 00 06600 PHYSI CAL THERAPY 2,403,919 0 2,403,919 0 0 67. 00 0CCUPATI ONAL THERAPY 2,403,919 0 713,911 0 0 0 68. 00 06800 SPEECH PATHOLOGY 434,093 0 434,093 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 1,551,304 1,551,304 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 3,535,925 3,535,925 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 1,481,284 1,481,284 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENT 5,025,572 0 0 0 0 0 90. 00 09000 CLINI C 2,046,394 2,046,394 0 0 0 0 0 90	54. 00 05400 RADI OLOGY-DI AGNOSTI C	17, 074, 202		17, 074, 20	2 0	0	54.00
65.00 06500 RESPI RATORY THERAPY 1,458,908 0 1,458,908 0 0 66.00 06600 PHYSI CAL THERAPY 2,403,919 0 2,403,919 0 0 67.00 06700 0CCUPATI ONAL THERAPY 713,911 0 713,911 0 0 68.00 06800 SPEECH PATHOLOGY 434,093 0 434,093 0 0 69.00 06900 ELECTROCARDI OLOGY 1,551,304 1,551,304 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 3,535,925 3,535,925 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 5,025,572 5,025,572 0 0 001701 MEDI CAL SUPPLI ES CHERGED PATI ENTS 5,025,572 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 5,025,572 5,025,572 0	60. 00 06000 LABORATORY	6, 440, 809		6, 440, 80	9 0	0	60.00
66.00 06600 PHYSI CAL THERAPY 2, 403, 919 0 2, 403, 919 0 0 67.00 06700 OCCUPATI ONAL THERAPY 713, 911 0 713, 911 0 0 68.00 06800 SPEECH PATHOLOGY 434, 093 0 434, 093 0 0 69.00 06900 ELECTROCARDI OLOGY 1, 551, 304 1, 551, 304 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 3, 535, 925 3, 535, 925 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 1, 481, 284 1, 481, 284 0 0 00100 OT300 DRUGS CHARGED TO PATI ENTS 5, 025, 572 5, 025, 572 0 0 00100 07300 DRUGS CHARGED TO PATI ENTS 2, 046, 394 0 0 0 00.00 09000 CLINC 2, 046, 394 0 0 0 00.01 09000 CLINC 643, 138 643, 138 0 0 00.02 09002 BEHAVI ORAL HEALTH 916, 575 916, 575 0	60.01 06001 BLOOD LABORATORY	0			0 0	0	60.01
67.00 06700 0CCUPATI 0NAL THERAPY 713, 911 0 713, 911 0 0 68.00 06800 SPEECH PATHOLOGY 434, 093 0 434, 093 0 0 69.00 06900 ELECTROCARDI 0LOGY 1, 551, 304 1, 551, 304 0 0 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 3, 535, 925 3, 535, 925 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 1, 481, 284 1, 481, 284 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 5, 025, 572 5, 025, 572 0 0 0UTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 0 88.00 0800 RURAL HEALTH CLINIC 2, 046, 394 2, 046, 394 0 0 0 90.00 09000 CLINIC 4, 083, 820 4, 083, 820 0 0 0 90.01 09001 WOUND CLINC 643, 138 643, 138 0 0 0 91.00 09002 BEHAVI 0RAL HEALTH 916, 575 916, 575 0	65. 00 06500 RESPI RATORY THERAPY	1, 458, 908	0	1, 458, 90	8 0	0	65.00
68.00 06800 SPEECH PATHOLOGY 434,093 0 434,093 0 0 69.00 06900 ELECTROCARDI OLOGY 1,551,304 1,551,304 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 3,535,925 3,535,925 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 1,481,284 1,481,284 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 5,025,572 5,025,572 0 0 0 00TPATIENT SERVICE COST CENTERS 5,025,572 5,025,572 0 0 0 0 0 90.00 09000 CLI NI C 2,046,394 2,046,394 0 0 0 90.01 09001 WOUND CLI NC 4,083,820 4,083,820 0 0 0 90.02 09002 BEHAVI ORAL HEALTH 916,575 916,575 0 0 0 91.00 09000 EMERGENCY 6,039,845 6,039,845 0 0 0 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 2,036	66. 00 06600 PHYSI CAL THERAPY	2, 403, 919	0	2, 403, 91	9 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY 1,551,304 1,551,304 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 3,535,925 3,535,925 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 1,481,284 1,481,284 0 0 73.00 07300 DRUGS CHARGED TO PATI ENT 1,481,284 1,481,284 0 0 007300 DRUGS CHARGED TO PATI ENTS 5,025,572 5,025,572 0 0 00TPATI ENT SERVICE COST CENTERS 2,046,394 2,046,394 0 0 90.00 09000 CLINIC 4,083,820 4,083,820 0 0 90.01 09001 WOUND CLINC 643,138 643,138 0 0 0 90.02 09002 BEHAVI ORAL HEALTH 916,575 916,575 0 0 0 91.00 090100 EMERGENCY 6,039,845 6,039,845 0 0 0 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 2,036,836 2,036,836 0 0 92.00 OBSERVATI	67.00 06700 OCCUPATI ONAL THERAPY	713, 911	0	713, 91	1 0	0	67.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 3, 535, 925 3, 535, 925 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 481, 284 1, 481, 284 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 5, 025, 572 5, 025, 572 0 0 0UTPATI ENT SERVICE COST CENTERS 2, 046, 394 2, 046, 394 0 0 0 88.00 0800 RURAL HEALTH CLINIC 2, 046, 394 0 0 0 90.00 09000 CLINIC 4, 083, 820 4, 083, 820 0 0 90.01 09001 WOUND CLINC 643, 138 643, 138 0 0 90.02 BEHAVI ORAL HEALTH 916, 575 916, 575 0 0 91.00 09100 EMERGENCY 6, 039, 845 6, 039, 845 0 0 92.00 092000 DESERVATI ON BEDS (NON-DI STI NCT PART) 2, 036, 836 2, 036, 836 0 0 92.00 092000 DESERVATI ON BEDS (NON-DI STI NCT PART) 2, 036, 836 2, 036, 836 0 0 <t< td=""><td>68.00 06800 SPEECH PATHOLOGY</td><td>434, 093</td><td>0</td><td>434, 09</td><td>3 0</td><td>0</td><td>68.00</td></t<>	68.00 06800 SPEECH PATHOLOGY	434, 093	0	434, 09	3 0	0	68.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 3, 535, 925 3, 535, 925 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 1, 481, 284 1, 481, 284 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 5, 025, 572 0 0 0 0UTPATI ENT SERVICE COST CENTERS 2, 046, 394 2, 046, 394 0 0 0 90.00 09000 CLINIC 4, 083, 820 4, 083, 820 0 0 90.01 09001 WOUND CLINC 643, 138 643, 138 0 0 90.02 09002 BEHAVI ORAL HEALTH 916, 575 916, 575 0 0 91.00 09100 EMERGENCY 6, 039, 845 6, 039, 845 0 0 92.00 OBSERVATION BEDS (NON-DI STINCT PART) 2, 036, 836 2, 036, 836 0 0 01000 HOME HEALTH AGENCY 3, 223, 155 3, 223, 155 0 0 92.00 OBSERVATION BEDS (NON-DI STINCT PART) 2, 036, 836 2, 036, 836 0 0 010100 HOME HEALTH AGENCY	69. 00 06900 ELECTROCARDI OLOGY	1, 551, 304		1, 551, 30	4 0	0	69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1,481,284 1,481,284 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 5,025,572 5,025,572 0 0 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 00.00 09000 CLINIC 2,046,394 2,046,394 0 0 0 90.01 09000 CLINIC 4,083,820 4,083,820 0 0 0 90.02 09000 BEHAVI ORAL HEALTH 916,575 916,575 0 0 0 91.00 09100 EMERGENCY 6,039,845 6,039,845 0 0 0 92.00 09200 DESERVATION BEDS (NON-DI STINCT PART) 2,036,836 2,036,836 0 0 0 91.00 09100 EMERGENCY 3,223,155 3,223,155 0 0 0 92.00 092000 DESERVATION BEDS (NON-DI STINCT PART) 2,036,836 2,036,836 0 0 01.00 HOME HEALTH AGENCY 3,223,155 3,223,155	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT					0	71.00
73.00 07300 DRUGS CHARGED TO PATI ENTS 5, 025, 572 0 0 0UTPATI ENT SERVICE COST CENTERS 5, 025, 572 0 0 0 88.00 08800 RURAL HEALTH CLINIC 2, 046, 394 2, 046, 394 0 0 90.00 09000 CLINIC 4, 083, 820 4, 083, 820 0 0 90.10 09001 WOUND CLINC 643, 138 643, 138 0 0 90.02 09002 BEHAVI ORAL HEALTH 916, 575 916, 575 0 0 91.00 09100 EMERGENCY 6, 039, 845 6, 039, 845 0 0 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 2, 036, 836 2, 036, 836 0 0 07HER REI MBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY 3, 223, 155 3, 223, 155 0 101.00 HOME HEALTH 3, 223, 155 3, 223, 155 0 0	72.00 07200 IMPL. DEV. CHARGED TO PATIENT					0	72.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 2,046,394 0 0 90.00 09000 CLINIC 4,083,820 4,083,820 0 0 90.01 09001 WOUND CLINC 643,138 643,138 0 0 90.02 09002 BEHAVI ORAL HEALTH 916,575 916,575 0 0 91.00 09100 EMERGENCY 6,039,845 0 0 0 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 2,036,836 2,036,836 0 0 0THER REI MBURSABLE COST CENTERS 101.00 HOME HEALTH AGENCY 3,223,155 3,223,155 0						0	73.00
88.00 08800 RURAL HEALTH CLINIC 2,046,394 0 0 90.00 09000 CLINIC 4,083,820 4,083,820 0 0 90.01 09001 WOUND CLINC 643,138 643,138 0 0 90.02 09002 BEHAVI ORAL HEALTH 916,575 916,575 0 0 91.00 09100 EMERGENCY 6,039,845 6,039,845 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2,036,836 2,036,836 0 0 0THER REI MBURSABLE COST CENTERS 3,223,155 3,223,155 0 0	OUTPATIENT SERVICE COST CENTERS	· · · ·					1
90.01 09001 WOUND CLINC 643, 138 643, 138 0 0 90.02 09002 BEHAVI ORAL HEALTH 916, 575 916, 575 0 0 91.00 09100 EMERGENCY 6, 039, 845 6, 039, 845 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 036, 836 2, 036, 836 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 910.00 10100 HOME HEALTH AGENCY 3, 223, 155 0 0		2, 046, 394		2,046,39	4 0	0	88. 00
90. 01 09001 WOUND CLINC 643, 138 643, 138 0 0 90. 02 09002 BEHAVI ORAL HEALTH 916, 575 916, 575 0 0 91. 00 09100 EMERGENCY 6, 039, 845 6, 039, 845 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 2, 036, 836 2, 036, 836 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0100 HOME HEALTH AGENCY 3, 223, 155 3, 223, 155 0	90. 00 09000 CLINIC	4, 083, 820		4, 083, 82	0 0	0	90.00
90. 02 09002 BEHAVI ORAL HEALTH 916, 575 0 0 0 91. 00 09100 EMERGENCY 6, 039, 845 6, 039, 845 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 2, 036, 836 2, 036, 836 0 0 0THER REI MBURSABLE COST CENTERS 3, 223, 155 3, 223, 155 0 0 101. 00 HOME HEALTH AGENCY 3, 223, 155 0 0	90.01 09001 WOUND CLINC					0	90.01
91.00 09100 EMERGENCY 6, 039, 845 6, 039, 845 0 0 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 2, 036, 836 2, 036, 836 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 101.00 HOME HEALTH AGENCY 3, 223, 155 3, 223, 155 0 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0	90. 02 09002 BEHAVI ORAL HEALTH					0	90.02
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 2, 036, 836 2, 036, 836 0 0THER REI MBURSABLE COST CENTERS 0						0	91.00
OTHER REI MBURSABLE COST CENTERS 101. 00 HOME HEALTH AGENCY 3, 223, 155 3, 223, 155 0 SPECI AL PURPOSE COST CENTERS						0	92.00
101. 00 10100 HOME HEALTH AGENCY 3, 223, 155 3, 223, 155 0 SPECI AL PURPOSE COST CENTERS		, _, _, _, _,,			-	-	
SPECIAL PURPOSE COST CENTERS		3 223 155		3 223 15	5	0	101.00
		0,220,100		0,220,10		Ŭ	1.0.1.00
							113.00
116. 00 11600 HOSPICE 1, 686, 963 1, 686, 963 0		1 686 963		1 686 96	3	0	116.00
							200.00
							201.00
							201.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1329	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/31/2020 7:5	epared: 54 am
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	4, 525, 566		4, 525, 5	66		30.0
31. 00 03100 I NTENSI VE CARE UNI T	599, 436		599, 4	36		31.00
13. 00 04300 NURSERY	2, 121, 655		2, 121, 6	55		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 815, 984	5, 780, 383	7, 596, 3		0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	192, 632	31, 549			0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 427, 167	76, 326, 864	77, 754, 0	31 0. 219592	0.00000	
50. 00 06000 LABORATORY	2, 929, 814	32, 579, 446	35, 509, 2		0.00000	
50. 01 06001 BLOOD LABORATORY	0	0		0 0. 000000	0.00000	
55. 00 06500 RESPI RATORY THERAPY	2, 921, 460	1, 554, 913	4, 476, 3		0.000000	
56. 00 06600 PHYSI CAL THERAPY	186, 235	4, 495, 310	4, 681, 5	45 0. 513488	0.00000	66.0
57.00 06700 OCCUPATI ONAL THERAPY	110, 442	1, 133, 661	1, 244, 1		0.00000	
58.00 06800 SPEECH PATHOLOGY	65, 470	635, 426	700, 8		0.00000	
59. 00 06900 ELECTROCARDI OLOGY	342, 348	5, 112, 195	5, 454, 5		0.00000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 571, 756	10, 082, 430			0.00000	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 067, 775	1, 086, 262	2, 154, 0		0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 714, 317	10, 181, 571	13, 895, 8	88 0. 361659	0.00000) 73.C
OUTPATIENT SERVICE COST CENTERS	i					
38.00 08800 RURAL HEALTH CLINIC	0	1, 610, 847	1, 610, 8			88.0
20. 00 09000 CLINIC	500	6, 027, 927	6, 028, 4		0.00000	
20. 01 09001 WOUND CLINC	0	1, 504, 455	1, 504, 4		0.00000	
20. 02 09002 BEHAVI ORAL HEALTH	0	272, 155	272, 1		0.000000	
91.00 09100 EMERGENCY	411, 770	13, 838, 175			0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	74, 696	2, 572, 584	2, 647, 2	80 0. 769407	0.00000	92.0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	1, 974, 191	1, 974, 1	91		101. C
SPECIAL PURPOSE COST CENTERS			1			l
13.00 11300 INTEREST EXPENSE						113.0
16. 00 11600 H0SPI CE	0	3, 031, 071	3, 031, 0			116. (
200.00 Subtotal (see instructions)	26, 079, 023	179, 831, 415	205, 910, 4	38		200.0
201.00 Less Observation Beds						201.0
202.00 Total (see instructions)	26, 079, 023	179, 831, 415	205, 910, 4	38		202.0

Hearth Financial Systems Man	RGARET MARY COMMU	INTER HUSPITAL	. In Lieu	I OT FORM CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1329	Peri od:	Worksheet C	
			From 01/01/2019	Part I	
			To 12/31/2019	Date/Time Pre	epared:
		THE NAME	11	8/31/2020 7:5	54 am
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 I NTENSI VE CARE UNI T					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 RESPI RATORY 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	0.000000				/3.00
88.00 08800 RURAL HEALTH CLINIC					88.00
90. 00 09000 CLINIC	0. 000000				90.00
90. 01 09001 WOUND CLINC	0.000000				90.00
90. 02 09002 BEHAVI ORAL HEALTH	0.000000				90.02
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00
OTHER REIMBURSABLE COST CENTERS	1				1.0.1.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS	1				1.1.0.05
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

MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/31/2020 7:5	pared: 4 am
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description		Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj.		Di sal I owance		
	B, Part I,					
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 03000 ADULTS & PEDIATRICS	8, 233, 117		8, 233, 11		8, 233, 117	
31. 00 03100 I NTENSI VE CARE UNI T	749, 973		749, 97			
43.00 04300 NURSERY	1, 240, 360		1, 240, 36	0 0	1, 240, 360	43.00
ANCI LLARY SERVICE COST CENTERS	0.000 (07		0.000.00	-	0.000 (07	
50. 00 05000 OPERATING ROOM	3, 932, 627		3, 932, 62			
52. 00 05200 DELIVERY ROOM & LABOR ROOM	352, 841		352, 84		352, 841	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	17,074,202		17,074,20		17,074,202	
60. 00 06000 LABORATORY	6, 440, 809		6, 440, 80		6, 440, 809	
60. 01 06001 BLOOD LABORATORY	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	1, 458, 908	0	.,,		1, 458, 908	
66.00 06600 PHYSI CAL THERAPY	2, 403, 919	0	2, 403, 91		2, 403, 919	
67.00 06700 OCCUPATI ONAL THERAPY	713, 911	0	713, 91		713, 911	
68.00 06800 SPEECH PATHOLOGY	434, 093	0	434, 09		434, 093	
69. 00 06900 ELECTROCARDI OLOGY	1, 551, 304		1, 551, 30		1, 551, 304	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 535, 925		3, 535, 92		3, 535, 925	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	1, 481, 284		1, 481, 28		1, 481, 284	
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 025, 572		5, 025, 57	2 0	5, 025, 572	73.00
OUTPATIENT SERVICE COST CENTERS				-		
88.00 08800 RURAL HEALTH CLINIC	2,046,394		2, 046, 39			
90. 00 09000 CLINIC	4, 083, 820		4, 083, 82		4, 083, 820	
90.01 09001 WOUND CLINC	643, 138		643, 13		643, 138	
90. 02 09002 BEHAVI ORAL HEALTH	916, 575		916, 57		916, 575	
91. 00 09100 EMERGENCY	6, 039, 845		6, 039, 84		6, 039, 845	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 036, 836		2, 036, 83	6	2, 036, 836	92.00
OTHER REIMBURSABLE COST CENTERS						
101.0010100 HOME HEALTH AGENCY	3, 223, 155		3, 223, 15	5	3, 223, 155	101.00
SPECIAL PURPOSE COST CENTERS			1			
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPI CE	1, 686, 963		1, 686, 96		1, 686, 963	
200.00 Subtotal (see instructions)	75, 305, 571	0				
201.00 Less Observation Beds	2, 036, 836		2, 036, 83		2, 036, 836	
202.00 Total (see instructions)	73, 268, 735	0	73, 268, 73	5 0	73, 268, 735	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1329	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/31/2020 7:5	epared: 54 am
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	4, 525, 566		4, 525, 5	66		30.0
31. 00 03100 I NTENSI VE CARE UNI T	599, 436		599, 4	36		31.0
13. 00 04300 NURSERY	2, 121, 655		2, 121, 6	55		43.0
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 815, 984	5, 780, 383	7, 596, 3		0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	192, 632	31, 549	224, 1	81 1. 573911	0.00000	52.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 427, 167	76, 326, 864	77, 754, 0	31 0. 219592	0.00000	
50. 00 06000 LABORATORY	2, 929, 814	32, 579, 446	35, 509, 2		0.00000	
50. 01 06001 BLOOD LABORATORY	0	0		0 0. 000000	0.00000	
55. 00 06500 RESPI RATORY THERAPY	2, 921, 460	1, 554, 913			0.00000	
56. 00 06600 PHYSI CAL THERAPY	186, 235	4, 495, 310	4, 681, 5	45 0. 513488	0.00000	66.0
57.00 06700 OCCUPATIONAL THERAPY	110, 442	1, 133, 661	1, 244, 1	03 0. 573836	0.00000	
58.00 06800 SPEECH PATHOLOGY	65, 470	635, 426	700, 8	96 0. 619340	0.00000	68.0
59. 00 06900 ELECTROCARDI OLOGY	342, 348	5, 112, 195	5, 454, 5		0.00000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 571, 756	10, 082, 430			0.00000	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 067, 775	1, 086, 262	2, 154, 0	37 0. 687678	0.00000	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 714, 317	10, 181, 571	13, 895, 8	88 0. 361659	0.00000	73.0
OUTPATIENT SERVICE COST CENTERS						
38.00 08800 RURAL HEALTH CLINIC	0	1, 610, 847			0.00000	
20. 00 09000 CLINIC	500	6, 027, 927	6, 028, 4		0.00000	
PO. 01 09001 WOUND CLINC	0	1, 504, 455	1, 504, 4		0.00000	
20. 02 09002 BEHAVI ORAL HEALTH	0	272, 155	272, 1	55 3. 367842	0.00000	
91.00 09100 EMERGENCY	411, 770	13, 838, 175			0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	74, 696	2, 572, 584	2, 647, 2	80 0. 769407	0.00000	92.0
OTHER REIMBURSABLE COST CENTERS			1			
101.00 10100 HOME HEALTH AGENCY	0	1, 974, 191	1, 974, 1	91		101. C
SPECIAL PURPOSE COST CENTERS	1		1			
13.00 11300 INTEREST EXPENSE						113. (
116. 00 11600 HOSPI CE	0	3, 031, 071				116. (
200.00 Subtotal (see instructions)	26, 079, 023	179, 831, 415	205, 910, 4	38		200.0
201.00 Less Observation Beds						201.0
202.00 Total (see instructions)	26, 079, 023	179, 831, 415	205, 910, 4	38		202.0

Health Financial Systems MA	RGARET MARY COMMU	INI TY HOSPI TAL	In Lieu	」of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1329	Peri od:	Worksheet C	
			From 01/01/2019	Part I	
			To 12/31/2019	Date/Time Pre 8/31/2020 7:5	
		Title XIX	Hospi tal	Cost	<u>04 alli</u>
Cost Center Description	PPS Inpatient		nospitui	0031	
	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					1
50. 00 05000 OPERATI NG 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 RESPI RATORY 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					1
88.00 08800 RURAL HEALTH CLINIC	0.000000				88.00
90. 00 09000 CLINIC	0. 000000				90.00
90.01 09001 WOUND CLINC	0. 000000				90.01
90. 02 09002 BEHAVI ORAL HEALTH	0. 000000				90.02
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				1
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

Health Financial Systems MAI	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period:	Worksheet D	
				From 01/01/2019 To 12/31/2019		norod.
				To 12/31/2019	Date/Time Pre 8/31/2020 7:5	pareu: 4 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1		I			
50.00 05000 OPERATING ROOM	362, 424				27, 592	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	76, 261				0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 299, 096				9, 157	54.00
60. 00 06000 LABORATORY	296, 844				8, 182	
60.01 06001 BLOOD LABORATORY	0	-	0. 00000		0	60.01
65. 00 06500 RESPI RATORY THERAPY	173, 323				57, 930	65.00
66. 00 06600 PHYSI CAL THERAPY	339, 965					
67.00 06700 OCCUPATI ONAL THERAPY	72, 996					67.00
68.00 06800 SPEECH PATHOLOGY	64, 612				4, 294	
69.00 06900 ELECTROCARDI OLOGY	163, 534					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	78, 552					
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	148, 263					72.00
73.00 07300 DRUGS CHARGED TO PATI ENTS	109, 597	13, 895, 888	0.00788	7 1, 352, 554	10, 668	73.00
OUTPATIENT SERVICE COST CENTERS	L					
88.00 08800 RURAL HEALTH CLINIC	109, 898				0	88.00
90. 00 09000 CLINIC	871, 308				0	90.00
90. 01 09001 WOUND CLINC	44, 960				0	90.01
90. 02 09002 BEHAVI ORAL HEALTH	94, 219				0	90.02
91. 00 09100 EMERGENCY	620, 854				340	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	276, 741					92.00
200.00 Total (lines 50 through 199)	5, 203, 447	193, 658, 519	l	7, 102, 527	182, 636	200.00

Health Financial Systems MA	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-1329	Period: From 01/01/2019	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2019		pared:
					8/31/2020 7:5	4 am
			XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician		Nursing		Allied Health	
	Anestheti st	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
	1.00	Adjustments 2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS	1.00	ZA	2.00	3A	3.00	
50. 00 05000 OPERATING ROOM	0	0		0	0	50.00
52. 00 05200 DELIVERY 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	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01
65.00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	-	-	1		-	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 WOUND CLINC	0	0		0 0	0	90.01 90.02
90. 02 09002 BEHAVI ORAL HEALTH 91. 00 09100 EMERGENCY	0	0		0 0	0	90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		91.00
200.00 Total (lines 50 through 199)	0			0 0	-	200.00
	1 0	0	I		1 0	200.00

Health Financial Systems M	ARGARET MARY CON	MUNITY HOSPITA	L	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	ERVICE OTHER PAS	S Provider C		Period: From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 7, 596, 367		•
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 224, 181	0. 000000	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 77, 754, 031	0.000000	54.00
60. 00 06000 LABORATORY	0	0		0 35, 509, 260	0.000000	60.00
60.01 06001 BLOOD LABORATORY	0	0		0 0	0.000000	60.01
65. 00 06500 RESPI RATORY THERAPY	0	0		0 4, 476, 373		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 4, 681, 545	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 244, 103		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 700, 896	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 5, 454, 543	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 13, 654, 186		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 2, 154, 037	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 13, 895, 888	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 1, 610, 847	0.000000	88.00
90. 00 09000 CLINIC	0	0		0 6, 028, 427	0.000000	90.00
90. 01 09001 WOUND CLINC	0	0		0 1, 504, 455	0.000000	
90. 02 09002 BEHAVI ORAL HEALTH	0	0		0 272, 155	0.000000	90.02
91. 00 09100 EMERGENCY	0	0		0 14, 249, 945	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 2, 647, 280		•
200.00 Total (lines 50 through 199)	0	0	1	0 193, 658, 519		200.00

Health Financial Systems MA	RGARET MARY COMM	UNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2019 To 12/31/2019		narod
				10 12/31/2019	8/31/2020 7:5	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	T		1			
50.00 05000 OPERATING ROOM	0. 000000	578, 322		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	548, 090		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	978, 706		0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 496, 131		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	117, 664		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	75, 111		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	46, 581		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	158, 000		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 161, 393		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	581, 247		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 352, 554		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01 09001 WOUND CLINC	0. 000000	0		0 0	0	90.01
90. 02 09002 BEHAVI ORAL HEALTH	0. 000000	0		0 0	0	90.02
91.00 09100 EMERGENCY	0. 000000	7, 810		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	918		0 0	0	92.00
200.00 Total (lines 50 through 199)		7, 102, 527		0 0	0	200.00

Health Financial Systems MA	RGARET MARY CON	IMUNITY HOSPITA	L	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period: From 01/01/2019 To 12/31/2019		
		Title	× XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 517698	0	1, 366, 96	7 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 573911	0	7,96	8 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 219592	0	26, 055, 78	1 8, 021	0	54.00
60. 00 06000 LABORATORY	0. 181384	0	9, 997, 87	9 0	0	60.00
60.01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0. 325913	0	452, 19	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 513488	0	1, 462, 41	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 573836	0	220, 64	5 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 619340	0	65, 57	6 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 284406	0	1, 885, 85	4 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 258963	0	2, 748, 50	6 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 687678	0	357,07	3 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 361659	l o	3, 585, 06	6 1, 250	0	73.00
OUTPATIENT SERVICE COST CENTERS			•			1
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
90. 00 09000 CLINIC	0. 677427	0	2,034,16	6 14	0	90.00
90.01 09001 WOUND CLINC	0. 427489	0	463,06	3 0	0	90.01
90. 02 09002 BEHAVI ORAL HEALTH	3. 367842	0	32, 61	1 3	0	90.02
91.00 09100 EMERGENCY	0. 423850		3, 529, 29		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 769407	0	782, 16		0	92.00
200.00 Subtotal (see instructions)		0	55, 047, 21		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)		o	55, 047, 21	6 9, 288	0	202.00

Health Financial Systems MA	RGARET MARY CON	IMUNI TY HOSPI TA	L	In Lieu	ı of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider CO	CN: 15-1329	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pro 8/31/2020 7:1	epared: 54 am
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				_
ANCI LLARY SERVI CE COST CENTERS	707 (7)					50.00
50. 00 05000 OPERATING ROOM	707, 676					50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	12, 541	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 721, 641	1, 761	1			54.00
60. 00 06000 LABORATORY	1, 813, 455					60.00
60. 01 06001 BLOOD LABORATORY	0	-				60.01
65. 00 06500 RESPI RATORY THERAPY	147, 375					65.00
66.00 06600 PHYSI CAL THERAPY	750, 930					66.00
67.00 06700 OCCUPATI ONAL THERAPY	126, 614					67.00
68.00 06800 SPEECH PATHOLOGY	40, 614	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	536, 348					69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	711, 761	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	245, 551					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 296, 571	452				73.00
		0				
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC	0	0				88.00 90.00
90. 01 09000 CLINIC 90. 01 09001 WOUND CLINC	1, 377, 999					90.00
	197, 954	-				
90. 02 09002 BEHAVI ORAL HEALTH 91. 00 09100 EMERGENCY	109,829					90.02 91.00
	1, 495, 893		•			91.00
	601,802					
200.00Subtotal (see instructions)201.00Less PBP Clinic Lab. Services-Program	15, 894, 554	2, 232				200.00 201.00
Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	15, 894, 554	2, 232				202.00
202.00 [Net charges (The 200 - The 201)	15, 674, 554	2,232	I			1202.00

MARGARET MARY COMMUNITY HOSPITAL

leal th	Financial Systems MARGARET MARY COMMUN	NETY HOSPITAL	In Lie	u of Form CMS-2	2552-1
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1329	Peri od:	Worksheet D-1	
			From 01/01/2019 To 12/31/2019		nared
			10 12/01/2017	8/31/2020 7:5	
		Title XVIII	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
. 00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		4, 992	1.0
. 00	Inpatient days (including private room days, excluding swing-			4, 992	
. 00	Private room days (excluding swing-bed and observation bed da	ys). If you have only p	orivate room days,	0	3.0
. 00	do not complete this line.			2 757	4.0
. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		per 31 of the cost	3, 757 0	
. 00	reporting period			Ū	
. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	⁻ 31 of the cost	0	6.0
	reporting period (if calendar year, enter 0 on this line)			_	
. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through Decembe	er 31 of the cost	0	7.0
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8.0
. 00	reporting period (if calendar year, enter 0 on this line)	all days) at ter becember		0	0.0
9.00	Total inpatient days including private room days applicable t	o the Program (excludir	ng swing-bed and	1, 572	9.0
0 00	newborn days) (see instructions)				10.0
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	0	10.0
1.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room davs) after	0	11.0
	December 31 of the cost reporting period (if calendar year, e				
2.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	ate room days)	0	12.0
2 00	through December 31 of the cost reporting period	V oply (i polyding prive	to room dovo)	0	12 0
3.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.0
4.00	Medically necessary private room days applicable to the Progr			0	14. C
5.00	Total nursery days (title V or XIX only)	(0	
6.00	Nursery days (title V or XIX only)			0	16.0
	SWING BED ADJUSTMENT		<u> </u>		1 4 7 6
7.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost		17.0
8.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	f the cost		18.0
0.00	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 d	of the cost	0.00	19.0
0 00	reporting period	a after December 21 of	the east	0.00	20.0
0.00	Medicaid rate for swing-bed NF services applicable to service reporting period	is after beceniber 31 01	the cost	0.00	20.0
1.00	Total general inpatient routine service cost (see instruction	s)		8, 233, 117	21.0
2.00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		
	5 x line 17)			_	
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost report	ng period (line e	0	23.0
4 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ting period (line	0	24.0
1.00	7 x line 19)		ting period (inite	0	21.0
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reportir	ng period (line 8	0	25.0
	x line 20)			_	
26.00	Total swing-bed cost (see instructions)	(Line 21 minus Line 24)		0 222 117	
7.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus the 26))	8, 233, 117	27.0
8.00	General inpatient routine service charges (excluding swing-be	d and observation bed o	charges)	0	28.0
9.00	Private room charges (excluding swing-bed charges)		5.00	0	
0.00	Semi-private room charges (excluding swing-bed charges)			0	
1.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
2.00 3.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
4.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	uctions)	0.00	
5.00	Average per diem private room cost differential (line 34 x li			0.00	
6.00	Private room cost differential adjustment (line 3 x line 35)			0	36.0
7.00	General inpatient routine service cost net of swing-bed cost	and private room cost o	differential (line	8, 233, 117	37.0
	27 minus line 36)				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			-
8.00	Adjusted general inpatient routine service cost per diem (see			1, 649. 26	38.0
9.00	Program general inpatient routine service cost (line 9 x line	-		2, 592, 637	
0.00	Medically necessary private room cost applicable to the Progr	. ,		0	
	Total Program general inpatient routine service cost (line 39	+ line 4())		2, 592, 637	1410

IPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1329	Period:	Worksheet D-1	1
				From 01/01/2019 To 12/31/2019		epare
					8/31/2020 7:5	
Cost Center Description	Total		XVIII Average Per	Hospital Program Days	Cost Program Cost	
cost center beschiption	Inpatient	Inpatient	Diem (col. 1	Trogram Days	(col. 3 x	
	Cost	Days	÷ col. 2)		col. 4)	
	1.00	2.00	3.00	4.00	5.00	
00 NURSERY (title V & XIX only)	0	0	0.00	0 0	0) 42
Intensive Care Type Inpatient Hospital Unit 00 INTENSIVE CARE UNIT	s 749, 973	277	2, 707. 4	3 152	411, 537	43
00 CORONARY CARE UNIT	149,913	211	2,707.40	152	411, 537	43
00 BURN INTENSIVE CARE UNIT						45
00 SURGICAL INTENSIVE CARE UNIT						46
00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description						
00 0		11			1.00	10
00 Program inpatient ancillary service cost (W 00 Total Program inpatient costs (sum of lines			2006)		2, 455, 836	
PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruction	505)		5, 460, 010	49
00 Pass through costs applicable to Program in	patient routine	services (fro	m Wkst. D. sum	of Parts L and	0	50
)					Ī	
00 Pass through costs applicable to Program in	patient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	0	51
and IV)					-	
00 Total Program excludable cost (sum of lines					0	
00 Total Program inpatient operating cost excl medical education costs (line 49 minus line		nateu, non-ph	ysician anestr	erist, and	0	53
TARGET AMOUNT AND LIMIT COMPUTATION	52)					
00 Program di scharges					0	54
00 Target amount per discharge					0.00	55
00 Target amount (line 54 x line 55)					0	56
00 Difference between adjusted inpatient opera	ting cost and ta	rget amount (line 56 minus	line 53)	0	
00 Bonus payment (see instructions)					0	
00 Lesser of lines 53/54 or 55 from the cost r market basket	eporting period	endi ng 1996,	updated and co	mpounded by the	0.00	59
00 Lesser of lines 53/54 or 55 from prior year	cost report un	dated by the	market basket		0.00	60
00 If line 53/54 is less than the lower of lin				the amount by	0.00	
which operating costs (line 53) are less th					-	
amount (line 56), otherwise enter zero (see	instructions)			0		
00 Relief payment (see instructions)					0	
00 Allowable Inpatient cost plus incentive pay	ment (see instru	ictions)			0	63
PROGRAM INPATIENT ROUTINE SWING BED COST 00 Medicare swing-bed SNF inpatient routine cc	sts through Dece	mber 31 of th	a cost reporti	na period (See	0	64
instructions)(title XVIII only)	St3 through bece		e cost reporti	ng period (see	Ĭ	/ 04
00 Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the	cost reporting	period (See	0	65
instructions)(title XVIII only)						
00 Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVII	l only). For	0	66
CAH (see instructions)	no costs through	December 21	of the cost re	porting poriod	0	47
00 Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through	December 31	of the cost re	porting period	0	67
00 Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost repo	ortina period	l o	68
(line 13 x line 20)				5 1 2		
00 Total title V or XIX swing-bed NF inpatient					0	69
PART III - SKILLED NURSING FACILITY, OTHER						1 70
00 Skilled nursing facility/other nursing faci	5		. ,			70
00 Adjusted general inpatient routine service 00 Program routine service cost (line 9 x line		ine /0 ÷ ine	2)			71
00 Medically necessary private room cost appli		(line 14 x l	ine 35)		1	73
00 Total Program general inpatient routine ser	, C	•	,		1	74
00 Capital-related cost allocated to inpatient				Part II, column	l	75
26, line 45)						
00 Per diem capital -related costs (line 75 ÷ 1					l	76
00 Program capital-related costs (line 9 x lin 00 Inpatient routine service cost (line 74 min					l -	77
00 Inpatient routine service cost (line 74 min 00 Aggregate charges to beneficiaries for exce		rovi der recor	ds)		1	78
00 Total Program routine service costs for com	· · ·			us line 79)	1	80
00 Inpatient routine service cost per diem lim	•		, <u>.</u>	/	l	81
00 Inpatient routine service cost limitation ()			l	82
00 Reasonable inpatient routine service costs	(see instruction	s)			l	83
00 Program inpatient ancillary services (see i					1	84
00 Utilization review - physician compensation						85
00 Total Program inpatient operating costs (su		rough 85)			1	86
PART IV - COMPUTATION OF OBSERVATION BED PA					1, 235	87
					1,230	, 0/
00 Total observation bed days (see instruction 00 Adjusted general inpatient routine cost per		line 2)			1, 649. 26	88

Health Financial Systems MAR	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 118, 620	8, 233, 117	0. 13586	8 2, 036, 836	276, 741	90.00
91.00 Nursing School cost	0	8, 233, 117	0.00000	0 2, 036, 836	0	91.00
92.00 Allied health cost	0	8, 233, 117	0.00000	0 2, 036, 836	0	92.00
93.00 All other Medical Education	0	8, 233, 117	0.00000	0 2, 036, 836	0	93.00

MARGARET MARY COMMUNITY HOSPITAL

artn	Financial Systems MARGARET MARY COMMUN	NI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-
OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1329	Period:	Worksheet D-1	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	pare
			10 12/31/2017	8/31/2020 7:5	
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
00	INPATIENT DAYS			4.000	
00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			4, 992 4, 992	
00	Private room days (excluding swing-bed and observation bed da		rivate room davs	4, 772	
00	do not complete this line.	ys). Thiyou have only p	firvate room days,	0	J.
00	Semi-private room days (excluding swing-bed and observation b	ed days)		3, 757	4.
00	Total swing-bed SNF type inpatient days (including private ro		per 31 of the cost		
	reporting period	<i>,</i> , ,			
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	er 31 of the cost	0	7.
~~	reporting period				
00	Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line)	a the Dreaman (avaludin	a owing bod and	00	9.
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excrudin	ig swillig-bed allu	88	9.
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private	room days)	0	10.
	through December 31 of the cost reporting period (see instruc			0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)	•		
2. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	ate room days)	0	12
	through December 31 of the cost reporting period				
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
00	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this li	ne)	0	11
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	i days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			945 0	
. 00	SWING BED ADJUSTMENT			0	1 10
. 00	Medicare rate for swing-bed SNF services applicable to servic	res through December 31	of the cost		17
. 00	reporting period	es through becomber of			''
. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	f the cost		18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 c	of the cost	0.00	19
~ ~	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction			8, 233, 117	21
	Swing-bed cost applicable to SNF type services through Decemb		ting poriod (ling		
. 00	5 x line 17)	iel 31 01 the cost repor	ting period (inte	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	na period (line 6	0	23
	x line 18)		5 T T T T		
. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	0	24
	7 x line 19)				
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportir	ng period (line 8	0	25
00	x line 20)			-	
. 00	Total swing-bed cost (see instructions)	(Line 21 minute Line 24)		0 000 117	
00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTHE 21 MITHUS TTHE 20)		8, 233, 117	27
. 00	General inpatient routine service charges (excluding swing-be	d and observation bed o	harges)	0	28
. 00	Private room charges (excluding swing-bed charges)		shar goo)	0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 mi		uctions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost c	urrerential (line	8, 233, 117	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
. 00	Adjusted general inpatient routine service cost per diem (see			1, 649. 26	38
	Program general inpatient routine service cost (line 9 x line			145, 135	
. 00					
	Medically necessary private room cost applicable to the Progr			0	40

MPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	u of Form CMS- Worksheet D-1	
				From 01/01/2019 To 12/31/2019	Date/Time Pre	epare
			e XIX	Hospi tal	8/31/2020 7:5 Cost	54 am
Cost Center Description	Total Inpatient	Total I npati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
	<u>Cost</u> 1.00	<u>Days</u> 2.00	÷ col. 2) 3.00	4.00	<u>col. 4)</u> 5.00	
.00 NURSERY (title V & XIX only)	1, 240, 360	945				42.
Intensive Care Type Inpatient Hospital Units	740.070	077	0.707.4	o	40.050	
. OO INTENSIVE CARE UNIT . OO CORONARY CARE UNIT	749, 973	277	2, 707. 4	8 /	18, 952	2 43.
. OO BURN I NTENSI VE CARE UNI T						45.
. 00 SURGI CAL I NTENSI VE CARE UNI T						46.
. 00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
·					1.00	
. 00 Program inpatient ancillary service cost (Wk					196, 819	
.00 Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)((see instruction	ons)		360, 906	49.
. 00 Pass through costs applicable to Program input	atient routine	services (from	m Wkst. D, sur	n of Parts I and	0	50.
.00 Pass through costs applicable to Program inp. and IV)	atient ancillar	ry services (fi	rom Wkst. D, s	sum of Parts II	0) 51.
.00 Total Program excludable cost (sum of lines	50 and 51)				0	52
.00 Total Program inpatient operating cost exclu		elated, non-ph	ysician anestł	netist, and	C	53.
medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)				<u> </u>	1
. 00 Program di scharges					0	54
.00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55) .00 Difference between adjusted inpatient operat	ing cost and to	arget amount (lino E4 minuc	Lino E2)		
. 00 Bonus payment (see instructions)	Thy Cost and ta	arget anount (TTTE SO INTIUS	TTHE 55)		
.00 Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, i	updated and co	ompounded by the		
market basket	anat rapart ur	datad by the	narkat baakat		0.00	
.00 Lesser of lines 53/54 or 55 from prior year .00 If line 53/54 is less than the lower of line				the amount by	0.00 0	
which operating costs (line 53) are less that						
amount (line 56), otherwise enter zero (see	instructions)			-		
.00 Relief payment (see instructions) .00 Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)				
PROGRAM INPATIENT ROUTINE SWING BED COST						
.00 Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	C	64
instructions)(title XVIII only) .00 Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the (cost reporting	n period (See	C	65
instructions)(title XVIII only)					-	
.00 Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66
.00 Title V or XIX swing-bed NF inpatient routing	e costs through	n December 31 (of the cost re	eporting period	C	67
(line 12 x line 19)	0					
.00 Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [December 31 of	the cost repo	orting period	0	68
.00 Total title V or XIX swing-bed NF inpatient	routine costs ((line 67 + line	e 68)		0	69
PART III - SKILLED NURSING FACILITY, OTHER NU					-	
.00 Skilled nursing facility/other nursing facil .00 Adjusted general inpatient routine service of	2		• •)		70
. 00 Program routine service cost (line 9 x line		The 70 ÷ The	2)			72
.00 Medically necessary private room cost applic	0	•				73
.00 Total Program general inpatient routine serv .00 Capital-related cost allocated to inpatient				Dart II column		74
.00 Capital-related cost allocated to inpatient 26, line 45)	Foutthe service		WOLKSHEEL D, H			15
.00 Per diem capital-related costs (line 75 ÷ li						76
.00 Program capital -related costs (line 9 x line	· ·					77
 .00 Inpatient routine service cost (line 74 minu: .00 Aggregate charges to beneficiaries for excess 		provi der i record	ds)			78
.00 Total Program routine service costs for comp				nus line 79)		80
.00 Inpatient routine service cost per diem limi						81
.00 Inpatient routine service cost limitation (I						82
 .00 Reasonable inpatient routine service costs (: .00 Program inpatient ancillary services (see in: 		13)				83
.00 Utilization review - physician compensation		ons)				85
. 00 Total Program inpatient operating costs (sum		nrough 85)				86
PART IV - COMPUTATION OF OBSERVATION BED PASS .00 Total observation bed days (see instructions					1, 235	87
. 00 Adjusted general inpatient routine cost per		÷line 2)			1, 649. 26	
	e instructions)				2, 036, 836	1 00

Health Financial Systems MAI	RGARET MARY CON	MUNI TY HOSPI TA	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
					8/31/2020 7:5	<u>4 am</u>
			e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		, i		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 118, 620	8, 233, 117	0. 13586	8 2, 036, 836	276, 741	90.00
91.00 Nursing School cost	0	8, 233, 117	0.00000	0 2, 036, 836	0	91.00
92.00 Allied health cost	0	8, 233, 117	0.00000	0 2, 036, 836	0	92.00
93.00 All other Medical Education	0	8, 233, 117	0.00000	0 2, 036, 836	0	93.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITA	L	In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
			From 01/01/2019 To 12/31/2019	Dato/Timo Dro	narod
			10 12/31/2019	Date/Time Pre 8/31/2020 7:5	
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			4 700 000		
30. 00 03000 ADULTS & PEDI ATRI CS			1, 789, 093		30.00
31. 00 03100 I NTENSI VE CARE UNI T			305, 236		31.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 51769	578, 322	299, 396	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		1. 57391		277, 370	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 21959		120, 356	
60. 00 06000 LABORATORY		0. 18138		177, 522	•
60. 01 06001 BLOOD LABORATORY		0. 00000		0	•
65. 00 06500 RESPI RATORY THERAPY		0. 32591		487,609	
66.00 06600 PHYSI CAL THERAPY		0. 51348		60, 419	
67.00 06700 OCCUPATI ONAL THERAPY		0. 57383	75, 111	43, 101	67.00
68.00 06800 SPEECH PATHOLOGY		0. 61934	46, 581	28, 849	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 28440	158, 000	44, 936	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	ſS	0. 25896	3 1, 161, 393	300, 758	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 68767		399, 711	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 36165	59 1, 352, 554	489, 163	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.00000		0	
90. 00 09000 CLINIC		0. 67742		0	
90. 01 09001 WOUND CLINC		0. 42748		0	,
90. 02 09002 BEHAVI ORAL HEALTH		3. 36784		0	
91.00 09100 EMERGENCY	E)	0. 42385		3, 310	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (sum of lines 50 through 94 a		0. 76940		706 2, 455, 836	
200.00 Total (sum of fines 50 through 94 a 201.00 Less PBP Clinic Laboratory Services			7, 102, 527	2, 400, 830	200.00
201.00 Less PBP Clinic Laboratory Services 202.00 Net charges (line 200 minus line 20			7, 102, 527		201.00
202.00 Inter charges (The 200 III hus The 20	<i>,</i> ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I	7, 102, 527		202.00

Health Financial Systems MARGARET MARY	COMMUNI TY HOSPI TA	L	In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1329	Peri od:	Worksheet D-3	
			From 01/01/2019 To 12/31/2019	Data/Tima Dra	narod
			10 12/31/2019	Date/Time Pre 8/31/2020 7:5	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati 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			01.00		
30.00 O3000 ADULTS & PEDIATRICS			31, 633		30.00
31.00 03100 I NTENSI VE CARE UNI T			6, 713		31.00
43.00 04300 NURSERY			71, 539		43.00
ANCI LLARY SERVI CE COST CENTERS		0. 5176	23, 272	12, 048	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		1. 5739		12, 048	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 21959		4, 566	•
60. 00 06000 LABORATORY		0. 2195		9, 772	
60. 01 06001 BLOOD LABORATORY		0. 00000		9,772	•
65. 00 06500 RESPI RATORY THERAPY		0. 3259		10, 631	
66. 00 06600 PHYSI CAL THERAPY		0. 51348		366	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 57383		147	
68. 00 06800 SPEECH PATHOLOGY		0. 61934		377	
69. 00 06900 ELECTROCARDI OLOGY		0. 28440		1, 942	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.25896		7,822	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 6876	6, 143	4, 224	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 36165	59 44, 304	16, 023	73.00
OUTPATIENT SERVICE COST CENTERS					1
88.00 08800 RURAL HEALTH CLINIC		1. 27038	34 0	0	88.00
90. 00 09000 CLINIC		0. 67742	27 119	81	90.00
90. 01 09001 WOUND CLINC		0. 42748	39 0	0	
90. 02 09002 BEHAVI ORAL HEALTH		3. 36784		0	
91.00 09100 EMERGENCY		0. 4238		7, 139	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 76940		0	
200.00 Total (sum of lines 50 through 94 and 96 through 9			313, 889	196, 819	
201.00 Less PBP Clinic Laboratory Services-Program only c	harges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			313, 889		202.00

CALCULATION OF RELIEVENENT SETTLEMENT Provider CX: B=1322 Period To Period To <th></th> <th>Financial Systems MARGARET MARY COMMUNIT ATION OF REIMBURSEMENT SETTLEMENT P</th> <th></th> <th></th> <th>u of Form CMS-2</th> <th>2552-10</th>		Financial Systems MARGARET MARY COMMUNIT ATION OF REIMBURSEMENT SETTLEMENT P			u of Form CMS-2	2552-10
Title 2011 Hespital Cnet 947 6 1.00 10 Med cal, and other services (see instructions) 15,895,786 1.00 10 Med cal, and other services (see instructions) 0 16,00 0 10 Med cal, and other services (see instructions) 0<	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	TOVI del CCN: 15-1329		Date/Time Pre	
Next n APPLICAL AND THRE LEAST IS STRUCTS 10 Medical and other services (see instructions) 15, 895, 786 1.00 2.00 Medical and other services releaves (see instructions) 0 0.00 2.00 Duttier payment (see instructions) 0 0.00 0.00 Duttiers (from West) 0 0 0 0.00 Duttiers (from West) 0 0 0 0 0.00 Duttiers (from West) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			Title XVIII	Hospi tal		4 am
Next n APPLICAL AND THRE LEAST IS STRUCTS 10 Medical and other services (see instructions) 15, 895, 786 1.00 2.00 Medical and other services releaves (see instructions) 0 0.00 2.00 Duttier payment (see instructions) 0 0.00 0.00 Duttiers (from West) 0 0 0 0.00 Duttiers (from West) 0 0 0 0 0.00 Duttiers (from West) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					1 00	
2.00 Well call and other services relativised under GPPS (see Instructions) 0 2 0 0.00 OPPS payments 0 <t< td=""><td></td><td>PART B - MEDICAL AND OTHER HEALTH SERVICES</td><td></td><td></td><td>1.00</td><td></td></t<>		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
3.00 DVPS payments 0 4.00 DVPS payments 0 4.00 DVPS payments 0 4.00 DVPS payments 0 0 4.00 DVPS payments 0			``````````````````````````````````````			
4.00 Outlier payment (see instructions) 0 4.01 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.00 0.00 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.00 0.00 5.00 Transit local corridor payment (see instructions) 0.00 0.00 6.00 Architery survice other pass through to costs from Wist. D. Pt. IV. col. 13, Linu 200 0.00 0.00 0.00 Organ acquisitions 15, 896, 786 11.00 0.00 Organ acquisitions charges 15, 896, 786 11.00 0.00 Organ acquisition charges (see instructions) 0 12.00 1.00 Organ acquisition charges (see instructions) 0 15.00 1.00 Total register down actually collected from gations liable for payment for services on a charge basis on instructions) 0 15.00 1.00 Register acoust actually collected from gations liable for payment for services on a charge basis on instructions) 0 15.00 1.00 Register acoust actually collected from gations liable for payment for services on a charge basis on instructions) 0 16.00 1.00 Register acoustal charges (see instructions) 0			ons)		-	
5.00 Enter the hospit file gayment to cost ratio (see instructions) 0.000 6.00 6.00 Line 2 times line 3 0.00 6.00 7.00 Sum of lines 3, 4, and 4, 0, divided by line 4 0.00 0.00 0.00 7.00 Sum of lines 3, 4, and 4, 0, divided by line 4 0.00 0.00 0.00 7.00 Sum of lines 1, 4, and 4, 0, divided by line 4 0.00 0.00 0.00 7.00 Sum of lines 1, and 100 (see instructions) 0.00 0.00 7.00 Coll divided by Coll Coll Coll Coll Coll Coll Coll Col		1.5				
6.00 Line 2 times 1 ines 3, 4, and 4.01, divided by line 6 0.00 0.00 10.01 Transitional corridor payment (see instructions) 0.00 0.00 11.00 Computational charges 0.00 0.00 0.00 0.00 11.00 Computation (see instructions) 0.00 <td></td> <td>, , ,</td> <td></td> <td></td> <td></td> <td></td>		, , ,				
2.00 Sam of lines 3, 4, and 4,01, divided by line 6 0.00 7.00 8.00 Transitional carried payment (see Instructions) 0.00 7.00 9.00 Ancillary service other pass through costs from (Kst. D. Pt. IV, coil 13, line 200 9.00 9.00 Ancillary service other pass through costs from (Kst. D. Pt. IV, coil 13, line 200 9.00 9.00 Maillary service other pass through costs from (Kst. D. Pt. IV, coil 13, line 200 9.00 9.00 Maillary service otherapes 15.996,778 11.00 9.00 Maillary service otherapes 0.10 12.00 Maillary service otherapes 0.10 9.00 Maillary service otherapes 0.00 13.00 13.00 13.00 9.00 Maintary service otherapes (from Wait Carp patients liable for payment for services on a charge basis nod otherapes (complete only if line 18 exceeds line 11) (see 0.00000 17.00 9.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see 0.00000 17.00 9.00 Excess of reasonable cost over customary charges (complete only if line 19.00 16.057,76 21.00 22.00 9.00 Excess of reasonable cost over customary charges (complete only if line 19.00 22.00 22.00			i ons)			
9.00 Ancl Hary service other pass through costs from West. D. Pt. IV, col. 13, line 200 0						
10.00 Organ acquisitions 0 10.00 10.00 10.00 10.00 10.00 Coll (sum of lines 1 and 10) (see instructions) 0 10.00 10.00 10.00 Coll (sum of lines 1 and 10) (see instructions) 0 10.00 10.00 Organ acquisition charges (ran within set 1 and 13) 0 12.00 10.00 Organ acquisition charges (ran of lines 12 and 13) 0 14.00 10.00 Acquisition charges (sum of lines 12 and 13) 0 14.00 10.00 Acquisition charges (sum of lines 12 and 13) 0 15.00 10.00 Acquisition charges (sum of lines 12 and 13) 0 16.00 10.00 Acquisition charges (sum of lines 12 and 13) 0 16.00 10.01 Total customery charges (see instructions) 0 0.000000 10.02 Instructions) 10.05, 754 21.00 10.01 Inters and calc dark (see instructions) 10.05, 754 21.00 10.02 Interts index (see instructions) 10.05, 754 21.00 10.01 Interts and calc and crimers and real dark (see instructions) 0 22.00 10.02 <td></td> <td>Transitional corridor payment (see instructions)</td> <td></td> <td></td> <td></td> <td></td>		Transitional corridor payment (see instructions)				
11.00 Total cost (sum of lines 1 and 10) (see instructions) 15,896,786 11.00 Community of our Lessen of Cost OF GHARGES Resonable charges 12.00 11.00 Resonable charges 11.00 12.00 12.00 11.00 14.00 Trust Service charges 11.00 12.00 11.00 14.00 Trust Service charges 11.00 10.00 10.00 15.00 Aggregate anount actually collected from patients liable for payment for services on a chargebasis 0 16.00 15.00 Aggregate anount actually collected from patients liable for payment for services on a chargebasis 0 16.00 16.00 Total collections of the collections 0 0.00000 17.00 17.00 Instructions 0 0.00000 17.00 0 19.00 Excess of customary charges over reasonable cost (complete only if line 11 exceeds line 11) (see instructions) 0 10.00 10.00 10.00 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 11) (see instructions) 0 22.00 0 0 0.00000 12.00 10.00 10.00 10.00 10.00 10.00			, col. 13, line 200			
COMPUTATION OF LESSER OF COST OF CHARGES Descense 12.00 Ancillary service charges 12.00 Stationary charges (run of lines 12 and 13) 14.00 Descense 15.00 Display charges (sum of lines 12 and 13) 14.00 Display charges (sum of lines 12 and 13) 14.00 Display charges (sum of lines 12 and 13) 16.00 Amain's that would have been realized from patients liable for payment for services on a charge basis 0 Display charges (see instructions) 0.00000 Display charges (see instructions) 0.00000 Display charges (see instructions) 16.00 Display charges (see instructions) 16.05, 784 Display charges (see instructions) 16.055, 784 Display charges (see instructions) 0 Display charges (see instructions) 0 Display charges services in a leaching basplat (see instructions) 0 Display charges services in a leaching basplat (see instructions) 0 Display charges services in a leaching basplat (see instructions) 122.00 Display charges services in a leaching basplat (see instructions) 22.00 Display		5 I			-	
12.00 Anciliary service charges 0 12.00 13.00 Organ acquisition charges (run of lines 12 and 13) 0 14.00 14.00 Dask charges (run of lines 12 and 13) 0 14.00 15.00 Aggregate anount actually collected from patients liable for payment for services on a charge basis 0 15.00 15.00 Aggregate anount actually collected from patients liable for payment for services on a charge basis 0 15.00 16.00 Accutation of line 15 to line 16 (not to exceed 1.00000) 0 0.00000 17.00 18.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0.00000 18.00 20.00 Excess of reasonable cost over customary charges (see instructions) 16.055,754 21.00 21.00 Excess of reasonable cost over customary charges (see instructions) 0 22.00 21.00 Excess of reasonable cost over customary charges (see instructions) 0 22.00 22.00 Excess of reasonable cost (sum of lines 3, 4, 4.01, 8 and 9) 22.00 22.00 Excess of reasonable cost (sum of lines 2 and 26) plus the sum of lines 22 and 23 (see instructions) 8.999,995 26.00 23.00 Excess of lines		COMPUTATION OF LESSER OF COST OR CHARGES				
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38.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)39.0039.00Demonstration payment adjustment (see instructions)39.5039.97Demonstration payment adjustment amount before sequestration039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)7, 500, 51840.00Subtotal (see instructions)150, 01040.01Sequestration adjustment (see instructions)040.02Demonstration payment adjustment amount after sequestration041.00Interim payments7, 782, 15441.00Interim payments41.0042.00Tentative settlement (for contractors use only)042.01Tentative settlement (for contractor use only)-431, 64643.00Balance due provi der/program (see instructions)43.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, sti15.244.0090.00Original outlier amount (see instructions)090.0091.00Dutlier reconciliation adjustment amount (see instructions)090.0092.00The rate used to calculate the Time Value of Money091.0092.00Time Value of Money (see instructions)092.0093.00Time Value of Money (see instructions)093.00		a i	ctions)			
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39. 97Demonstration payment adjustment amount before sequestration039. 9739. 98Partial or full credits received from manufacturers for replaced devices (see instructions)039. 9839. 99RECOVERY OF ACCELERATED DEPRECIATION039. 990.00Subtotal (see instructions)7, 500, 51840. 0040. 01Sequestration adjustment (see instructions)150, 01040. 0140. 02Demonstration payment adjustment amount after sequestration040. 0240. 03Sequestration adjustment-PARHM pass-throughs7, 782, 15441. 0041. 01Interim payments7, 782, 15441. 0142. 01Tentative settlement (for contractors use only)42. 0143. 01Bal ance due provi der/program (see instructions)-431, 64643. 0044. 00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,44. 0090. 00Original outlier amount (see instructions)090. 0091. 00Outlier reconciliation adjustment amount (see instructions)091. 0092. 00The rate used to calculate the Time Value of Money0. 0093. 0093. 00Time Value of Money (see instructions)093. 00		, , , ,			0	
39.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9839.99RECOVERY OF ACCELERATED DEPRECIATION039.9940.00Subtotal (see instructions)7,500,51840.0040.01Sequestration adjustment (see instructions)150,01040.0140.02Demonstration payment adjustment amount after sequestration150,01040.0240.03Sequestration adjustment-PARHM pass-throughs7,782,15441.0041.01Interim payments-PARHM7,782,15441.0042.00Tentative settlement (for contractor use only)42.0042.0042.01Tentative settlement (see instructions)43.0043.0143.00Bal ance due provider/program (see instructions)-431,64643.0043.01Bal ance due provider/program (see instructions)40.0041.0144.00Stits.2-431,64643.0045.00Origi nal outlier amount (see instructions)090.0090.00Origi nal outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The value of Money (see instructions)093.00					0	
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40.01Sequestration adjustment (see instructions)150,01040.0140.02Demonstration payment adjustment amount after sequestration040.0240.03Sequestration adjustment-PARHM pass-throughs40.0341.00Interim payments7,782,15441.0041.01Interim payments-PARHM7,782,15441.0142.00Tentative settlement (for contractor use only)042.0043.00Bal ance due provider/program (see instructions)-431,64643.0043.01Bal ance due provider/program-PARHM (see instructions)-431,64643.0044.00\$115.2TO BE COMPLETED BY CONTRACTOR44.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)090.0092.00The value of Money (see instructions)091.0093.00Time Value of Money (see instructions)093.00						
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43.00Balance due provider/program (see instructions)-431,64643.0043.01Balance due provider/program-PARHM (see instructions)-431,64643.0144.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00					0	
43.01 Balance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 0 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 0.00 93.00 Time Value of Money (see instructions) 0		· · · · · · · · · · · · · · · · · · ·				
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, <u>\$115.2</u> <u>TO BE COMPLETED BY CONTRACTOR</u> 90.00 44.00 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 0.00 93.00 Time Value of Money (see instructions) 0					-431, 646	
TO BE COMPLETED BY CONTRACTOR90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00		Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	
91.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00		TO BE COMPLETED BY CONTRACTOR			-	
92.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00						
93.00 Time Value of Money (see instructions) 0 93.00						
94.00 Iotal (sum of lines 91 and 93) 0 94.00	93.00	Time Value of Money (see instructions)			0	93.00
	94.00	liotal (sum of lines 91 and 93)			0	94.00

ANALY:	I Financial Systems MARGARET MARY COM SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-1329	Period: From 01/01/2019 To 12/31/2019		pared:
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to 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		5, 269, 58	39 0	7, 782, 154 0	1.00 2.00 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	08/29/2019	85, 10	00	0	3.0
3.02				0	0	3.0
3. 03 3. 04				0	0	3.0
3.04 3.05				0	0	3.0
	Provider to Program					0.0
. 50	ADJUSTMENTS TO PROGRAM			0	0	3.5
. 51				0	0	3.5
. 52 . 53				0	0	3.5 3.5
s. 53 s. 54				0	0	3.5
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		85, 10	00	0	3.9
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5, 354, 68	39	7, 782, 154	4. C
	TO BE COMPLETED BY CONTRACTOR				1	
. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.0
	Program to Provider					
. 01	TENTATI VE TO PROVIDER			0	0	5.0
. 02 . 03				0	0	5.0 5.0
. 03	Provider to Program			U	0	1 5.0
. 50	TENTATI VE TO PROGRAM			0	0	5.5
. 51				0	0	
. 52				0	0	5.5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.9
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
. 01	SETTLEMENT TO PROVIDER			0	0	6.0
. 02	SETTLEMENT TO PROGRAM		496, 70		431, 646	6. (
00	Total Medicare program liability (see instructions)		4, 857, 92		7, 350, 508	7.0
				Contractor Number	NPR Date (Mo/Day/Yr)	
)			

Heal th	Financial Systems MARGARET MARY COMMU	INI TY HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1329	Period: From 01/01/2019		
			To 12/31/2019	Date/Time Pre 8/31/2020 7:	
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	••			-
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1 1 00
1.00	Total hospital discharges as defined in AARA §4102 from Wkst		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168 $$	certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1329	Peri od: From 01/01/2019 To 12/31/2019	Date/Time Pre 8/31/2020 7:5	pare
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIC	CARE PART A SERVICES - COS	T REIMBURSEMENT		
00	Inpatient services			5, 460, 010	
00	Nursing and Allied Health Managed Care payment (see instru	uctions)		0	. –
00	Organ acquisition			0	-
00	Subtotal (sum of lines 1 through 3)			5, 460, 010	
00	Primary payer payments	`		3, 658	
00	Total cost (line 4 less line 5). For CAH (see instructions	5)		5, 510, 952	6
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable charges Routine service charges			0	1 7
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
. 00	Total reasonable charges			0	
50	Customary charges			0	
. 00	Aggregate amount actually collected from patients liable f	for payment for services on	a charge basi s	0	111
2.00	Amounts that would have been realized from patients liable	1 5	5	0	
	had such payment been made in accordance with 42 CFR 413.1	13(e)	5		
8.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	13
. 00	Total customary charges (see instructions)			0	14
. 00	Excess of customary charges over reasonable cost (complete	e only if line 14 exceeds l	ine 6) (see	0	15
	instructions)				
5.00	Excess of reasonable cost over customary charges (complete	e only if line 6 exceeds li	ne 14) (see	0	16
	instructions)				
7.00	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	17
3. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Direct graduate medical education payments (from Worksheet	t E 4 lipo 40)		0	1 18
9.00	Cost of covered services (sum of lines 6, 17 and 18)	(L-4, 11116 49)		5, 510, 952	
). 00	Deductibles (exclude professional component)			589, 152	
. 00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21)			4, 921, 800	
3.00	Coinsurance			3, 751	
. 00	Subtotal (line 22 minus line 23)			4, 918, 049	
5.00	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		60, 029	25
. 00	Adjusted reimbursable bad debts (see instructions)			39, 019	26
7.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		25, 549	27
3.00	Subtotal (sum of lines 24 and 25, or line 26)			4, 957, 068	28
00 .	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29
9.50	Pioneer ACO demonstration payment adjustment (see instruct			0	
9. 99	Demonstration payment adjustment amount before sequestrati	on		0	1
0. 00	Subtotal (see instructions)			4, 957, 068	
0. 01	Sequestration adjustment (see instructions)			99, 141	
). 02	Demonstration payment adjustment amount after sequestration	วท		0	
0. 03	Sequestration adjustment-PARHM				30
. 00	Interim payments			5, 354, 689	
	Interim payments-PARHM			-	31
2.00	Tentative settlement (for contractor use only)			0	
2.01	Tentative settlement-PARHM (for contractor use only)	20.02.21 and 22)		404 740	32
. 00	Balance due provider/program (line 30 minus lines 30.01, 3		and 22 01)	-496, 762	
3.01 4.00	Balance due provider/program-PARHM (lines 2, 3, 18, and 26 Protested amounts (nonallowable cost report items) in acco			0	33
r. UU	§115. 2	Divance with two Pub. 15-2,	chapter I,	0	34

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Peri od:	Worksheet E-3	2552 }
.2002			From 01/01/2019 To 12/31/2019	Part VII	
			10 12/31/2019	8/31/2020 7:5	
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	<u> </u>
			1.00	2.00	-
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH : COMPUTATION OF NET COST OF COVERED SERVICES	SERVICES FOR TITLES V OR	XIX SERVICES		1
00	Inpatient hospital/SNF/NF services		360, 906		1 1
00	Medical and other services		000,700	0	
00	Organ acquisition (certified transplant centers only)		0	_	3
00	Subtotal (sum of lines 1, 2 and 3)		360, 906	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		360, 906	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				-
00	Routi ne servi ce charges		109, 885		8
00	Ancillary service charges		313, 889	0	
	Organ acquisition charges, net of revenue		0	Ű	10
	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		423, 774	0	12
	CUSTOMARY CHARGES				
. 00	Amount actually collected from patients liable for payment	for services on a charge	0	0	13
. 00	basis Amounts that would have been realized from patients liable	for payment for services	on 0	0	14
	a charge basis had such payment been made in accordance wit				
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	
	Total customary charges (see instructions)		423, 774	0	
. 00	Excess of customary charges over reasonable cost (complete	only if line 16 exceeds	62, 868	0	17
00	line 4) (see instructions)	only if line 4 exceeds li	ne 0	0	18
5. 00	Excess of reasonable cost over customary charges (complete 16) (see instructions)	only IT ITTLE 4 exceeds IT	lie 0		
9.00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see in	structions)	0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or lin	e 16)	360, 906	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only I	be completed for PPS prov			
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24
	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	25
	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)	0	0	28
	Titles V or XIX (sum of lines 21 and 27)	,	360, 906	-	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
0. 00	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	360, 906	0	
	Deducti bl es		0	0	
			0	0	
	Allowable bad debts (see instructions)		0	0	34
	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32	and 33)	360, 906	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	unu 33 <i>)</i>	300, 9 00 N	0	37
	Subtotal (line 36 \pm line 37)		360, 906	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	Ű	39
	Total amount payable to the provider (sum of lines 38 and 3		360, 906	0	
. 00	Interim payments		260, 599	0	
00	Balance due provider/program (line 40 minus line 41)		100, 307	0	
	Protested amounts (nonallowable cost report items) in accor			0	43

ınd-t	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-1329	Period: From 01/01/2019	Worksheet G	naro
nly)				To 12/31/2019	8/31/2020 7:5	
		General Fund	Specific Purpose Fund		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	2, 613, 602		0 0	0	1 1.
00	Temporary investments	0		0 0	0	2
00	Notes receivable	0		0 0	0	
00	Accounts receivable	51, 854, 845		0 0	0	
00	Other receivable	01 (05 005		0 0	0	
00	Allowances for uncollectible notes and accounts receivable			0 0	0	
00 00	Inventory Prepaid expenses	1, 480, 031 1, 569, 098		0 0	0	
00	Other current assets	350, 192		0 0	0	
. 00	Due from other funds	0		0 0	0	
	Total current assets (sum of lines 1-10)	26, 242, 733		0 0	0	
	FIXED ASSETS					
. 00	Land	5, 798, 684		0 0	0	12
. 00	Land improvements	272, 044		0 0	0	
	Accumulated depreciation	-209, 846		0 0	0	
	Buildings	80, 236, 081		0 0	0	
	Accumulated depreciation Leasehold improvements	-45, 950, 275		0 0	0	
	Accumulated depreciation			0 0	0	
	Fixed equipment	5, 245, 768		0 0	0	
	Accumulated depreciation	-5, 151, 744		0 0	0	
	Automobiles and trucks	0		0 0	0	21
	Accumulated depreciation	0		0 0	0	22
	Major movable equipment	60, 149, 906		0 0	0	
	Accumulated depreciation	-38, 439, 422		0 0	0	
	Minor equipment depreciable	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	HIT designated Assets Accumulated depreciation	0		0 0	0	
	Mi nor equi pment-nondepreci abl e			0 0	0	
	Total fixed assets (sum of lines 12-29)	61, 951, 196		0 0	0	
	OTHER ASSETS					1
. 00	Investments	0		0 0	0	31
	Deposits on leases	0		0 0	0	
	Due from owners/officers	0		0 0	0	
	Other assets	81, 471, 056		0 0	0	
	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	81, 471, 056 169, 664, 985		0 0 0 0	0	
. 00	CURRENT LIABILITIES	109,004,905		0 0	0	1 30
. 00	Accounts payable	10, 108, 532		0 0	0	37
	Salaries, wages, and fees payable	0		0 0	0	
. 00	Payroll taxes payable	11, 185, 891		0 0	0	39
	Notes and loans payable (short term)	0		0 0	0	
	Deferred income	0		0 0	0	
	Accel erated payments	0				42
	Due to other funds	3, 337, 012		0 0 0 0	0	
	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	24, 631, 435		0 0		
. 00	LONG TERM LIABILITIES	24,031,433		0 0	0	43
. 00	Mortgage payable	0		0 0	0	46
. 00	Notes payable	0		0 0	0	47
. 00	Unsecured Loans	0		0 0	0	48
. 00	Other long term liabilities	22, 418, 438		0 0	0	49
	Total long term liabilities (sum of lines 46 thru 49)	22, 418, 438		0 0	0	
. 00	Total liabilities (sum of lines 45 and 50)	47, 049, 873		0 0	0	51
00	CAPI TAL ACCOUNTS General fund balance	100 415 110	1			1 6 2
	Specific purpose fund	122, 615, 112		0		52
. 00	Donor created - endowment fund balance - restricted			n		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
. 00	Total fund balances (sum of lines 52 thru 58)	122, 615, 112		0 0	0	
. 00	Total liabilities and fund balances (sum of lines 51 and	169, 664, 985		0 0	0	60

STATE	Financial Systems MAR MENT OF CHANGES IN FUND BALANCES	GARET MARY COMM	Provi der CC		Peri od:		u of Form CM Worksheet		
					From 01/ To 12/	01/2019 31/2019			
		General	Fund	Speci al	Purpose F	und	Endowment Fund		
		1.00	2.00	3.00	1	00	5.00		
1.00	Fund balances at beginning of period	1.00	118, 988, 551	3.00	4.	00		_	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3, 626, 561						2.00
3.00	Total (sum of line 1 and line 2)		122, 615, 112			0			3.00
4.00 5.00	Additions (credit adjustments) (specify)	0			0			0	4.00 5.00
5.00 6.00		0			0			0	5.00 6.00
7.00		0			0			0	7.00
8.00		0			0			0	8.00
9.00		0	_		0	_		0	9.00
10.00 11.00	Total additions (sum of line 4–9) Subtotal (line 3 plus line 10)		0 122, 615, 112			0			10. 00 11. 00
12.00	Deductions (debit adjustments) (specify)	0	122,015,112		0	0		0	12.00
13.00		0			0			0	13.00
14.00		0			0			0	14.00
15.00		0			0			0	15.00
16.00 17.00		0			0			0	16. 00 17. 00
18.00	Total deductions (sum of lines 12-17)	0	0		0	0		0	17.00
19.00	Fund balance at end of period per balance		122, 615, 112			0			19.00
	sheet (line 11 minus line 18)								
		Endowment Fund	Pl ant	Fund					
		T UNU							
		6.00	7.00	8.00					
1.00	Fund balances at beginning of period	0			0				1.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0			0				2.00 3.00
4.00	Additions (credit adjustments) (specify)	0	0		U				4.00
5.00			0						5.00
6.00			0						6.00
7.00			0						7.00
8.00 9.00			0						8.00 9.00
10.00	Total additions (sum of line 4-9)	0	0		0				10.00
11.00	Subtotal (line 3 plus line 10)	0			0				11.00
12.00	Deductions (debit adjustments) (specify)		0						12.00
13.00			0						13.00
14.00 15.00			0						14.00 15.00
16.00			0						16.00
			Ő						17.00
17.00									
17.00 18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0				18.00 19.00

ΓΑΤΕΜ	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-1329	Peri From To	od: 01/01/2019 12/31/2019	Worksheet G-2 Parts I & II Date/Time Pre 8/31/2020 7:5	pared
	Cost Center Description		I npati ent	C	Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						-
00	General Inpatient Routine Services Hospital		6, 658, 7	F 7		6, 658, 757	1 1.0
00	SUBPROVIDER - IPF		0,000,7	57		0,000,707	2.0
00	SUBPROVIDER - IPF						3.0
00	SUBPROVIDER						4.0
00	Swing bed - SNF			0		0	
00	Swing bed - NF			0		0	
00	SKILLED NURSING FACILITY			-		-	7.0
00	NURSING FACILITY						8.0
00	OTHER LONG TERM CARE						9.0
0. 00	Total general inpatient care services (sum of lines 1-9)		6, 658, 7	57		6, 658, 757	10.0
	Intensive Care Type Inpatient Hospital Services						
I. 00	I NTENSI VE CARE UNI T		599, 4	36		599, 436	11.0
2.00	CORONARY CARE UNIT						12.0
3.00	BURN INTENSIVE CARE UNIT						13.0
1.00	SURGI CAL I NTENSI VE CARE UNI T						14.0
	OTHER SPECIAL CARE (SPECIFY)						15.0
5.00	Total intensive care type inpatient hospital services (sum of	lines	599, 4	36		599, 436	16. (
,	11-15)	`	7 050 1	0.0		7 050 100	17.
7.00 3.00	Total inpatient routine care services (sum of lines 10 and 16)	7, 258, 1 18, 335, 4		140 000 207	7, 258, 193	
9.00 9.00	Ancillary services Outpatient services		486, 9		148, 998, 387	167, 333, 875 24, 702, 262	
). 00	RURAL HEALTH CLINIC		400, 9	0	24, 215, 296 1, 610, 847	1, 610, 847	
	FEDERALLY QUALIFIED HEALTH CENTER			0	1,010,047	1,010,047	
	HOME HEALTH AGENCY			Ŭ	1, 974, 191	1, 974, 191	
3.00	AMBULANCE SERVICES				., , , , , , , , ,	1, 7, 1, 171	23.0
1.00	CMHC						24.0
5.00	AMBULATORY SURGICAL CENTER (D. P.)						25.
5.00	HOSPI CE			0	3, 031, 071	3, 031, 071	26.0
7.00	NON-PROVIDER BASED		87, 8	32	18, 817, 682	18, 905, 514	27.0
7.01	OTHER REVENUE			0	66, 310	66, 310	27.0
7.02	PROFESSIONAL FEES		2, 472, 9	99	19, 292, 355	21, 765, 354	27.0
3.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	28, 641, 4	78	218, 006, 139	246, 647, 617	28.0
	G-3, line 1)						
	PART II - OPERATING EXPENSES		1		115 7/1 707		1
9.00).00	Operating expenses (per Wkst. A, column 3, line 200)			0	115, 761, 737		29. 30.
J. 00 I. 00	ADD (SPECI FY)			0			30.
2.00				0			31.
. 00				0			33.
. 00				0			34.
. 00				0			35.
. 00	Total additions (sum of lines 30-35)			-	0		36.
. 00	DEDUCT (SPECIFY)			0	-		37.
3.00				0			38.
. 00				0			39.
0. 00				0			40.
I. 00				0			41.
2.00	Total deductions (sum of lines 37-41)				0		42.
3.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer			115, 761, 737		43.

Heal th	Financial Systems MARGARET MARY COM	MUNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1329	Peri od:	Worksheet G-3	
			From 01/01/2019		
			To 12/31/2019		
	· · · · · · · · · · · · · · · · · · ·			8/31/2020 7:5	4 аш
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, I	ine 28)		246, 647, 617	1.00
2.00	Less contractual allowances and discounts on patients' acco			141, 707, 205	2.00
3.00	Net patient revenues (line 1 minus line 2)			104, 940, 412	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, lin	ne 43)		115, 761, 737	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-10, 821, 325	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	on services		0	8.00
9.00	Revenue from television and radio service			0	9.00
	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other	r than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18.00 19.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00 20.00
	Revenue from gifts, flowers, coffee shops, and canteen Rental of vending machines			0	20.00
	Rental of hospital space			0	21.00
	Governmental appropriations			0	22.00
	OTHER INCOME			1, 039, 970	
	CONTRIBUTIONS			386, 840	
	INVESTMENT RETURN			9, 768, 465	
	UNREALIZED GAIN, DERIVATIVE			-216, 944	
	UNREALIZED GAIN, INVESTMENTS			3, 321, 785	24.03
	TEMPORARI LY RESTRICTED ASSETS			147, 770	
	Total other income (sum of lines 6-24)			14, 447, 886	
	Total (line 5 plus line 25)			3, 626, 561	26.00
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
	Net income (or loss) for the period (line 26 minus line 28))		3, 626, 561	29.00

	Financial Systems SIS OF HOSPITAL-BASED HOME HEALT		GARET MARY COMM	Provi der C		Peri od:	eu of Form CMS-: Worksheet H	2002
				HHA CCN:	15-7143	From 01/01/2019 To 12/31/2019	Date/Time Pre	pared
						Home Health	8/31/2020 7:5 PPS	54 am
		Sal ari es		[[ransportatio	Contracted /	Agency I Pu Other Costs	Total (sum of	
		Salaries	Benefits	n (see nstructions)	rchased		col s. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &			0	1			0 1.
00	Fixtures			0				
00	Capital Related - Movable			0		0		2.
00	Equipment Plant Operation & Maintenance	0	0	0		0 0		3.
00	Transportati on	0	0	0		0 (0	
00	Administrative and General HHA REIMBURSABLE SERVICES	416, 737	0	0		0 198, 347	615, 084	5.
00	Skilled Nursing Care	520, 758	0	0		0 0	520, 758	6.
00	Physical Therapy	440, 477	0	0		0 (
00 00	Occupational Therapy Speech Pathology	180, 746 3, 609	0	0		0 0		
00	Medi cal Soci al Servi ces	15, 384	0	0		0 0		
. 00	Home Heal th Ai de	35, 072	0	0		0 0		
2. 00	Supplies (see instructions)	0	0	0		0 0	0 0	
3.00 4.00	Drugs DME	0	0	0		0 0		
. 00	HHA NONREI MBURSABLE SERVI CES	0	0	0		0 (14.
5. 00	Home Dialysis Aide Services	0	-	0		0 (
00 .	Respiratory Therapy	520	0	0		0 0		
2.00 3.00	Private Duty Nursing Clinic	0	0	0		0 0		
0.00	Health Promotion Activities	0	0	0		0 0		
. 00	Day Care Program	0	0	0		0 0		
. 00	Home Delivered Meals Program	0	0	0		0 0		
2.00	Homemaker Service All Others (specify)	0	0	0		0 0		
s. 50	Tel emedi ci ne	0	0	0		0 0	-	
. 00	Total (sum of lines 1-23)	1, 613, 303		0		0 198, 347	1, 811, 650	24.
		Reclassificat ion	Reclassified Trial Balance	Adjustments	Net Expense for	S		
		TON	(col. 6 +		Allocation			
			col.7)		(col. 8 +			
		7.00	8.00	9.00	<u>col. 9)</u> 10.00			+
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00			
00	Capital Related - Bldg. &	0	0	0		0		1.
00	Fixtures Capital Related - Movable	0	0	0		0		2.
00	Equipment	0	0	0		0		2.
00	Plant Operation & Maintenance	0	0	0		0		3.
00	Transportation	0	0	0		0		4.
00	Administrative and General HHA REIMBURSABLE SERVICES	0	615, 084	0	615, 0	84		5.
00	Skilled Nursing Care	0	520, 758	0	520, 7	58		6.
00	Physical Therapy	0	440, 477	0				7.
00 00	Occupational Therapy Speech Pathology	0	180, 746 3, 609	0	180, 7 3, 6			8. 9.
00	Medi cal Soci al Servi ces	0	15, 384	0	15, 3			10.
. 00	Home Health Aide	0	35, 072	0	35, 0			11.
2.00	Supplies (see instructions)	0	0	0		0		12.
8.00 .00	Drugs DME	0	0	0		0		13.
r. 00	HHA NONREI MBURSABLE SERVI CES	0		0		0		1 14.
6. 00	Home Dialysis Aide Services	0		0		0		15.
. 00	Respiratory Therapy	0	520	0	5.	20		16.
2.00 3.00	Private Duty Nursing Clinic		0	0		0		17.
	Health Promotion Activities	0	o	0		0		19.
. 00	Day Care Program	0	0	0		0		20.
	5	0	0	0		0		21.
. 00								1 11
. 00 2. 00		0	0	0				
. 00 2. 00 3. 00	Homemaker Service All Others (specify) Telemedicine	0 0 0	0	0		0		23. 23.

	Financial Systems		GARET MARY COMM				ieu of Form CMS-	
COST A	LLOCATION - HHA GENERAL SERVICE	E COST		Provider C		Period: From 01/01/20		
				HHA CCN:	15-7143	To 12/31/20	19 Date/Time Pre 8/31/2020 7:5	epared: 54 am
						Home Health	PPS	
			Capital Rela	ated Costs		Agency I		
		Net Expenses	BIdgs &	Movabl e	Pl ant	Transportati	o Subtotal	-
		for Cost	Fixtures	Equi pment	Operation a	& n	(col s. 0-4)	
		Allocation (from Wkst.			Mai ntenance	e		
		H, col. 10)						
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	4A. 00	
1.00	Capital Related - Bldg. &	0	0				C	1.00
2.00	Fixtures Capital Related - Movable	0		0			0	2.00
	Equi pment							
3.00 4.00	Plant Operation & Maintenance Transportation	0	0	0		0	O C	3.00
5.00	Administrative and General	615, 084	Ő	0		0	0 615, 084	
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	520, 758	0	0		0	0 520, 758	6.00
7.00	Physical Therapy	440, 477	0	0		0	0 440, 477	7.00
8.00 9.00	Occupational Therapy Speech Pathology	180, 746 3, 609	0	0		0	0 180, 746	
10.00	Medical Social Services	15, 384	0	0		0	0 15, 384	
11.00 12.00	Home Health Aide Supplies (see instructions)	35, 072 0	0	0		0	0 35,072 0 0	
12.00	Drugs	0	0	0		0		
14.00		0	0	0		0	0 0	14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0	0 0	15.00
16.00	Respiratory Therapy	520	0	0		0	0 520	16.00
17.00 18.00	Private Duty Nursing Clinic	0	0	0		0		
19.00	Health Promotion Activities	0	Ō	0		0	0 0	19.00
20.00 21.00	Day Care Program Home Delivered Meals Program	0	0	0		0		
22.00	Homemaker Service	0	0	0		0	0 0	1
23.00 23.50	All Others (specify) Telemedicine	0	0	0		0 0		
	Total (sum of lines 1-23)	1, 811, 650	0	0		0	0 1, 811, 650	
		Administrativ						
		e & General 5.00	4A + 5) 6.00					
1.00	GENERAL SERVICE COST CENTERS							1.00
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation	615, 084						4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	015,084						5.00
6.00	Skilled Nursing Care	267, 692	788, 450					6.00
7.00 8.00	Physical Therapy Occupational Therapy	226, 423 92, 911	666, 900 273, 657					7.00
9.00	Speech Pathology	1, 855	5, 464					9.00
10.00 11.00	Medical Social Services Home Health Aide	7, 908 18, 028	23, 292 53, 100					10.00
12.00	Supplies (see instructions)	0	0					12.00
13.00 14.00	Drugs DME	0	0					13.00
	HHA NONREI MBURSABLE SERVI CES		-					
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0 267	0 787					15.00 16.00
16.00	Private Duty Nursing	0	/8/					17.00
	Clinic	0	0					18.00
19.00 20.00	Health Promotion Activities Day Care Program	0	0 0					19.00 20.00
21.00	Home Delivered Meals Program	0	0					21.00
~~ ~ ~	Homemaker Service	0	0					22.00
22.00 23.00		0	0					
23.00 23.50	All Others (specify) Telemedicine Total (sum of lines 1-23)	0	0 0 1, 811, 650					23.00 23.50 24.00

COST A	ALLOCATION - HHA STATISTICAL BAS	SI S		Provider C HHA CCN:		Period: From 01/01/2019 To 12/31/2019		pared:
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		BIdgs &	Movabl e	PI ant	Transportati	Reconciliatio	Administrativ	-
		Fixtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Maintenance			(ACCUM. COST)	
			VALUE)	(SQUARE FEET)			(ACCOM: COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		0			0		2.00
	Equipment		_	_		_		
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see	0	0	0		0		4.00
5.00	instructions) Administrative and General	0	0	0		-615, 084	1 104 544	5.0
5.00	HHA REIMBURSABLE SERVICES	0	0	0		0 -615, 084	1, 196, 566	5.00
6.00	Skilled Nursing Care	0	0	0		0 0	520, 758	6.00
7.00	Physical Therapy	0	0	0		0 0	440, 477	
8.00	Occupational Therapy	0	0	0		0 0	180, 746	
9.00	Speech Pathology	0	0	0		0 0	3, 609	
10.00	Medical Social Services	0	0	0		0 0	15, 384	
11.00	Home Health Aide	0	0	0		0 0	35, 072	
12.00	Supplies (see instructions)	0	0	0		0 0	0	12.0
13.00	Drugs	0	0	0		0	0	13.0
14.00	DME	0	0	0		0 0	0	14.00
	HHA NONREI MBURSABLE SERVI CES							
15.00	Home Dialysis Aide Services	0	0	0		0 0		
16.00	Respiratory Therapy	0	0	0		0 0		
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	
21.00	Home Delivered Meals Program	0	0	0		0 0	0	21.0
22.00 23.00	Homemaker Service All Others (specify)	0	0	0		0 0	0	22.0
23.00	Telemedicine	0	0	0		0 0	0	23.0
23.50	Total (sum of lines 1-23)	0	0	0		0 -615,084		
24.00	Cost To Be Allocated (per	0	0	0		0 -015,084	615, 084	
20.00	Worksheet H-1, Part I)	0	0	0			015,064	25.0
					1			1

Heal th	n Financial Systems	MAR	GARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
ALLOC	ATION OF GENERAL SERVICE COSTS T	TO HHA COST CEN	TERS	Provider CO	CN: 15-1329 15-7143	Period: From 01/01/2019 To 12/31/2019	Worksheet H-2 Part I Date/Time Pre 8/31/2020 7:5	pared:
						Home Health	PPS	
				CAPI TAL REL	ATED COSTS	Agency I		
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUI P	NEW MVBLE EQUIP OFFSIT	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	1.01	2.00	2.01	4. 00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine 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.	0 788, 450 666, 900 273, 657 5, 464 23, 292 53, 100 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	48, 665 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 540 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	99, 7:	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	527, 165 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ \end{array}$
	Cost Center Description	Subtotal	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	OPERATION O PLANT -OFFSITE	F OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	
		4A	5.00	7.00	7.01	7.02	8.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	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) Telemedicine Total (sum of lines 1-19) (2)	678, 139 788, 450 666, 900 273, 657 5, 464 23, 292 53, 100 0 0 0 0 787 0 0 0 0 0 0 0 0 0 0 0 0 0	147, 705 171, 731 145, 257 59, 605 1, 190 5, 073 11, 566 0 0 0 0 171 0 0 0 0 0 0 0 0 0 0 0 0 0 0	100, 023 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		73 18, 689 0 0 <		$\begin{array}{c} 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ 19.50\\ \end{array}$

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE CO	STS TO HHA COST CEN	ITERS	Provider C HHA CCN:	CN: 15-1329 15-7143	Period: From 01/01/2019 To 12/31/2019 Home Health	Worksheet H-2 Part I Date/Time Pre 8/31/2020 7:5 PPS	pared:
Cost Center Descript	i on HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI N	Agency I CENTRAL	PHARMACY	
	9.00	10.00	11.00	13.00	14.00	15.00	
 1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 5.00 Medical Social Services 7.00 Home Health Aide 3.00 Supplies (see instructions) 7.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Servica 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activitie 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Unit Cost Multiplier: colu 26, line 1 divided by the of column 26, line 1, rounded 6 decimal places. 	s) 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0 0 0 0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.50
Cost Center Descript	i on 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 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 5.00 Medical Social Services 7.00 Home Health Aide 3.00 Supplies (see instructions 9.00 DRE 11.00 Home Dialysis Aide Service 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activitie 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Home Mealing Service 19.00 All Others (specify) 19.50 Tel emedicine 20.00 Total (sum of lines 1-19) 	(i)			1, 016, 91 960, 18 812, 15 333, 26 6, 65 28, 36 64, 66 95	$\begin{array}{c} 12 \\ 31 \\ 442, 571 \\ 57 \\ 374, 343 \\ 52 \\ 153, 609 \\ 54 \\ 3, 067 \\ 55 \\ 13, 074 \\ 56 \\ 29, 806 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\$	1, 402, 752 1, 186, 500 486, 871 9, 721 41, 439 94, 472 0 0 0 0 0 1, 400 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS T		GARET MARY COMM TERS STATISTICA			Period:	u of Form CMS-2 Worksheet H-2	
BASIS	o min cost cen		HHA CCN:	1	From 01/01/2019 To 12/31/2019	Part II	pared:
					Home Health	PPS	
		CAPI TAL RELA	TED COSTS		Agency I		
Cost Costos Deseriation						Deservitientie	-
Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	NEW MVBLE EQUI P OFFSI T (SQUARE FEET)	DEPARTMENT (GROSS SALARI ES)	Reconciliatio n	
1.00 Administrative and General	<u>1.00</u> 3,415	1.01	2.00	2.01	4.00	5A 0	1 00
 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Unit cost multiplier 	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14 1, 03 6. 95302 OPERATI ON OF PLANT -	0 0 0 0 0 0 0 0 0 0 0 0 0 0	HOUSEKEEPI NG (SQUARE	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
	(ACCUM. COST)	(SQUARE FEET)	-OFFSITE (SQUARE FEET)	HOSPI TAL & OFFS (SQUARE FEET)	(POUNDS OF LAUNDRY)	FEET)	
1.00 Administrative and General	5. 00 678, 139	7.00	7.01	7.02	8.00 4 0	9.00	1.00
 Administrative and object and objec	788, 450 666, 900 273, 657 5, 464 23, 292 53, 100 0 0 0 0 787 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	149 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 56 18, 68		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 20.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$

Heal th	Financial Systems	MAR	GARET MARY CON	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	TERS STATISTIC	CAL Provider CO	CN: 15-1329	Peri od:	Worksheet H-2	
BASI S				HHA CCN:	15-7143	From 01/01/2019 To 12/31/2019		nared
					13 /143	10 12/31/2017	8/31/2020 7:5	
						Home Health	PPS	
		DI CTADY	0.455750LA		05117541	Agency I		
	Cost Center Description	DIETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MEALS	(FTE'S)	ADMI NI STRATI O	SERVICES &	· · · · · ·	RECORDS &	
		SERVED)			SUPPLY	DRUGS)		
				(HOURS OF SERVICE)	(100% MED SUPPLIES)		(TIME SPENT)	
		10, 00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0		0	1 4. 00	0 0	0	1.00
2.00	Skilled Nursing Care	0	0	0		0 0	0	2.00
3.00	Physical Therapy	0	0	0		0 0	0	3.00
4.00	Occupational Therapy	0	0	0		0 0	0	4.00
5.00	Speech Pathology	0	0	0		0 0	0	5.00
6.00	Medical Social Services	0	0	0		0 0	0	6.00
7.00	Home Health Aide	0	0	0		0 0	0	7.00
8.00	Supplies (see instructions)	0	0	0		0 0	0	8.00
9.00	Drugs	0	0	0		0 0	0	9.00
10.00	DME	0	0	0		0 0	0	
11.00	Home Dialysis Aide Services	0	0	0		0 0	0	
12.00	Respiratory Therapy	0	0	0		0 0	0	
13.00	Private Duty Nursing	0	0	0		0 0	0	
14.00	Clinic	0	0	0		0 0	0	
15.00	Health Promotion Activities	0	0	0		0 0	0	1 101 00
16.00	Day Care Program	0	0	0		0 0	0	
17.00	Home Delivered Meals Program	0	0	0		0 0	0	1
18.00	Homemaker Service	0	0	0		0 0	0	1 10.00
19.00	All Others (specify) Telemedicine	0	0	0		0 0	0	1
19.50		0	0	0		0 0	0	1
20.00 21.00	Total (sum of lines 1-19)	0	0	0		0 0	0	20.00
	Total cost to be allocated Unit cost multiplier	0.000000	0. 000000	0. 000000	0. 0000	0 0.00000	0	200
22.00		0.000000	0.00000	0.00000	0.0000	0.00000	0.00000	22.00

Heal th	Financial Systems	MAF	RGARET MARY COM	IMUNI TY HOSPI TA	NL.	In Lie	u of Form CMS-2	2552-10
	IONMENT OF PATIENT SERVICE COS				CN: 15-1329	Peri od:	Worksheet H-3	
				HHA CCN:	15-7143	From 01/01/2019 To 12/31/2019		pared: 4 am
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols		Per Visit	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
			Part I)	Part II)			col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF T	HE PROGRAM LI	MITATION COST, O	DR BENEFICIARY	
	COST LIMITATION Cost Per Visit Computation							-
1.00	Skilled Nursing Care	2.00	1, 402, 752		1, 402, 7	52 5, 116	274.19	1.00
2.00	Physical Therapy	3.00						•
3.00	Occupational Therapy	4.00						•
4.00	Speech Pathology	5.00						
5.00	Medi cal Soci al Servi ces	6.00			41, 4			
6.00	Home Heal th Ai de	7.00			94, 4			•
7.00	Total (sum of lines 1-6)	7.00	3, 221, 755					7.00
7.00	Total (suil of Triles 1-0)		3,221,755	L C	Program Visi			7.00
					FIOGIAIII VISI	15		
					P	art B		1
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
	i i i i i i i i i i i i i i i i i i i				to	Deductibles		
					Deducti bl es	&		
					Coi nsurance			
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation				1			
8.00	Skilled Nursing Care		17140	0		43		8.00
8.01	Skilled Nursing Care		99915	(C				8.01
9.00	Physical Therapy		17140	(C	2	75		9.00
9.01	Physical Therapy		99915	(C	1, 7	44		9.01
10.00	Occupational Therapy		17140	0) 10	02		10.00
10.01	Occupational Therapy		99915	0	9	10		10.01
11.00	Speech Pathology		17140	C		5		11.00
11.01	Speech Pathology		99915	C		35		11.01
12.00	Medical Social Services		17140	0		2		12.00
12.01	Medical Social Services		99915	0		8		12.01
13.00	Home Health Aide		17140	0	1:	25		13.00
13.01	Home Health Aide		99915	0	2	82		13.01
14.00				0	6, 5	22		14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges	Ratio (col. 3	
		H-2 Part I,	Costs (from	Ancillary	Costs (cols	. (from HHA	÷ col. 4)	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)	Records)		
			Part I)	Part II)				
		0	1.00	2.00	3.00	4.00	5.00	
45 00	Supplies and Drugs Cost Comput				1			1 45 00
	Cost of Medical Supplies	8.00			•	0 0		
16.00	Cost of Drugs	9.00				0 0	0. 000000	16.00
			Program Visits		Cost of Services			
			Par	t B	Jervices	Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	cost center bescription		to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance	oor nour anee		Coi nsurance	oor nour ande	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION Cost Per Visit Computation							+
1.00	Skilled Nursing Care	C	3, 034		1	0 831, 892		1.00
2.00	Physical Therapy					0 831, 892		2.00
	Occupational Therapy							•
3.00	1 13	0				0 325, 651		3.00
4.00	Speech Pathology	0				0 7, 201		4.00
5.00	Medical Social Services	0				0 23,022		5.00
6.00	Home Health Aide	0				0 53, 183		6.00
7.00	Total (sum of lines 1-6)	C	6, 522	I	I	0 2, 036, 556	I	7.00

PORTIONMENT OF PATIENT SERVICE COST	TS		Provider CC	CN: 15-1329	Peri od:	Worksheet H-3	3
			HHA CCN:	15-7143	From 01/01/2019 To 12/31/2019	Part I Date/Time Pre 8/31/2020 7:	epare
			Title	XVIII	Home Health	PPS	<u>34 ali</u>
Cost Center Description					Agency I		
	6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation	1	1					
00 Skilled Nursing Care							8.
01 Skilled Nursing Care							8.
00 Physical Therapy 01 Physical Therapy							9.
01 Physical Therapy .00 Occupational Therapy							10.
. 01 Occupational Therapy							10.
. 00 Speech Pathol ogy							11
. 01 Speech Pathology							11
. 00 Medical Social Services							12
. 01 Medical Social Services							12.
. 00 Home Heal th Ai de							13
01 Home Heal th Ai de							13
00 Total (sum of lines 8-13)							14
	Prog	ram Covered Cha	raes	Cost of			
			3.4	Servi ces			
		Par	t B		Part B		
Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			Deductibles &		to	Deductibles &	
		Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
	(Coi nsurance	0.00		Coi nsurance	44.00	
Supplies and Drugs Cost Comput	6.00	7.00	8.00	9.00	10.00	11.00	
00 Cost of Medical Supplies	0	67, 519	0		0 0	(15
00 Cost of Drugs		0	0		0	(16
Cost Center Description	Total Program						
	Cost (sum of						
	cols. 9-10)	-					
	12.00	DDOODAN OOCT					
						R BENEFICIARY	
PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PRUGRAM CUST, F	GGREGATE OF TE				
COST LIMITATION Cost Per Visit Computation	OF AGGREGATE	PRUGRAM CUST, F	GOREGATE OF T				
COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	831, 892		GOREGATE OF T				
COST LIMITATION Cost Per Visit Computation 00 Skilled Nursing Care 00 Physical Therapy	831, 892 795, 607						2
COST LIMITATIONCost Per Visit Computation00Skilled Nursing Care00Physical Therapy00Occupational Therapy	831, 892 795, 607 325, 651						2
COST LIMITATION Cost Per Visit Computation 00 Skilled Nursing Care 00 Physical Therapy 00 Occupational Therapy 00 Speech Pathology	831, 892 795, 607 325, 651 7, 201						2 3 4
COST LIMITATION Cost Per Visit Computation 00 Skilled Nursing Care 00 Physical Therapy 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services	831, 892 795, 607 325, 651 7, 201 23, 022						2 3 4 5
COST LIMITATION Cost Per Visit Computation 00 Skilled Nursing Care 00 Physical Therapy 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services 00 Home Health Aide	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183						2 3 4 5 6
COST LIMITATION Cost Per Visit Computation 00 Skilled Nursing Care 00 Physical Therapy 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services 00 Home Health Aide 00 Total (sum of lines 1-6)	831, 892 795, 607 325, 651 7, 201 23, 022						2 3 4 5 6
COST LIMITATION Cost Per Visit Computation 00 Skilled Nursing Care 00 Physical Therapy 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services 00 Home Health Aide	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183						2 3 4 5 6
COST LIMITATION Cost Per Visit Computation 00 Skilled Nursing Care 00 Physical Therapy 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services 00 Home Health Aide 00 Total (sum of lines 1-6)	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183 2, 036, 556						2 3 4 5 6
COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy O Occupational Therapy O Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183 2, 036, 556						2 3 4 5 6 7
COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy O Occupational Therapy O Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183 2, 036, 556						2 3 4 5 6 7 7 8 8 8
COST LIMITATION Cost Per Visit Computation 00 Skilled Nursing Care 00 Physical Therapy 00 Occupational Therapy 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services 00 Home Health Aide 00 Total (sum of lines 1-6) Cost Center Description 00 Skilled Nursing Care 01 Skilled Nursing Care 02 Physical Therapy	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183 2, 036, 556						2 3 4 5 6 7
COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Cocupational Therapy Cocupational Therapy Cocupational Therapy Cocupational Therapy Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183 2, 036, 556						2 3 4 5 6 7 7 8 8 8 9 9 9
COST LIMITATION Cost Per Visit Computation O Skilled Nursing Care Physical Therapy O Occupational Therapy O Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation O Skilled Nursing Care I Skilled Nursing Care O Physical Therapy O Occupational Therapy	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183 2, 036, 556						2 3 4 5 6 7 7 8 8 8 9 9 9 10
COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy O Ccupational Therapy O Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care No Physical Therapy O Ccupational Therapy O Ccupational Therapy	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183 2, 036, 556						2 3 4 5 6 7 7 8 8 8 9 9 9 10 10
COST LIMITATION Cost Per Visit Computation Cost Per Visit Computation Skilled Nursing Care Physical Therapy O Occupational Therapy O Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy O Occupational Therapy O Occupational Therapy O Occupational Therapy O Occupational Therapy O Speech Pathology	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183 2, 036, 556						2 3 4 5 6 7 7 8 8 8 9 9 10 10 10
COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy OCcupational Therapy Cocupational Therapy Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy OCcupational Therapy OCcupational Therapy OSpeech Pathology Speech Pathology	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183 2, 036, 556						2 3 4 5 6 7 7 - 8 8 8 8 9 9 9 10 10 10 11 11
COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy O Occupational Therapy O Occupational Therapy O Speech Pathology Medical Social Services Home Health Aide O Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care N Skilled Nursing Care N Skilled Nursing Care N Skilled Nursing Care N Skilled Nursing Care O Physical Therapy O Occupational Therapy O Occupational Therapy O Speech Pathology O Medical Social Services	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183 2, 036, 556						2 3 3 4 5 6 6 7 7 - - - - - - - - - - - - - - - - - -
COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Cocupational Therapy Cocupational Therapy Cocupational Therapy Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care No Skilled Nursing Care No Scupational Therapy O Occupational Therapy O Occupational Therapy O Speech Pathology O Medical Social Services No Medical Social Services	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183 2, 036, 556						223344556677 77 8888999910010011111122122
COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Cocupational Therapy Cocupational Therapy Cocupational Therapy Cocupational Therapy Comme Health Aide Cost Center Description Limitation Cost Computation Cost Center Description Limitation Cost Computation Cost Center Description Limitation Cost Computation Cost Center Description Cost Center Description Limitation Cost Computation Cost Center Description Cost Center D	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183 2, 036, 556						88 88 99 99 100 110 111 12 12 12 13
COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy OCcupational Therapy Cost Center Description Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Nysical Therapy OCcupational Therapy OCCUPATION Cost Center Description Cost Center Description C	831, 892 795, 607 325, 651 7, 201 23, 022 53, 183 2, 036, 556						2 3 3 4 5 6 7 7 6 7 7 9 9 9 9 10 10 11 11 12 12 12

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-									
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provi der C	CN: 15-1329	Period: From 01/01/2019	Worksheet H-3 Part II			
						Date/Time Pre 8/31/2020 7:5	pared: 4 am		
			Title	e XVIII	Home Health	PPS			
					Agency I				
Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to				
	Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as				
	9, line	Ũ	provi der	Costs (col.	1 Indicated				
			records)	x col. 2)					
	0	1.00	2.00	3.00	4.00				
PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNI SHED	BY SHARED HOSP	ITAL DEPARTME	INTS				
1.00 Physical Therapy	66.00	0. 513488	0		0 col. 2, line 2	. 00	1.00		
2.00 Occupational Therapy	67.00	0. 573836	0		0 col. 2, line 3	. 00	2.00		
3.00 Speech Pathology	68.00	0. 619340	0		0 col. 2, line 4	. 00	3.00		
4.00 Cost of Medical Supplies	71.00	0. 258963	0		0 col. 2, line 1	5.00	4.00		
5.00 Cost of Drugs	73.00	0. 361659	0		0 col. 2, line 1	6.00	5.00		

	Financial Systems MARGARET MARY CO ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CO		Peri od:		eet H-4	
		HHA CCN:	15-7143	From 01/01/20 To 12/31/20	019 Date/T	-11 ime Prep 020 7:54	
		Title	XVIII	Home Health Agency I	1	PPS	
					Part B		
			Part A	Not Subjec to Deductibles	Deducti & Coinsu	bles &	
			1.00	Coi nsuranc 2.00	e 3. (20	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR (CUSTOMARY CHARGE		2100			
	Reasonable Cost of Part A & Part B Services			-	-	-	
00	Reasonable cost of services (see instructions)			0	0	0	
00	Total charges Customary Charges			0	0	0	2
00	Amount actually collected from patients liable for paymen	t for services		0	0	0	
00	on a charge basis (from your records) Amount that would have been realized from patients liable for services on a charge basis had such payment been made			0	0	0	4
00	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0, 0000	0.000	000 0	000000	Ę
00	Total customary charges (see instructions)		0.0000	0	0	000000	l
00	Excess of total customary charges over total reasonable conly if line 6 exceeds line 1)	ost (complete		0	0	0	-
00	Excess of reasonable cost over customary charges (complete 1 exceeds line 6)	e only if line		0	0	0	8
00	Primary payer amounts			0	0	0	0
				Part A Servi ces	Par Servi		
				1.00	2. (
~~	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT						
00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				0	0 749, 025	10 1
00	Total PPS Reimbursement - Full Episodes with Outliers					264, 203	
00	Total PPS Reimbursement - LUPA Episodes				0	16, 564	
00	Total PPS Reimbursement - PEP Episodes				0	5, 624	14
00	Total PPS Outlier Reimbursement - Full Episodes with Outl	iers			0	72, 720	15
00	Total PPS Outlier Reimbursement - PEP Episodes				0	0	
00	Total Other Payments				0	0	
00 00	DME Payments Oxygen Payments				0	0	18
00	Prosthetic and Orthotic Payments				0	0	20
	Part B deductibles billed to Medicare patients (exclude c	oi nsurance)			Ŭ	0	
00	Subtotal (sum of lines 10 thru 20 minus line 21)				0 1,	108, 136	
00					0	0	
00	Subtotal (line 22 minus line 23)				0 1, 1	108, 136	24
. 00	Coinsurance billed to program patients (from your records))				0	25
	Net cost (line 24 minus line 25)				0 1, 1	108, 136	
	Reimbursable bad debts (from your records)						27
. 00	5)		0 1	100 124	28
00	Total costs - current cost reporting period (line 26 plus OTHER ADJUSTMENT				0 1, 1	108, 136 983	
50	Pioneer ACO demonstration payment adjustment (see instruc	tions)			0	903	
	Demonstration payment adjustment amount before sequestrat	,			0	0	
. 99	Subtotal (see instructions)				0 1, 1	109, 119	
	Sequestration adjustment (see instructions)				0	22, 182	
. 00		on			0	0	31
. 00 . 01 . 02	Demonstration payment adjustment amount after sequestration				0 1.0	086, 936	32
. 00 . 01 . 02 . 00	Interim payments (see instructions)						
), 99 , 00 , 01 , 02 2, 00 3, 00	Interim payments (see instructions) Tentative settlement (for contractor use only)				0	0	33
. 00 . 01 . 02 . 00	Interim payments (see instructions)		2 Dub 15 0				33 34

	SIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider C	CN: 15-1329		eri od:	Worksheet H-5	
PR	DGRAM BENEFI CI ARI ES	HHA CCN:	15-7143		rom 01/01/2019 5 12/31/2019	Date/Time Prep 8/31/2020 7:54	
					Home Health Agency I	PPS	T UI
		I npati en	it Part A		Par	t B	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
0	Total interim normante neid te provider	1.00	2.00	0	3.00	4.00	1
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0		1, 086, 936 0	1
0	List separately each retroactive lump sum adjustment 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)						9
1	Program to Provider		1	0		0	3
)1)2				0		0	3
)3				0		0	3
)4				0		0	3
)5	Provider to Program			0		0	3
0				0		0	3
1				0		0	:
52 53				0		0	
53 54				0		0	
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		1, 086, 936	2
0	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		1				Ę
0	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						
1	Program to Provider		1	0		0	Ę
)2				0		0	Ę
3				0		0	Ę
0	Provider to Program		1	0		0	Ę
0 1				0		0	Ę
2				0		0	Ę
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0	í
10	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER			0		1	é
)2	SETTLEMENT TO PROVIDER			0		0	6
00	Total Medicare program liability (see instructions)			0		1, 086, 937	7
					Contractor Number	NPR Date (Mo/Day/Yr)	
00	Name of Contractor	(0		1.00	2.00	6

	Financial Systems M SIS OF HOSPITAL-BASED HOSPICE COSTS	ARGARET MARY COMMU	INITY HOSPITA Provider C		Peri od:	u of Form CMS-: Worksheet O	2552-1
			Hospi ce CCI	N: 15-1551	From 01/01/2019 To 12/31/2019	Date/Time Pre 8/31/2020 7:5	pared: 4 am
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI FI - CATI ONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	- T - T		I	-1		
. 00	CAP REL COSTS-BLDG & FIXT* CAP REL COSTS-MVBLE EQUIP*		0		0 0	0	1.00
. 00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		0 0 0 0	0	2.00
. 00	ADMI NI STRATI VE & GENERAL*	134, 687	154, 518	289, 20		289, 205	4.00
. 00	PLANT OPERATION & MAINTENANCE*	0	0		0 0	0	5.00
. 00	LAUNDRY & LINEN SERVICE*	0	0		0 0	0	6.0
00	HOUSEKEEPI NG*	0	0		0 0	0	7.0
. 00		0	0		0 0	0	8.0
. 00 0. 00	NURSI NG ADMI NI STRATI ON* ROUTI NE MEDI CAL SUPPLI ES*	0	0		0 0	0	9.0 10.0
1.00	MEDICAL RECORDS*	0	0		0 0	0	11.00
2.00	STAFF TRANSPORTATION*	0	65, 151	65, 15	-	65, 151	12.0
3.00	VOLUNTEER SERVICE COORDINATION*	0	0		0 0	0	13.0
4.00	PHARMACY*	0	188, 950	188, 95	50 0	188, 950	14.0
5.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		0 0	0	15.0
6.00	OTHER GENERAL SERVICE*	0	0		0 0	0	16.0
7.00	PATIENT/RESIDENTIAL CARE SERVICES						17.0
5.00	DI RECT PATI ENT CARE SERVI CE COST CENTERS		0	1	0 0	0	25.0
5.00	PHYSICIAN SERVICES**	0	19, 800			19,800	26.0
7.00	NURSE PRACTI TI ONER**	4,010	0			4, 010	
3.00	REGI STERED NURSE**	382, 062	0	382, 00		382, 062	
9.00	LPN/LVN**	0	0		0 0	0	29.0
0.00	PHYSI CAL THERAPY**	0	0		0 0	0	30.0
1.00	OCCUPATIONAL THERAPY**	0	0		0 0	0	31.0
2.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		0 0 05 0	0	32.0 33.0
3.00 4.00	MEDI CAL SOCI AL SERVI CES** SPI RI TUAL COUNSELI NG**	56, 605 29, 957	0			56, 605 29, 957	33.0
5.00	DI ETARY COUNSELI NG**	27, 737	0	27, 7.	0 0	27, 757	35.0
6.00	COUNSELING - OTHER**	0	0		0 0	0	36.0
7.00	HOSPICE AIDE & HOMEMAKER SERVICES**	113, 852	0			113, 852	37.0
8.00	DURABLE MEDICAL EQUI PMENT/OXYGEN**	0	0		0 0	0	38.0
9.00	PATIENT TRANSPORTATION**	0	0		0 0	0	39.0
0.00	I MAGI NG SERVI CES**	0	0		0 0	0	40.0
1.00	LABS & DI AGNOSTI CS**	0	0		0 0	0	41.0
2.00 2.50	MEDI CAL SUPPLI ES-NON-ROUTI NE** DRUGS CHARGED TO PATI ENTS**	0	0		0 0	0	42.0 42.5
3.00	OUTPATI ENT SERVI CES**	0	0		0 0	0	43.0
4.00	PALLIATIVE RADIATION THERAPY**	0	0		0 0	0	44.0
5.00	PALLIATIVE CHEMOTHERAPY**	0	0		0 0	0	45.0
6. 00	OTHER PATIENT CARE SERVICES (SPECIFY)** NONREIMBURSABLE COST CENTERS	0	0		0 0	0	46.0
0. 00	BEREAVEMENT PROGRAM *	0	0		0 0	0	60.0
1.00	VOLUNTEER PROGRAM *	0	0		0 0	0	
2.00	FUNDRAI SI NG*	0	0		0 0	0	62.0
3.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		0 0	0	63.0
4.00	PALLIATIVE CARE PROGRAM*	0	0		0 0	0	64.0
5.00	OTHER PHYSI CI AN SERVI CES*	0	0		0 0	0	65.0
5.00	RESI DENTI AL CARE* ADVERTI SI NG*	0	0		0 0	0	66.0
3.00	TELEHEALTH/TELEMONI TORI NG*	0	0			0	67.0 68.0
9.00		0	0		0 0	0	
). 00	NURSING FACILITY ROOM & BOARD*	0	0		0 0	0	
	OTHER NONREI MBURSABLE (SPECI FY)*	0	0		0 0	0	71.0
	TOTAL	721, 173	428, 419	1, 149, 59	92 0	1, 149, 592	1100 0

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. ** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

VALYS	SIS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN:	15-1329	Peri od:	Worksheet O	
			Hospi ce CCN:	15-1551	From 01/01/2019 To 12/31/2019	Date/Time P 8/31/2020 7	
					Hospi ce I	0/31/2020 /	. <u>54</u> ai
		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS						
00	CAP REL COSTS-BLDG & FIXT*	0	0				1
00	CAP REL COSTS-MVBLE EQUIP*	0	0				2
00	EMPLOYEE BENEFITS DEPARTMENT*	0	0				3
00	ADMI NI STRATI VE & GENERAL*	0	289, 205				4
00	PLANT OPERATION & MAINTENANCE*	0	0				5
00	LAUNDRY & LINEN SERVICE*	0	0				6
00	HOUSEKEEPI NG*	0	0				7
00	DI ETARY*	0	0				8
00	NURSING ADMINISTRATION*	0	0				9
0. 00	ROUTINE MEDICAL SUPPLIES*	0	0				10
I. 00	MEDI CAL RECORDS*	0	0				11
2.00	STAFF TRANSPORTATION*	0	65, 151				12
3.00		0	0				13
1.00	PHARMACY*	0	188, 950				14
	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0				15
	OTHER GENERAL SERVICE*	0	0				16
	PATI ENT/RESI DENTI AL CARE SERVI CES	0	0				17
. 00	DI RECT PATI ENT CARE SERVICE COST CENTERS						- ''
5.00	INPATIENT CARE-CONTRACTED**	0	0				25
	PHYSICIAN SERVICES**	0	19, 800				26
		0					
	NURSE PRACTITIONER**	-	4,010				27
	REGI STERED NURSE**	0	382, 062				28
9.00	LPN/LVN**	0	0				29
	PHYSICAL THERAPY**	0	0				30
		0	0				31
2.00	SPEECH/LANGUAGE PATHOLOGY**	0	0				32
	MEDICAL SOCIAL SERVICES**	0	56, 605				33
	SPIRITUAL COUNSELING**	0	29, 957				34
5.00	DI ETARY COUNSELI NG**	0	0				35
5.00	COUNSELING - OTHER**	0	0				36
7.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	113, 852				37
3.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0				38
9.00	PATI ENT TRANSPORTATI ON**	0	0				39
0. 00	I MAGI NG SERVI CES**	0	0				40
1.00	LABS & DI AGNOSTI CS**	0	o				41
2.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	o				42
2.50	DRUGS CHARGED TO PATIENTS**	0	0				42
	OUTPATI ENT SERVI CES**	0	0				43
1.00	PALLIATIVE RADIATION THERAPY**	0	Ő				44
5.00	PALLIATIVE CHEMOTHERAPY**	0	0				45
5.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0				46
. 00	NONREI MBURSABLE COST CENTERS		0				
	BEREAVEMENT PROGRAM *	0	0				60
	VOLUNTEER PROGRAM *	0	0				61
	FUNDRAI SI NG*	0					62
	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63
		0	0				
	PALLIATIVE CARE PROGRAM*	0	0				64
	OTHER PHYSICIAN SERVICES*	0	0				65
	RESIDENTIAL CARE*	0	0				66
	ADVERTI SI NG*	0	0				6
	TELEHEALTH/TELEMONI TORI NG*	0	0				68
	THRI FT STORE*	0	0				69
	NURSING FACILITY ROOM & BOARD*	0	0				70
1.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0				71
	TOTAL	0	1, 149, 592				100

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Health Financial Systems	MARGARET MARY COMM	UNITY HOSPITA	L .	In Lieu	u of Form CMS-2	2552-10
ANALYSI'S OF HOSPITAL-BASED HOSPICE COST CARE	S FOR HOSPICE ROUTINE HOME	Provider CO		Period: From 01/01/2019	Worksheet 0-2	
		Hospi ce CCN	N: 15-1551	To 12/31/2019	Date/Time Pre 8/31/2020 7:5	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST	CENTERS					
25.00 INPATIENT CARE-CONTRACTED						25.00
26.00 PHYSICIAN SERVICES	0	19, 800	19, 80	0 0	19, 800	26.00
27.00 NURSE PRACTITIONER	4, 008	0	4,00	8 0	4,008	27.00
28.00 REGI STERED NURSE	381, 863	0	381, 86	3 0	381, 863	28.00
29.00 LPN/LVN	0	0		0 0	0	29.00
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	56, 576	0	56, 57	6 0	56, 576	33.00
34.00 SPIRITUAL COUNSELING	29, 942	0	29, 94	2 0	29, 942	34.00
2E OO DIETADY COUNSELLNC		0			0	25 00

34.00	SPI RI TUAL COUNSELI NG	29, 942	0	29, 942	0	29, 942	34.00
35.00	DI ETARY COUNSELI NG	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	113, 793	0	113, 793	0	113, 793	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0	0	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	586, 182	19, 800	605, 982	0	605, 982	100.00

 * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSI CI AN SERVI CES	0	19, 800	26.00
27.00	NURSE PRACTITIONER	0	4,008	27.00
28.00	REGI STERED NURSE	0	381, 863	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	56, 576	33.00
34.00	SPI RI TUAL COUNSELI NG	0	29, 942	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	113, 793	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	605, 982	100.00
* Tran	isfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 51		

Health Financial Systems MA ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI	ARGARET MARY COMM	Provider CC		Period:	u of Form CMS-: Worksheet 0-3	
RESPITE CARE		Hospi ce CCN	l: 15-1551	From 01/01/2019 To 12/31/2019	Date/Time Pre 8/31/2020 7:5	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATIONS		
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED		0		0 0	0	
26.00 PHYSICIAN SERVICES	0	0		0 0	0	26.00
27.00 NURSE PRACTITIONER	1	0		1 0	1	27.00
28.00 REGI STERED NURSE	142	0	1	42 0	142	28.00
29.00 LPN/LVN	0	0		0 0	0	29.00
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	21	0		21 0	21	33.00
34.00 SPI RI TUAL COUNSELI NG	11	0		11 0	11	34.00
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	42	0		42 0	42	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00 PATIENT TRANSPORTATION	0	0		0 0	0	39.00
40.00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00 OUTPATIENT SERVICES	0	0		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100.00 TOTAL *	217	0	2	17 0	217	100.00

 45.00
 PALLIATIVE CHEMOTHERAPY
 0

 46.00
 OTHER PATIENT CARE SERVICES (SPECIFY)
 0

 100.00
 TOTAL *
 217

 * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5		
		6.00	± col. 6) 7.00	-	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	1 1100		
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSI CI AN SERVI CES	0	0		26.00
27.00	NURSE PRACTI TI ONER	0	1		27.00
28.00	REGI STERED NURSE	0	142		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	21		33.00
34.00	SPI RI TUAL COUNSELI NG	0	11		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	42		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATI ENT TRANSPORTATI ON	0	0		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DI AGNOSTI CS	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATI ENT SERVI CES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	217		100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 52			

ealth Financial Systems NALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOS	MARGARET MARY COMM	Provider CC		Peri od:	In Lie	u of Form CMS- Worksheet 0-4	
NPATIENT CARE	PICE GENERAL	Provider CC	N: 15-1329	From 01/	/01/2019	worksneet 0-4	ł
NPATIENI CARE		Hospice CCN	: 15-1551		/31/2019	Date/Time Pre 8/31/2020 7:5	
				Hospi	ce I		_
	SALARI ES	OTHER	SUBTOTAL		SSIFI -	SUBTOTAL	
			(col. 1 +	CAT	IONS		
			<u>col. 2)</u>				
	1.00	2.00	3.00	4.	00	5.00	-
DI RECT PATI ENT CARE SERVI CE COST CENTERS							
25.00 INPATIENT CARE-CONTRACTED		0		0	0	0	
26.00 PHYSI CI AN SERVI CES	0	0		0	0	0	
27.00 NURSE PRACTITIONER		0			0		27.00
28.00 REGISTERED NURSE	57	0		57	0	57	
9.00 LPN/LVN 0.00 PHYSICAL THERAPY	0	0		0	0	0	
1. 00 OCCUPATIONAL THERAPY	0	0		0	0	0	
2.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0	0	0	
3. 00 MEDICAL SOCIAL SERVICES	0	0		0	0	8	33.00
4. 00 SPIRITUAL COUNSELING	0	0		0	0	0	34.00
5. 00 DIETARY COUNSELING	4	0		4	0	4	
6.00 COUNSELING - OTHER	0	0		0	0	0	
7.00 HOSPICE AIDE & HOMEMAKER SERVICES	17	0		17	0	17	
8. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN		0		0	0	0	
9.00 PATIENT TRANSPORTATION	0	0		0	0	0	
0.00 I MAGI NG SERVI CES	0	0		0	0	0	
1. 00 LABS & DI AGNOSTI CS	0	0		0	0	0	
2. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0	0	0	
2.50 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	
3. 00 OUTPATI ENT SERVICES	0	0		0	0	0	
4.00 PALLIATIVE RADIATION THERAPY	0	o		0	o	0	
5.00 PALLIATIVE CHEMOTHERAPY	0	o		0	o	0	
6.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	o		0	0	0	
00.00 TOTAL *	87	o		87	0	87	100.0

 100.00
 TOTAL *
 87

 * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5		
		6.00	<u>± col. 6)</u> 7.00	-	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00		
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSI CI AN SERVI CES	0	0		26.00
27.00	NURSE PRACTI TI ONER	0	1		27.00
28.00	REGI STERED NURSE	0	57	,	28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	8		33.00
34.00	SPI RI TUAL COUNSELI NG	0	4		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	17		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATI ENT TRANSPORTATI ON	0	0		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATI ENT SERVI CES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	87	1	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 53			

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552	2-10
COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET Provider CCN: 15-1329	Period: Worksheet 0-5	
EXPENSES FOR ALLOCATION Hospice CCN: 15-1551	From 01/01/2019 To 12/31/2019 Date/Time Prepar 8/31/2020 7:54 a	
	Hospi ce I	4111
Descriptions H0SPICE		
DIRECT	SERVICE EXPENSES (sum	
	see EXPENSES FROM of cols. 1 +	
	ns) WKST B PART I 2)	
	(see	
	instructions)	
1.00	2.00 3.00	
GENERAL SERVICE COST CENTERS		
1.00 CAP REL COSTS-BLDG & FIXT	0 0 0 1	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	0 0 2	2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT	0 235, 652 235, 652 3	3.00
4.00 ADMINISTRATIVE & GENERAL 289,	205 301, 719 590, 924 4	4.00
5. 00 PLANT OPERATION & MAINTENANCE	0 0 5	5.00
6.00 LAUNDRY & LI NEN SERVICE	0 0 6	6.00
7. 00 HOUSEKEEPING	0 0 7	7.00
8. 00 DI ETARY	o o a	8.00
9.00 NURSING ADMINISTRATION	0 0 9	9.00
10.00 ROUTINE MEDICAL SUPPLIES	0 0 10	D. 00
11.00 MEDICAL RECORDS	0 0 11	1.00
12.00 STAFF TRANSPORTATION 65,	151 65, 151 12	2.00
13.00 VOLUNTEER SERVICE COORDINATION	0 0 13	3.00
14.00 PHARMACY 188,	950 0 188,950 14	4.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	0 0 15	5.00
16.00 OTHER GENERAL SERVICE	0 0 16	6.00
17.00 PATI ENT/RESI DENTI AL CARE SERVI CES	0 0 17	7.00
LEVEL OF CARE	· · · · · · · · · · · · · · · · · · ·	
50.00 HOSPICE CONTINUOUS HOME CARE	0 0 50	D. 00
51.00 HOSPICE ROUTINE HOME CARE 605,	982 605, 982 51	1.00
52.00 HOSPICE INPATIENT RESPITE CARE	217 217 52	2.00
53.00 HOSPICE GENERAL INPATIENT CARE	87 87 53	3.00
NONREIMBURSABLE COST CENTERS		
60. 00 BEREAVEMENT PROGRAM	0 0 60	D. 00
61.00 VOLUNTEER PROGRAM	0 0 61	1.00
62.00 FUNDRAI SI NG	0 0 62	2.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0 0 63	3.00
64.00 PALLIATIVE CARE PROGRAM	0 0 64	4.00
65.00 OTHER PHYSICIAN SERVICES	0 0 65	5.00
66. 00 RESIDENTIAL CARE	0 0 66	6.00
67. 00 ADVERTI SI NG	0 0 67	7.00
68. 00 TELEHEALTH/TELEMONI TORI NG	0 0 68	B. 00
69.00 THRIFT STORE	0 0 69	9.00
70.00 NURSING FACILITY ROOM & BOARD	0 0 70	D. 00
71.00 OTHER NONREI MBURSABLE (SPECI FY)		1.00
99.00 NEGATIVE COST CENTER		9.00
100. 00 T0TAL 1, 149,	592 537, 371 1, 686, 963 100	0. 00

	Financial Systems M ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	ARGARET MARY COM SERVICE COSTS		CN: 15-1329	Peri od:	eu of Form CMS-2 Worksheet 0-6	
0001 7	LEUGATION - HUSTTAL-DASED HUSTTEL ULIVERAL	SERVICE COSTS	Hospi ce CC		From 01/01/2019 To 12/31/2019	9 Part I	pared:
					Hospi ce I	0/31/2020 7.3	
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVB		SUBTOTAL	
		EXPENSES	& FIX	EQUI P	BENEFI TS		
					DEPARTMENT		
		0	1.00	2.00	3.00	3A	
1 00	GENERAL SERVICE COST CENTERS	0	0	1		T	1 1 00
1.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	0	0		0		1.00
2.00 3.00	EMPLOYEE BENEFITS DEPARTMENT	235, 652	0		0 235, 652		3.00
3.00 4.00	ADMI NI STRATI VE & GENERAL	590, 924			0 235, 652		
4.00 5.00	PLANT OPERATION & MAINTENANCE	590, 924					
5.00 6.00	LAUNDRY & LINEN SERVICE	0			0 0		
7.00	HOUSEKEEPI NG	0	0				
8.00	DI ETARY	0					
9.00	NURSI NG ADMI NI STRATI ON	0					
10.00	ROUTINE MEDICAL SUPPLIES	0					
11.00	MEDICAL RECORDS	0			0 0		
12.00	STAFF TRANSPORTATION	65, 151				65, 151	
12.00	VOLUNTEER SERVICE COORDINATION	03, 131			0 0		1
14.00	PHARMACY	188, 950				188,950	
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0 0		
16.00	OTHER GENERAL SERVICE	0	0		0 0		
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	0		0		
17.00	LEVEL OF CARE					<u> </u>	17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0			(0 10	50.00
51.00	HOSPICE ROUTINE HOME CARE	605, 982			235, 529	841, 511	
52.00	HOSPI CE I NPATI ENT RESPI TE CARE	217	C C		0 88		•
53.00	HOSPI CE GENERAL I NPATI ENT CARE	87	0		0 35	5 122	53.00
	NONREIMBURSABLE COST CENTERS			•			1
60.00	BEREAVEMENT PROGRAM	0	0		0 (0 0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0 0	61.00
62.00	FUNDRAI SI NG	0	0		0 0	0 0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0 0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0 0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0 0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0 0	66.00
67.00	ADVERTI SI NG	0	0		0 0	0 0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 (0 0	
69.00	THRI FT STORE	0	0		0 0	0 0	
70.00	NURSING FACILITY ROOM & BOARD	0				0	
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0 0	0 0	
99.00	NEGATI VE COST CENTER	0	0		0 (1	99.00
100.00	TOTAL	1, 686, 963	0		0 235, 652	2 1, 686, 963	100.00

Heal th	Financial Systems M	ARGARET MARY COM	MUNI TY HOSPI TA	AL.		In Lie	u of Form CMS	-25	52-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C Hospice CC	CN: 15-1329 N: 15-1551		eriod: rom 01/01/2019 o 12/31/2019	Worksheet O- Part I Date/Time Pr 8/31/2020 7:	ера	ared: am
						Hospice I			
	Descriptions	ADMI NI STRATI V E & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY &		HOUSEKEEPI NG	DI ETARY		
		4.00	5.00	6.00		7.00	8.00		
	GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT								1.00
2.00	CAP REL COSTS-MVBLE EQUIP								2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT								3.00
4.00	ADMI NI STRATI VE & GENERAL	590, 924							4.00
5.00	PLANT OPERATION & MAINTENANCE	0	C						5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0				6.00
7.00	HOUSEKEEPING	0	0		0	0			7.00
8.00	DI ETARY	0	0			0		0	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0			0		Ĭ	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0			0		-	10.00
11.00	MEDI CAL RECORDS	0				0			11.00
12.00	STAFF TRANSPORTATION	35, 126				0			12.00
13.00	VOLUNTEER SERVICE COORDINATION	00, 120				0			13.00
14.00	PHARMACY	101, 871				0			14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				0			15.00
	OTHER GENERAL SERVICE	0				0			16.00
	PATI ENT/RESI DENTI AL CARE SERVI CES	0				0			17.00
17.00	LEVEL OF CARE	0		/		U0			17.00
50,00	HOSPICE CONTINUOUS HOME CARE	0			_			٦,	50.00
51.00	HOSPICE ROUTINE HOME CARE	453, 697							51.00
52.00	HOSPICE INPATIENT RESPITE CARE	164	C		0	o			52.00
	HOSPICE GENERAL INPATIENT CARE	66			0	0			53.00
55.00	NONREI MBURSABLE COST CENTERS	00		/	0	0		4	55.00
60,00	BEREAVEMENT PROGRAM	0	C			0			50.00
61.00	VOLUNTEER PROGRAM	0				0			50.00 51.00
62.00	FUNDRAI SI NG	0				0			52.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0			52.00 53.00
64.00	PALLIATIVE CARE PROGRAM	0				0			53.00 54.00
65.00	OTHER PHYSICIAN SERVICES	0				0			54.00 55.00
66.00	RESI DENTI AL CARE	0			0	0			56.00 56.00
67.00	ADVERTI SI NG	0			0	0			50.00 57.00
68.00	TELEHEALTH/TELEMONI TORI NG	0				0			57.00
69.00	THRI FT STORE	0				0			58.00 59.00
70.00	NURSING FACILITY ROOM & BOARD	0		1		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	c		0	0			71.00
99.00	NEGATI VE COST CENTER	0			0	0			71.00 79.00
	TOTAL	590, 924	C C		0	0			00.00
100.00	1.0	0,0,724		1	5	9		5110	

	Financial Systems	MARGARET MARY COMM			Daval		u of Form CMS-	
CUST	ALLOCATION - HOSPITAL-BASED HOSPICE GENERA	L SERVICE COSIS	Provider C Hospice CC		Peri From To	od: 01/01/2019 12/31/2019	Worksheet 0-6 Part I Date/Time Pre 8/31/2020 7:5	epared:
					н	ospice I	0/31/2020 7.5	alli
	Descriptions	NURSI NG ADMI NI STRATI O	ROUTI NE MEDI CAL	MEDI CAL RECORDS		STAFF ANSPORTATIO	VOLUNTEER SERVI CE	
		N	SUPPLI ES			N	COORDI NATI ON	
		9.00	10.00	11.00		12.00	13.00	
	GENERAL SERVICE COST CENTERS			-				
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMI NI STRATI VE & GENERAL							4.00
5.00	PLANT OPERATION & MAINTENANCE							5.00
6.00	LAUNDRY & LINEN SERVICE							6.00
7.00	HOUSEKEEPING							7.00
8.00	DI ETARY							8.00
9.00	NURSING ADMINISTRATION	0						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0					10.00
11.00	MEDI CAL RECORDS	0			0			11.00
12.00	STAFF TRANSPORTATION	0				100, 277		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0				0	0	13.00
14.00	PHARMACY	0				0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				0	0	15.00
16.00	OTHER GENERAL SERVICE	0				0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES							17.00
	LEVEL OF CARE			·				
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0		0	100, 225	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0	37	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0	15	0	53.00
	NONREIMBURSABLE COST CENTERS			·				1
60.00	BEREAVEMENT PROGRAM	0				0	0	60.00
61.00	VOLUNTEER PROGRAM	0				0	0	61.00
62.00	FUNDRAI SI NG	0				0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0				0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0				0	0	65.00
66.00	RESI DENTI AL CARE	0				0	0	66.00
67.00	ADVERTI SI NG	0				0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0				0	0	68.00
69.00	THRI FT STORE	0				0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0				0	0	71.00
99.00	NEGATI VE COST CENTER	0	0		0	0	0	99.00
100 00	TOTAL	0	0		0	100, 277	0	100.00

COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CO Hospice CCI		Period: From 01/01/2019 To 12/31/2019	Worksheet 0-0 Part I Date/Time Pro 8/31/2020 7:5	epared:
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN ADMI NI STRATI V E SERVI CES	OTHER GENER SERVI CE	AL PATI ENT/ RESI DENTI AL CARE SERVI CES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
	ROUTINE MEDICAL SUPPLIES						10.00
	MEDI CAL RECORDS						11.00
	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION	000.001					13.00
		290, 821	0				14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES OTHER GENERAL SERVI CE	0	0		0		15.00
	PATIENT/RESIDENTIAL CARE SERVICES	0			0		17.00
17.00	LEVEL OF CARE				0		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	C	50.00
	HOSPICE ROUTINE HOME CARE	290, 669	0		0	1, 686, 102	
	HOSPICE INPATIENT RESPITE CARE	109	0		0 0	615	
	HOSPICE GENERAL INPATIENT CARE	43	0		0 0	246	
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	C	60.00
61.00	VOLUNTEER PROGRAM	0			0	C	61.00
62.00	FUNDRAI SI NG	0			0	C	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	C	63.00
	PALLIATIVE CARE PROGRAM	0			0	C	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	C	65.00
	RESI DENTI AL CARE	0	0		0 0	C	
67.00		0			0	C	
68.00		0			0	C	
	THRI FT STORE	0			0	C	
	NURSING FACILITY ROOM & BOARD	_	_		-	C	
	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0 0	C	
	NEGATIVE COST CENTER	0	0		0 0	1 (0) 0)	
100.00	TOTAL	290, 821	0		0 0	1, 686, 963	GUUU. 00

Heal th	Financial Systems	MARGARET MARY CON	IMUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENE	RAL SERVICE COSTS	Provider C		Peri od:	Worksheet 0-6)
STATI S	TI CAL BASI S		lloopi oo CC		From 01/01/2019		norod.
			Hospi ce CC	N: 15-1551	To 12/31/2019	Date/Time Pre 8/31/2020 7:5	
					Hospi ce I	0/ 51/ 2020 7. 5	
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	RECONCILIATIO	ADMI NI STRATI V	
	···· · · · · · · · · · · · · · · · · ·	& FIX	EQUI P	BENEFI TS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
			VALUE)	(GROSS		COSTS)	
			,	SALARI ES)		ŕ	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	235, 65	52		3.00
4.00	ADMINISTRATIVE & GENERAL	0	0		0 -590, 924	1, 096, 039	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPI NG	0	0		0 0	0	7.00
8.00	DI ETARY	0	0		0 0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0 0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0 0	0	10.00
11.00	MEDI CAL RECORDS	0	0		0 0	0	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	65, 151	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.00
14.00	PHARMACY	0	0		0 0	188, 950	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0		0 0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE					•	1
50.00	HOSPICE CONTINUOUS HOME CARE				0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			235, 52	9 0	841, 511	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	8	8 0	305	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	3	5 0	122	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0		61.00
62.00	FUNDRAI SI NG	0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
69.00	THRI FT STORE	0	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	
	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Pa			200,00		590, 924	
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	1.00000	00	0. 539145	101.00

Heal th	Financial Systems MAR	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provider C	CN: 15-1329	Peri od:	Worksheet 0-6	
STATI S	STI CAL BASI S			N. 1E 1EE1	From 01/01/2019		norod.
			Hospi ce CC	N: 15-1551	To 12/31/2019	Date/Time Pre 8/31/2020 7:5	
					Hospi ce I	0/31/2020 7.3	
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPIN		NURSI NG	
		OPERATION &	LINEN SERVICE			ADMI NI STRATI O	
		MAI NTENANCE	(IN-FACILITY	C = -	DAYS)	N	
		(SQUARE FEET)	DAYS)		, í	(DI RECT NURS.	
		. ,				HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0			0		7.00
8.00	DI ETARY	0			0 0		8.00
9.00	NURSI NG ADMI NI STRATI ON	0			0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0			0	0	10.00
11.00	MEDI CAL RECORDS	0			0	0	11.00
12.00	STAFF TRANSPORTATION	0			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0			0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0 0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0 0	0	53.00
	NONREI MBURSABLE COST CENTERS	· · · · · ·			-		
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES	0			0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				_		70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0 0	0	71.00
99.00	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0		0 0		100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.0000	0. 000000	0. 000000	101.00

Heal th	Financial Systems MAR	GARET MARY COMM	UNITY HOSPITA	L	In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provider C	CN: 15-1329	Peri od:	Worksheet 0-6)
STATI S	ITI CAL BASI S		Hospi ce CCI	N: 15-1551	From 01/01/2019 To 12/31/2019		pared:
						8/31/2020 7:5	
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATI		(CHARGES)	
		SUPPLI ES	(PATI ENT	N	COORDI NATI ON		
		(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS)	44.00	10.00	SERVICE)	11.00	
		10.00	11.00	12.00	13.00	14.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	CAP REL COSTS-BLDG & FIXT						1.00
	CAP REL COSTS-MVBLE EQUIP						
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00 5.00	ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE						4.00 5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
8.00 9.00	NURSI NG ADMI NI STRATI ON						9.00
9.00 10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS	0	0				11.00
12.00	STAFF TRANSPORTATION		0	109, 8	77		12.00
12.00	VOLUNTEER SERVICE COORDINATION			107, 0	0 0		12.00
14.00	PHARMACY				0 0		
14.00	PHYSICIAN ADMINISTRATIVE SERVICES				0 0	310, 349	
16.00	OTHER GENERAL SERVICE				0 0	0	
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES				0 0	0	17.00
17.00	LEVEL OF CARE						17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0				
52.00	HOSPICE INPATIENT RESPITE CARE	Ő	0		41 0		1
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		16 0		
	NONREI MBURSABLE COST CENTERS				<u> </u>		
60.00	BEREAVEMENT PROGRAM				0 0	0	60.00
61.00	VOLUNTEER PROGRAM				0 0	0	61.00
62.00	FUNDRAI SI NG			1	0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			1	0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM				0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES				0 0	0	65.00
66.00	RESI DENTI AL CARE				0 0	0	66.00
67.00	ADVERTI SI NG				0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG				0 0	0	68.00
69.00	THRI FT STORE				0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)				0 0	0	
99.00	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0	100/2	-	290, 821	
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 9129	62 0.000000	0. 912955	101.00

Heal th	Financial Systems MAR	RGARET MARY CON	IMUNI TY HOSPI TA	L	In Lieu	u of Form CMS	-2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provider C	CN: 15-1329	Period:	Worksheet 0-	-6
STATI S	ITI CAL BASI S		Hospi ce CC	N: 15-1551	From 01/01/2019 To 12/31/2019	Part II Date/Time Pr	repared:
						8/31/2020 7:	
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL SERVI CE	PATI ENT/ RESI DENTI AL			
		ADMI NI STRATI V E SERVI CES	(SPECI FY	CARE SERVICE			
		(PATIENT	BASIS)	(IN-FACILIT			
		DAYS)	Brior 0)	DAYS)	•		
		15.00	16.00	17.00			
	GENERAL SERVICE COST CENTERS		L				
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION PHARMACY						13.00
14.00 15.00	PHARMACY PHYSI CLAN ADMI NI STRATI VE SERVI CES	0					14.00 15.00
16.00	OTHER GENERAL SERVICE	0	0				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
17.00	LEVEL OF CARE				0		
50.00	HOSPICE CONTINUOUS HOME CARE	0	0				50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0)			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0)	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0		53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0				60.00
61.00	VOLUNTEER PROGRAM		0				61.00
62.00	FUNDRAI SI NG		0				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63.00
64.00	PALLIATIVE CARE PROGRAM		0	1			64.00
65.00	OTHER PHYSI CI AN SERVI CES		0		0		65.00
66.00	RESIDENTIAL CARE	0	-		0		66.00
67.00 68.00	ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG		0				67.00 68.00
69.00	THRIFT STORE						69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0		71.00
99.00	NEGATI VE COST CENTER				J J		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0		0		100.00
	UNIT COST MULTIPLIER	0. 000000	-		-		101.00
					1		

	Financial Systems M I ONMENT OF HOSPITAL-BASED HOSPICE SHARED SE	ARGARET MARY COM RVICE COSTS BY	Provider C		Peri od:	u of Form CMS-: Worksheet 0-7	
	OF CARE			N: 15-1551	From 01/01/2019 To 12/31/2019		pared:
					Hospi ce I		
				Charges by	/ LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	НСНС	HRHC	HI RC	
		0	1.00	2.00	3.00	4.00	
	ANCI LLARY SERVICE COST CENTERS		0 540 100			-	1
1.00 2.00 3.00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	66. 00 67. 00 68. 00	0. 513488 0. 573836 0. 619340		0 0 0 0 0 0	0 0 0	1.00 2.00 3.00
4.00 5.00 6.00	DRUGS CHARGED TO PATIENTS DURABLE MEDICAL EQUIP-RENTED LABORATORY	73.00 96.00 60.00	0. 361659 0. 181384		0 0	0	4.00 5.00 6.00
. 01	BLOOD LABORATORY MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	60. 01 71. 00	0. 000000		0 0	0	6.01 7.00
	OTHER OUTPATIENT SERVICE COST CENTER RADIOLOGY-THERAPEUTIC OTHER ANCILLARY SERVICE COST CENTERS Totals (sum of lines 1-11)	93. 00 55. 00 76. 00					8.00 9.00 10.00 11.00
		Charges by LOC (from Provider Records)		Shared Serv	ice Costs by LOC		
	Cost Center Descriptions	HGI P	HCHC (col. 1 x col. 2)	HRHC (col. x col. 3)	x col. 4)	HGIP (col. 1 x col. 5)	
	ANCILLARY SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
	PHYSI CAL THERAPY OCCUPATIONAL THERAPY	0	0		0 0 0 0	0	1.00 2.00
. 00 . 00 . 00	SPEECH PATHOLOGY DRUGS CHARGED TO PATIENTS DURABLE MEDICAL EQUIP-RENTED	0	0		0 0 0 0	0 0	3.00 4.00 5.00
5. 00 5. 01 7. 00	LABORATORY BLOOD LABORATORY MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0 0		0 0 0 0 0 0	0 0 0	6.00 6.01 7.00
. 00 . 00	OTHER OUTPATIENT SERVICE COST CENTER RADIOLOGY-THERAPEUTIC OTHER ANCILLARY SERVICE COST CENTERS					U	8. 00 9. 00 10. 00
	Totals (sum of lines 1–11)		0		0 0	0	11.00

MCRI F32 - 16. 2. 168. 1

CALCUL	ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provider C	CN: 15-1329		ri od:	Worksheet 0-8	
		Hospi ce CCI	N: 15-1551	Fr To	om 01/01/2019 12/31/2019	Date/Time Prep 8/31/2020 7:54	
					Hospi ce I		
			TITLE XVIII		TITLE XIX	TOTAL	
			MEDI CARE		MEDI CAI D		
			1.00		2.00	3.00	
	HOSPI CE CONTI NUOUS HOME CARE						
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	-7, col. 6,				0	1.0
	line 11)						
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 10)					0	2.0
. 00	Total average cost per diem (line 1 divided by line 2)			-		0.00	
. 00	Unduplicated program days (Wkst. S-9 col. as appropriate, lir	ne 10)		0	0		4.0
. 00	Program cost (line 3 times line 4)			0	0		5.0
00	HOSPICE ROUTINE HOME CARE Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	7 col 7			1	1 (0(10)	
. 00	line 11)	-7, COL. 7,				1, 686, 102	6.0
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 11)					14, 393	7.
. 00	Total average cost per diem (line 6 divided by line 7)					14, 375	8.
. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	11, 7	75	939	117.15	9.0
0.00	Program cost (line 8 times line 9)		1, 379, 4		110, 004		10.0
0.00	HOSPICE INPATIENT RESPITE CARE		1,077,1		110,001		
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	-7, col. 8,				615	11.
	line 11)						
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)					5	12.
3.00	Total average cost per diem (line 11 divided by line 12)					123.00	13.
4.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)		5	0		14.(
5.00	Program cost (line 13 times line 14)		6	15	0		15.
	HOSPICE GENERAL INPATIENT CARE						
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	-7, col. 9,				246	16.
7 00	line 11)						47
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)					2 123. 00	17.
B. 00 9. 00	Total average cost per diem (line 16 divided by line 17)	no 12)		0	0	123.00	18. 19.
9.00 0.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li Program cost (line 18 times line 19)	110 13)		0	0		20.
0.00	TOTAL HOSPICE CARE			U	U		20.1
1.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				1	1, 686, 963	21
	Total unduplicated days (Wkst. S-9, col. 4, line 14)					14, 400	
22.00							

	Financial Systems MAR		Provider C		Peri od:	u of Form CMS-2 Worksheet M-1	
ANAL 13	IS OF HUSPITAL-BASED RHC/FUHC CUSTS		Provider C	UN: 15-1329	From 01/01/2019	worksneet M-T	
			Component	CCN: 15-8511	To 12/31/2019	Date/Time Pre 8/31/2020 7:5	
					RHC I	Cost	alli
		Compensati on	Other Costs	Total (col	1 Recl assi fi cat		
		oomponiou er on	00000	+ col . 2)	ions	Trial Balance	
						(col. 3 +	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
. 00	Physi ci an	0	0		0 0	0	1.00
2.00	Physician Assistant	127, 363	0	127, 36	53 C	127, 363	2.00
8.00	Nurse Practitioner	396, 646	0	396, 64	46 C	396, 646	3.00
l. 00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	108, 701	0	108, 70	D1 C	108, 701	5.00
b. 00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	
3.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	285, 005	0	285, 00		285, 005	9.0
0.00	Subtotal (sum of lines 1 through 9)	917, 715	0	917, 71	15 C	917, 715	
1.00	Physician Services Under Agreement	0	0		0 0	0	11.0
2.00	Physician Supervision Under Agreement	0	0		0 0	0	
3.00	Other Costs Under Agreement	0	0		0 0	0	
4.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
5.00	Medical Supplies	0	68, 094	68, 09		68, 094	
6.00	Transportation (Health Care Staff)	0	0		0 0	0	
7.00	Depreciation-Medical Equipment	0	0		0 0	0	
8.00	Professional Liability Insurance	0	0		0 0	0	
9.00	Other Health Care Costs	0	0		0 0	0	
20.00	Allowable GME Costs						20.0
1.00	Subtotal (sum of lines 15 through 20)	0	68, 094				
22.00	Total Cost of Health Care Services (sum of	917, 715	68, 094	985, 80	09 C	985, 809	22.0
	Lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23.0
4.00	Dental	0	0		0 0		
5.00	Optometry	0	0		0 0	0	
5.01	Tel eheal th	0	0		0 0	0	
25.02	Chronic Care Management	0	0		0 0	0	
6.00	All other nonreimbursable costs	0	0		0 0	0	
27.00	Nonallowable GME costs	Ű	0		0	, U	27.0
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	
	through 27)	-					
	FACILITY OVERHEAD						
9.00	Facility Costs	0	31, 975	31, 97	75 C	31, 975	29.0
30.00	Administrative Costs	177, 280	22, 789	200, 06	59 C	200, 069	30.0
31.00	Total Facility Overhead (sum of lines 29 and	177, 280	54, 764	232, 04	14 C	232, 044	31.0
	30)						
32.00	Total facility costs (sum of lines 22, 28	1, 094, 995	122, 858	1, 217, 85	53 C	1, 217, 853	32.00
	and 31)					1	1

	Financial Systems MAR	GARET MARY COM	Provi der C		Peri od:	u of Form CMS- Worksheet M-*	
INAL IS	IS OF HUSPITAL-DASED RHC/FURC CUSTS		Provider C	UN. 10-1329	From 01/01/2019	WOIKSHEEL M-	1
			Component	CCN: 15-8511	To 12/31/2019	Date/Time Pre 8/31/2020 7:5	
					RHC I	Cost	34 alii
		Adjustments	Net Expenses		1		
		2	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6.00	7.00				
. 00	FACILITY HEALTH CARE STAFF COSTS Physician	0	0				1.0
2.00	Physician Assistant	0	127, 363				2.0
. 00 . 00	Nurse Practitioner	0	396, 646				3.0
. 00	Visiting Nurse	0	0+0 0				4.0
. 00 . 00	Other Nurse	0	108, 701				5.0
. 00 . 00	Clinical Psychologist	0	100, 701				6.0
. 00	Clinical Social Worker	0	0				7.0
. 00	Laboratory Techni ci an	Ő	0				8.0
. 00	Other Facility Health Care Staff Costs	0	285,005				9.0
0.00	Subtotal (sum of lines 1 through 9)	0	917, 715				10.0
1.00	Physician Services Under Agreement	0	0				11.0
2.00	Physician Supervision Under Agreement	0	0				12.0
3.00	Other Costs Under Agreement	0	0				13.0
4.00	Subtotal (sum of lines 11 through 13)	0	0				14.0
5.00	Medical Supplies	0	68, 094				15.0
6.00	Transportation (Health Care Staff)	0	0				16.0
7.00	Depreciation-Medical Equipment	0	0				17.0
8.00	Professional Liability Insurance	0	0				18.0
9.00	Other Health Care Costs	0	0				19. (
0.00	Allowable GME Costs						20.0
1.00	Subtotal (sum of lines 15 through 20)	0	68, 094				21.0
2.00	Total Cost of Health Care Services (sum of	0	985, 809				22.0
	lines 10, 14, and 21)						_
	COSTS OTHER THAN RHC/FQHC SERVICES						-
	Pharmacy	0	0				23.0
4.00 5.00	Dental	0	0				24.0
5.00	Optometry Talahaalith	0	0				25.0
5.01	Telehealth Chronic Care Management	0	0				25.0
25.02	All other nonreimbursable costs	0	0				25.0
7.00	Nonallowable GME costs	0	0				27.0
8.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.0
5.00	through 27)	0	0				20.0
	FACILITY OVERHEAD						1
9.00	Facility Costs	0	31, 975				29.0
0.00	Admini strati ve Costs	0	200, 069				30.0
1.00	Total Facility Overhead (sum of lines 29 and	0	232, 044				31.0
	30)						
2.00	Total facility costs (sum of lines 22, 28	0	1, 217, 853				32.0
	and 31)						

	Financial Systems MA ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	RGARET MARY CON SERVICES	Provi der C		Peri od:	u of Form CMS-2 Worksheet M-2	
					From 01/01/2019		
			Component	CCN: 15-8511	To 12/31/2019	Date/Time Pre 8/31/2020 7:5	
			_	_	RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons		1	1			
I. 00	Physi ci an	0.00					1.00
2.00	Physician Assistant	0. 82					2.00
3.00	Nurse Practitioner	2.59					3.00
1.00	Subtotal (sum of lines 1 through 3)	3. 41	9, 399		7, 161		4.00
5.00	Visiting Nurse	0.00				0	5.00
5.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7.02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	3. 41	9, 399			9, 399	8.00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE			RVICES		005 000	
10.00						985, 809	
11.00						0	
2.00						985, 809	
3.00	Ratio of hospital-based RHC/FQHC services (<i>,</i>			1.000000	
4.00				ine 31)		232, 044	
15.00	Parent provider overhead allocated to facil	ity (see instru	ctions)			828, 541	
16.00	Total overhead (sum of lines 14 and 15)					1, 060, 585	
17.00						0	17.00
	Enter the amount from line 16					1, 060, 585	
	Overhead applicable to hospital-based RHC/F					1, 060, 585	
20 00	Total allowable cost of hospital-based RHC/	FOHC services (sum of lines 10) and 19)		2,046,394	20 00

JALUU	Financial Systems MARGARET MARY COMMUN ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI C			From 01/01/2019		,
		Component CCN: 15-8511	To 12/31/2019		
		Title XVIII	RHC I	8/31/2020 7:5 Cost	54 am
			KIIC I	CUST	
			-	1.00	<u> </u>
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		I		
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		2, 046, 394	1.
. 00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		47, 169	2.
. 00	Total allowable cost excluding vaccine (line 1 minus line 2)			1, 999, 225 9, 399	
. 00	Total Visits (from Wkst. M-2, column 5, line 8)				
. 00	Physicians visits under agreement (from Wkst. M-2, column 5,		0		
. 00	Total adjusted visits (line 4 plus line 5)			9, 399	
. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	212.71	7.
			Carcuration		
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Period 1)	Period 2)	-
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20) 6 or your contractor)	1.00	2.00	8.
. 00	Rate for Program covered visits (see instructions)	. o or your contractor)	212. 71	212. 71	
. 00	CALCULATION OF SETTLEMENT		212.71	212.71	7.
0.00	Program covered visits excluding mental health services (from	contractor records)	0	1, 954	1 10.
1.00	Program cost excluding costs for mental health services (line	e 9 x line 10)	0	415, 635	11.
2.00	Program covered visits for mental health services (from contr	ractor records)	0	4	12.
3.00	Program covered cost from mental health services (line 9 x li	ne 12)	0	851	13.
4.00	Limit adjustment for mental health services (see instructions	-	0	851	
5.00	Graduate Medical Education Pass Through Cost (see instructions)				15.
6.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	416, 486	
6. 01 6. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov	-		290, 629 27, 206	
6.03	Total program preventive costs ((line 16.02/line 16.01) times	-		38, 988	
6.04	Total Program non-preventive costs ((line 16 minus lines 16.0			282, 855	
	(Titles V and XIX see instructions.)				
6.05	Total program cost (see instructions)		0	321, 843	
7.00	Primary payer amounts			0	
8.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		23, 929	18.
10.00	records)	and) (from contractor		47 004	10
9.00	Beneficiary coinsurance for RHC/FQHC services (see instructio records)			47, 904	19.
20.00	Net Medicare cost excluding vaccines (see instructions)			321, 843	20.
1.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		24, 465	
2.00	Total reimbursable Program cost (line 20 plus line 21)			346, 308	22.
3.00	Allowable bad debts (see instructions)			0	23.
3. 01	Adjusted reimbursable bad debts (see instructions)			0	
4.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
5.50 5.99	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	157		0	
6.00	Net reimbursable amount (see instructions)			346, 308	
	Sequestration adjustment (see instructions)			6, 926	
(6. UT	Demonstration payment adjustment amount after sequestration			0, 120	
	Interim payments			323, 147	
26. 02					1
26. 02 27. 00	Tentative settlement (for contractor use only)			0	28.
 26. 01 26. 02 27. 00 28. 00 29. 00 30. 00 				0 16, 235 0	29.

Heal th	Financial Systems MARGARET MARY COMMUN	In Lie	u of Form CMS-2	2552-10	
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1329	Peri od:	Worksheet M-4	
VACCIN	E COST	Component CCN: 15-8511	From 01/01/2019 To 12/31/2019		
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		917, 715		1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,	1, 856		3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	5	9, 292		4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu		11, 148		5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22			6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 060, 585		7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 011308	0. 011742	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x		11, 993		
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	23, 141	24, 028	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	94	315	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	246. 18	76.28	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	56	140	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)	heir) administration	13, 786	10, 679	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (the			47, 169	15.00
16.00	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3 Total Program cost of pneumococcal and influenza vaccine and			24, 465	16.00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems MARGARET MARY C	OMMUNI TY HOSPI TAL	Inlie	eu of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provi der CCN: 15-1329	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES		From 01/01/2019		
SERVICES RENDERED TO TROUGHT DENETTOTARTES	Component CCN: 15-8511	To 12/31/2019	Date/Time Prep 8/31/2020 7:54	
		RHC I	Cost	
			T B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC			294, 547	1.00
2.00 Interim payments payable on individual bills, either subr	nitted or to be submitted to		0	2.00
the contractor for services rendered in the cost reportin			Ŭ	2.00
"NONE" or enter a zero	ig poirtour in nono, in to			
3.00 List separately each retroactive lump sum adjustment amou	int based on subsequent			3.00
revision of the interim rate for the cost reporting period				0.00
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
3. 01		08/29/2019	28, 600	3.01
3. 02		00/2//2017	20,000	3.02
3. 03			0	3.02
3. 04			0	3.03
3. 05			0	3.04
Provider to Program			0	3.05
3. 50			0	3.50
3. 50			0	3.50
			0	3.51
3. 52 3. 53			0	3.52
3. 53			0	3.53
	2,00)		-	3.54 3.99
		_	28,600	
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (tra	ansrer to worksneet M-3, line	e	323, 147	4.00
27) TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after (had noview. Also show data	of		5.00
each payment. If none, write "NONE" or enter a zero. (1)	JESK FEVIEW. AISO SHOW Date (5.00
Program to Provider				
5. 01			0	5.01
5. 02			0	5.01
5. 02			0	5.02 5.03
			0	5.03
Provider to Program			0	F F0
5. 50			0	5.50
5. 51			0	5.51
5.52	F 00)		0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-			0	5.99
6.00 Determined net settlement amount (balance due) based on	ine cost report. (1)		1/ 005	6.00
6.01 SETTLEMENT TO PROVIDER			16, 235	6.01
6.02 SETTLEMENT TO PROGRAM			0	6.02
7.00 Total Medicare program liability (see instructions)			339, 382	7.00
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	0.02
8.00 Name of Contractor			1	8.00