	•						
Healt	1 Financial Systems	COMMUNITY HOSPITA	OF RREMEN		In Lie	u of Form CMS-7	2552-10
This	report is required by law (42 USC 1395g; 42 C	FR 413,20(b)), Fai	Ture to repo	ort can resul	t in all interim	FORM APPROVED	
payme	nts made since the beginning of the cost repo	<u>rting period being</u>	deemed ove	rpayments (42	USC 1395g),	OMB NO. 0938-	
	TAL AND HOSPITAL HEALTH CARE COMPLEX COST REP ETTLEMENT SUMMARY	ORT CERTIFICATION	Provider	CCN: 151300	Period: From 05/01/2013	Worksheet S Parts I-III	
AND 3	ETTEMENT SUMMARY				To 04/30/2014	Date/Time Pre	pared:
DAOT	I - COST REPORT STATUS	V/V -47% b-Prosective College of				9/30/2014 11:	00 am
Provi		port	- Landa -		Date: 9/30/20	14 Time: 11	:00 am
use o	nly 2.[ ]Manually submitted cost repo	rt			, ,		voo am
	<ol> <li>[ 0 ] If this is an amended report</li> <li>4. [ F ] Medicare Utilization, Enter</li> </ol>		of times the " for low.	e provider re	submitted this c	ost report	
Contr use o	nly (1) As Submitted 7. Cont (2) Settled without Audit 8. [ N	Received; ractor No. ]Initial Report fo ]Final Report for	or this Prov this Provid	11.C ider CCN 12.[		or Code: Jumn 1 is 4: E nes reopened =	
PART	II - CERTIFICATION					VI V	
ADMIN: PROVI	PRESENTATION OR FALSIFICATION OF ANY INFORMAT ISTRATIVE ACTION, FINE AND/OR IMPRISOMMENT UNED OR PROCURED THROUGH THE PAYMENT DIRECTLY ISTRATIVE ACTION, FINES AND/OR IMPRISOMMENT MEDICAL OF ACTION, FINES AND/OR IMPRISOMMENT METERIFICATION BY OFFICER OR ADMINITY INTO A DESCRIPTION OF THE ADDRESS OF THE ACTION OF THE ADDRESS OF THE ACTION	DER FEDERAL LAW. OR INDIRECTLY OF A AY RESULT.  ESTRATOR OF PROVID  e certification st cost report and t BREMEN ( 151300 ) y knowledge and be ecords of the pro- am familiar with	FURTHERMORE, KICKBACK OF ER(S)  Eatement and the Balance Solitor the cost rider in accuthe laws and is cost reported to the cost of the laws and the	that I have sheet and sta ordance with d regulations ort were prov	IDENTIFIED IN TI ISE ILLEGAL, CRIM  examined the accidement of Revenuperiod beginning atement are true applicable instring regarding the p	ompanying e and o5/01/2013 , correct, uctions, rovision of ce with such	ŧ
		Title V	Title Part A	XVIII Part B	ніт	Title XIX	
		1.00	2.00	3.00	4.00	5.00	A Maryana and a second
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital Subprovider - IPF	0	148,757	-226,10		377,200	1.00
3.00	Subprovider - IPF	0	0		0	0	2.00 3.00
4.00	SUBPROVIDER I	ŏ	0		ŏ	0	4.00
5.00	Swing bed - SNF	0	78,834		o	ő	5.00
6.00	Swing bed - NF	0				0	6.00

9.00 HOME HEALTH AGENCY I 0 9.00 10.00 RURAL HEALTH CLINIC I 0 0 10.00 11.00 FEDERALLY QUALIFIED HEALTH CENTER I 0 0 11.00 200.00 Total 227,591 -226,106 889,272 377,200,200.00

200.00|Total | | 0| 227,591| -226,106| 889,272| 377,200|200. The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete 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.

							From 05/01/ To 04/30/	2014	Part I Date/Ti 9/30/20		
	1.00	2	. 00		3. 00			4. 00	.,		
	Hospital and Hospital Health Care Co										
1.00	Street: 1020 HIGH RD	PO Box:		7: n Coo	la. 4/EO/	Count	E. A. MADCHALL				1.00
2. 00	City: BREMEN	State: Component N		CCN	le: 46506- CBSA	Provi der	ty: MARSHALL Date	Davmo	nt Syst	om (D	2. 00
		Component N	allie	Number	Number		Certi fi ed		0, or		
								V	XVIII	XIX	
		1.00		2.00	3. 00	4.00	5. 00	6. 00	7. 00	8.00	
	Hospital and Hospital-Based Componer										
3.00	Hospi tal	COMMUNITY HOSPIT	AL OF	151300	99915	1	07/01/1966	0	0	0	3. 00
4 00	Cubaravi dan IDE	BREMEN									4 00
4. 00 5. 00	Subprovi der - IPF Subprovi der - IRF										4. 00 5. 00
6. 00	Subprovider - (Other)										6. 00
7. 00	Swing Beds - SNF	COMMUNITY HOSPIT	AL	15Z300	99915		05/01/1984	N	0	N	7. 00
		SWING BED									
8.00	Swing Beds - NF										8. 00
9.00	Hospi tal -Based SNF										9. 00
10.00	Hospital -Based NF										10.00
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA										11. 00 12. 00
13. 00	Separately Certified ASC										13. 00
14. 00	Hospi tal -Based Hospi ce										14. 00
15. 00	Hospital -Based Health Clinic - RHC										15. 00
16.00	Hospital -Based Health Clinic - FQHC										16. 00
17. 00	Hospital-Based (CMHC) I										17. 00
17. 10	Hospi tal -Based (CORF) I										17. 10
18.00	Renal Dialysis										18. 00
19. 00	0ther						From		To		19. 00
							From: 1.00		To 2. (		
20. 00	Cost Reporting Period (mm/dd/yyyy)						05/01/2		04/30/		20. 00
21. 00	Type of Control (see instructions)							2			21. 00
	Inpatient PPS Information										
22. 00	Does this facility qualify and is it						N		N		22. 00
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, en				12.06(0)	(2) (PLCKLE					
22. 01	Did this hospital receive interim un				is cost n	reporting	N				22. 01
	period? Enter in column 1, "Y" for y										
	reporting period occurring prior to						r				
	no for the portion of the cost repor	ting period occu	rring on	or afte	r October	r 1. (see					
23. 00	instructions) Which method is used to determine Me	dicaid days on Li	inos 24 s	and/or 2	5 holow?	In column		3	N		23. 00
23.00	1, enter 1 if date of admission, 2 i							3	IN		23.00
	method of identifying the days in th										
	used in the prior cost reporting per	iod? In column									
			In-Stat			Out-of		ledi cai		ther	
			Medicai paid da			State edi cai d	State   F Medicaid	IMO day		li cai d lays	
			para da	, , ,			eligible			iays	
					iys	u uuyo	unpai d				
			1.00	2.	00	3. 00	4. 00	5. 00	6	. 00	
24. 00	If this provider is an IPPS hospital			0	0	0	0		0	0	24. 00
	in-state Medicaid paid days in col.										
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in cout-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in										
25.00	If this provider is an IRF, enter th	e in-state		O	O	О	o		0		25.00
	Medicaid paid days in col. 1, the in										
	eligible unpaid days in col. 2, out-	of-state									
	Medicaid days in col. 3, out-of-stateligible unpaid days in col. 4, Medi										
	and eligible but unpaid days in col.										
	Medicaid days in col. 6.										
	-			•			•				

0. od

o. od

61.06

61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being

care or general surgery. (see instructions)

used for cap relief and/or FTEs that are nonprimary

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPL		Y HOSPITAL O			In Lie Period: From 05/01/2013 To 04/30/2014		pared:
		Program	Name	Program Code	Unweighted IME FTE Count		
		1.0	0	2. 00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specis specialty, if any, and the number for each new program. (see instrucolumn 1 the program name, enter program code, enter in column 3 unweighted count and enter in column 3 free unweighted count. 61.20 Of the FTEs in line 61.05, specis program specialty, if any, and the residents for each expanded proginstructions) Enter in column 1 enter in column 2 the program column 3 the LME FTE unweighted count and state CME FTE unweighted count and special type in the column 2 the program column 3 the limit 2 the limit	r of FTE residents uctions) Enter in in column 2 the the IME FTE lumn 4 direct GME fy each expanded he number of FTE ram. (see the program name, de, enter in column				0. 00		61. 10
direct GME FTE unweighted count.							
						1.00	
ACA Provisions Affecting the Hea 62.00 Enter the number of FTE residents your hospital received HRSA PCRE	s that your hospital	trained in	istration this cost	(HRSA) reporting per	oiod for which	0.00	62. 00
62.01 Enter the number of FTE resident: during in this cost reporting pe	s that rotated from a	a Teaching H			your hospital	0.00	62. 01
Teaching Hospitals that Claim Re	sidents in Non-Provid	der Settings					
63.00 Has your facility trained resider	nts in non-provider s umn 1. If yes, comple	settings dur ete lines 64	ing this of the control of the contr	cost reporting instructions Unweighted	g period? Enter Unweighted	N Ratio (col. 1/	63. 00
				FTEs Nonprovi der Si te	FTEs in	(col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Yea period that begins on or after J	uly 1, 2009 and befor	re June 30,	2010.	This base yea	r is your cost m	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the number resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column)	ber of unweighted non tations occurring in number of unweighted ur hospital. Enter in 1 + column 2)). (see	n-primary ca all non-pro d non-primar n column 3 t	re vider y care he ratio	0. (	0. 00	0. 000000	64. 00
	Program Name	Program		Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.0	0	3. 00	4.00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in				0. (	0. 00	0. 000000	65.00

the program code, enter in column 3 the number of

unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of

column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

Health Financial Systems COMMUNITY HOSPI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	TAL OF BREMEN	CCN: 151300 F	Peri od:		of For Workshe		2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider	F	rom 05/01/ o 04/30/	′2013 ′2014	Part I Date/Ti	me Pre	pared:
			V		9/30/20 XI		58 am
			1. 00		2.0	00	
96.00 Does title V or XIX reduce operating cost? Enter "Y" for year applicable column.	s or "N" for n	o in the	N		N		96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the appropriate Rural Providers	plicable colum	n.		0. 00		0. 00	97. 00
105.00 Does this hospital qualify as a Critical Access Hospital (CA 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		hod of payment	Y N				105. 00 106. 00
107.00 Column 1: If this facility qualifies as a CAH, is it eligible for I &R training programs? Enter "Y" for yes or "N" for no instructions) If yes, the GME elimination would not be on W 25 and the program would be cost reimbursed. If yes complete Column 2: If this facility is a CAH, do I&Rs in an approved train in the CAH's excluded IPF and/or IRF unit? Enter "Y"	N				107. 00		
column 2. (see instructions) 108.00 s this a rural hospital qualifying for an exception to the	•		N				108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speec	h	Respi r	atory	
109.00 If this hospital qualifies as a CAH or a cost provider, are	1. 00 N	2. 00 N	3. 00 Y		4. C		109. 00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	IV.	IN IN			IV		104.00
				1. 00	2. 00	3.00	
Miscellaneous Cost Reporting Information	HAIH C						115.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of enter the method used (A, B, or E only) in column 2. If columither "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospital providers 15-1, §2208.1.	umn 2 is "E", o for long term	enter in colum care (include	n 3 s	N		0	115. 00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu			"N" for	N Y			116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence policial minutes. Enter 2 if the policy is occurrence.	licy? Enter 1	if the policy	is	2			118. 00
Crariii-iiiade. Effer 2 11 the portey 13 occurrence.		Premi ums	Losse	s	Insur	ance	
		1.00	2.00		2.0		
118.01 List amounts of malpractice premiums and paid losses:		1. 00 126, 36	2.00	0	3.0	00	118. 01
118.01 List amounts of malpractice premiums and paid losses:			0	0		))) (	0118. 01
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schee		126, 36 than the		0	2.0	))) (	118. 02
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that questions hold Harmless provision in ACA §3121 and applicable amendments?	dule listing co d Harmless pro n column 1 "Y" ualifies for tl	than the ost centers vision in ACA for yes or he Outpatient	1.00	0		00 C	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2 "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implementations.	d Harmless pron n column 1 "Y" ualifies for the nts? (see inst	than the ost centers  vision in ACA for yes or he Outpatient ructions)	1. 00 N	0	2. (	00 C	118. 02
<ul> <li>118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.</li> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2 "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implications.</li> </ul>	dule listing co d Harmless pro n column 1 "Y" ualifies for th nts? (see inst antable device	than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to	1. 00 N	0	2. (	00 C	118. 02 119. 00 120. 00
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2 "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implementations. Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for	dule listing or d Harmless pro- n column 1 "Y" ualifies for ti nts? (see inst- antable devices or yes and "N"	than the ost centers  vision in ACA for yes or he Outpatient ructions) s charged to	1.00 N	0	2. (	00 C	118. 02 119. 00 120. 00
118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein.  119. 00 DO NOT USE THIS LINE  120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2 "Y" for yes or "N" for no.  121. 00 Did this facility incur and report costs for high cost implications? Enter "Y" for yes or "N" for no.  Transplant Center Information  125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126. 00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1.	dule listing of different	than the ost centers  vision in ACA for yes or he Outpatient ructions) s charged to  for no. If	1.00 N	0	2. (	00 C	118. 02 119. 00 120. 00 121. 00
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein.  119.00 DN NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that query Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2 "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implications? Enter "Y" for yes or "N" for no.  125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, enter toolumn 1 and termination date, if applicable, in column 2 and 128.00 If this is a Medicare certified liver transplant center, entermination date, if applicable, in column 2 and 128.00 If this is a Medicare certified liver transplant center, entermination date, if applicable, in column 2 and 128.00 If this is a Medicare certified liver transplant center, entermination date, if applicable, in column 3 and 128.00 If this is a Medicare certified liver transplant center, entermination date, if applicable, in column 3 and 128.00 If this is a Medicare certified liver transplant center, entermination date, if applicable, in column 3 and 128.00 If this is a Medicare certified liver transplant center.	d Harmless prome column 1 "Y" ualifies for the test in the certification of the certification	than the ost centers  vision in ACA for yes or he Outpatient ructions) s charged to  for no. If fication date ication date	1.00 N	0	2. (	00 C	118. 02 119. 00 120. 00 121. 00 125. 00 126. 00
118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.  119. 00 D0 NOT USE THIS LINE  120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2 "Y" for yes or "N" for no.  121. 00 Did this facility incur and report costs for high cost implifications? Enter "Y" for yes or "N" for no.  Transplant Center Information  125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126. 00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 127. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified liver transplant center in column 129. 00 If th	d Harmless production of the column 1 "Y" ualifies for the certification of the certification	than the ost centers  vision in ACA for yes or he Outpatient ructions) s charged to  for no. If fication date ication date	N N	0	2. (	00 C	118. 02 119. 00 120. 00 121. 00 125. 00 126. 00 127. 00
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118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.  119. 00 D0 NOT USE THIS LINE  120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2 "Y" for yes or "N" for no.  121. 00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no.  125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126. 00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 127. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 128. 00 If this is a Medicare certified liver transplant center, enter column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified liver transplant center, enter column 1 and termination date, if applicable, in column 2.  130. 00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2.	d Harmless prome column 1 "Y" ualifies for the the certification that the certification that the certification that certification certification t	than the ost centers  vision in ACA for yes or he Outpatient ructions) s charged to  for no. If fication date ication date cation date in the cation date it is a control of the cation date in the cation	N N	0	2. (	00 C	118. 02 119. 00 120. 00 121. 00 125. 00 126. 00 127. 00 128. 00 129. 00
118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.  119. 00 DN NOT USE THIS LINE  120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies in column 2 "Y" for yes or "N" for no.  121. 00 Did than facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no.  125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126. 00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 127. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified lung transplant center, date in column 1 and termination date, if applicable, in column 130. 00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 131. 00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 132. 00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 132. 00 If this is a Medicare certified intestinal transplant center.	d Harmless prome column 1 "Y" ualifies for the terms and "N" terms the certification of the c	than the ost centers  vision in ACA for yes or he Outpatient ructions) s charged to  for no. If fication date ication date cation date in tification determinents of the control of the co	N N	0	2. (	00 C	118. 02 119. 00 120. 00 121. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00
118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.  119. 00 D0 NOT USE THIS LINE  120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2 "Y" for yes or "N" for no.  121. 00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no.  Transplant Center Information  125. 00 Does this facility operate a transplant center? Enter "Y" for 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 127. 00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 128. 00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified lung transplant center, en column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 131. 00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 132. 00 If this is a Medicare certified intestinal transplant center in column 1 and termination date, if applicable, in column 133. 00 If this is a Medicare certified other transplant center, en in column 1 and termination date, if applicable, in column 133. 00 If this is a Medicare certified other transplant center, en in column 1 and termination date, if applicable, in column 133. 00 If this is a Medicare certified other transplant center, en in column 1 and termination date, if applic	d Harmless prome column 1 "Y" ualifies for the term or yes and "N" er the certification to the certification of th	than the ost centers  vision in ACA for yes or he Outpatient ructions) s charged to  for no. If fication date ication date ication date in tification date in tification date	N N	0	2. (	00 C	118. 02 119. 00 120. 00 121. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00
118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.  119. 00 DO NOT USE THIS LINE  120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter if "N" for no. Is this a rural hospital with < 100 beds that qualifies in Column 2 "Y" for yes or "N" for no.  121. 00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no.  125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126. 00 If this is a Medicare certified kidney transplant center, entering column 1 and termination date, if applicable, in column 1.  127. 00 If this is a Medicare certified heart transplant center, entering column 1 and termination date, if applicable, in column 1.  128. 00 If this is a Medicare certified liver transplant center, entering column 1 and termination date, if applicable, in column 1.  129. 00 If this is a Medicare certified lung transplant center, entering column 1 and termination date, if applicable, in column 1.  129. 00 If this is a Medicare certified lung transplant center, entering column 1 and termination date, if applicable, in column 2.  130. 00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 1.  131. 00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 1.  132. 00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 1.	d Harmless prome column 1 "Y" ualifies for the term or yes and "N" meter the certification to the certification of	than the ost centers  vision in ACA for yes or he Outpatient ructions) s charged to  for no. If fication date ication date ication date it in the cation date it is a control of the cation date in the cation date ication date	N N	0	2. (	00 C	118. 02 119. 00 120. 00 121. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00 132. 00

alth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMF		PITAL OF BREMEN Provider	CCN: 151300	Peri od		u of Form C Worksheet	
				From O	5/01/2013 4/30/2014	Part I Date/Time	
						9/30/2014	10: 58 ar
					1. 00	2. 00	
All Providers 0.00 Are there any related organizat	ion or home office costs a	s dofined in CMS	Dub 15 1		N		140.
chapter 10? Enter "Y" for yes o are claimed, enter in column 2	r "N" for no in column 1.	If yes, and home	office cost:	s	IN		140.
1.00		2. 00	1 0113)		3. 00		
If this facility is part of a c				name and	d address	of the	
home office and enter the home  1.00 Name:	Contractor name and Contractor's Name:	contractor number	er. Contrac	tor's Nu	ımher:		141.
2. 00 Street:	PO Box:		Journal		iiiber .		142.
3. 00 Ci ty:	State:		Zi p Code	e:			143.
						1. 00	
4.00 Are provi der based physi ci ans'	costs included in Workshee	t A?				1.00 Y	144.
5.00 If costs for renal services are	claimed on Worksheet A, I		costs for i	npati ent		N	145.
services only? Enter "Y" for ye	s or "N" for no.						
					1. 00	2. 00	
6.00 Has the cost allocation methodo					N		146.
Enter "Y" for yes or "N" for no enter the approval date (mm/dd/		. 15-2, section 4	1020) If yes	,			
7.00 Was there a change in the stati		r yes or "N" for	no.		N		147.
8.00Was there a change in the order	of allocation? Enter "Y"	for yes or "N" fo	or no.		N		148
9.00 Was there a change to the simplino.	ified cost finding method?	Enter "Y" for ye	es or "N" fo	r	N		149.
JIIO.		Part A	Part B	Т	itle V	Title XI	х
I		1.00	2.00		3. 00	4. 00	
Does this facility contain a pr or charges? Enter "Y" for yes o							
5.00 Hospi tal	THE TOTAL COMP	N N	N N		N N	N N	155.
6.00 Subprovi der - IPF		N	N		N	N	156.
7.00 Subprovi der - IRF 8.00 SUBPROVI DER		N	N N		N	N	157. 158.
9. 00 SNF		N	N		N	N	159.
O.OOHOME HEALTH AGENCY		N	N		N	N	160.
1. 00 CMHC			N		N	N	161.
1. 10 CORF			N N		N	N	161.
Mul +i compue						1.00	
Multicampus 5.00 s this hospital part of a Mult	icampus hospital that has	one or more campu	uses in diff	erent CE	BSAs?	N	165.
Enter "Y" for yes or "N" for no		C	C+-+- 7		CDCA	FTF /0	
	Name 0	County 1.00	2. 00	i p Code 3.00	4. 00	FTE/Campu 5.00	15
6.00  f  line 165 is yes, for each	,	11 00	2.00	0.00	11.00		0. 00 166.
campus enter the name in column							
O, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5							
						1. 00	
Health Information Technology (	HIT) incentive in the Amer	ican Recovery and	d Reinvestme	nt Act		1.00	
7.00 s this provider a meaningful u						Y	167.
8.00 If this provider is a CAH (line reasonable cost incurred for th			e 167 is "Y"	), enter	the	976,	350168.
9.00  f this provider is a meaningfu	e mir assets (see flistruct Luser (line 167 is "Y") a	nd is not a CAH (	(line 105 is	"N"), ∈	enter the		0. 00169.
transition factor. (see instruc							
				l Ro	gi nni ng	Endi ng	
				De	1. 00	2.00	

10SPLT	Financial Systems ( TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	COMMUNITY HOSPITAL OF BREMEN STIONNAIRF Provider	CCN: 151300	Peri od:	eu of Form CMS- Worksheet S-2	
03111	AL AND HOST FAC HEACTH CARE RETWINDORSEMENT QUE	STI ONIVALINE THOU del		From 05/01/2013 Fo 04/30/2014	Part II	
				. 04/30/2014	9/30/2014 10:	
				Y/N	Date	
	Constant I and the state of the	Francis N. San all NO		1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format.	onses. Enter N for all NO re	sponses. Enter	all dates in	tne	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation			1		
. 00	Has the provider changed ownership immediately reporting period? If yes, enter the date of			N		1.
	reporting perrous in yes, enter the date of	the change in cordiii 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
. 00	Has the provider terminated participation in		N			2.
	yes, enter in column 2 the date of termination voluntary or "I" for involuntary.	on and in column 3, "V" for				
00	Is the provider involved in business transact	tions, including management	N			3.
	contracts, with individuals or entities (e.g.					
	or medical supply companies) that are related officers, medical staff, management personnel					
	of directors through ownership, control, or					
	relationships? (see instructions)					
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
00	Column 1: Were the financial statements pre	pared by a Certified Public	Y	A		4.
	Accountant? Column 2: If yes, enter "A" for	Audited, "C" for Compiled,				
	or "R" for Reviewed. Submit complete copy or					
. 00	column 3. (see instructions) If no, see instructions are the cost report total expenses and total		l N			5.
. 00	those on the filed financial statements? If					5.
				Y/N	Legal Oper.	
	In			1. 00	2. 00	
. 00	Approved Educational Activities  Column 1: Are costs claimed for nursing scho	nol? Column 2: If was is th	e provider is	N		6.
. 00	the legal operator of the program?	501 : 001 dilli1 2. 11 yes, 13 til	ic provider 13	14		0.
00	Are costs claimed for Allied Health Programs			N		7.
00	Were nursing school and/or allied health produced the school and s		l during the	N		8.
. 00	cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program		t report? If	N		9.
. 00	yes, see instructions.	or ar mea or. the ear rent ess	т торол ст тт			"
0. 00	Was an Intern-Resident program been initiated	d or renewed in the current c	ost reporting	N		10.
1. 00	period? If yes, see instructions. Are GME cost directly assigned to cost center	rs other than I & R in an ∆nn	roved	N		11.
00	Teaching Program on Worksheet A? If yes, see		0 7 0 4			
					Y/N	
	Bad Debts				1. 00	
2. 00	Is the provider seeking reimbursement for bac	d debts? If ves. see instruct	i ons.		Υ	12.
3. 00	If line 12 is yes, did the provider's bad del			st reporting	N	13.
	period? If yes, submit copy.					١
4. 00	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments waived? If	yes, see ins	tructi ons.	N N	14.
5. 00	Did total beds available change from the price	or cost reporting period? If	ves. see inst	ructions.	N	15.
	,		r e	rt A	Part B	
		Description	Y/N	Date	Y/N	
	PS&R Data	0	1.00	2. 00	3. 00	
6. 00	Was the cost report prepared using the PS&R		Υ	09/02/2014	Υ	16.
	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					
7. 00			N		N	17.
7. 00	Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records		N		N	17.
7. 00	Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is		N		N	17.
7. 00	Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns		N		N	17.
	Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is		N N		N Y	
	Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional					
	Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not					
	Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file					
8. 00	Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not					18.
8. 00	Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of		N		Y	18.
8. 00	Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see		N		Y	18.
7. 00 8. 00 9. 00	Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N N		Y N	18.
8. 00	Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see		N		Y	18.

Health Financial Systems	COMMUNITY HOSPITAL OF BREMEN	In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REI	MBURSEMENT QUESTIONNAIRE Provider CCN:	151300   Peri od:   Worksheet S-2   From 05/01/2013   Part II

					From 05/01/2013 To 04/30/2014		
				Р	art A	Part B	
		Descr	ription	Y/N	Date	Y/N	
			0	1. 00	2. 00	3. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21. 00
						1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EVC	EDT CUIINDENS UC	CDITALC)		1.00	
	Capital Related Cost	INEO ONET (ENO	EL L'OILLENE LIG	301111120)			
22. 00	Have assets been relifed for Medicare purpose	es? If yes, se	e instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreci			als made duri	ng the cost	N	23. 00
	reporting period? If yes, see instructions.	·	• • •		·		
24. 00	Were new leases and/or amendments to existing	g Leases enter	ed into during t	this cost rep	porting period?	N	24. 00
	If yes, see instructions						05.00
25. 00	Have there been new capitalized leases entere	ed into during	the cost report	ting period?	If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acqu	uired during t	he cost reportin	na neriod2 la	F VAS SAA	N	26. 00
20.00	instructions.	arrea darring t	ne cost reportir	ig perrou: T	yes, see	14	20.00
27. 00	Has the provider's capitalization policy char	nged during th	e cost reportino	period? If	yes, submit	N	27. 00
	сору.	<u> </u>			· .		
	Interest Expense						
28. 00	Were new Loans, mortgage agreements or Letter	rs of credit e	ntered into duri	ing the cost	reporti ng	N	28. 00
29. 00	period? If yes, see instructions.	account and/an	band funda (Dal	at Camilaa D	noorus Fund)	N	29. 00
29.00	Did the provider have a funded depreciation a treated as a funded depreciation account? If			ot service K	eserve runu)	IN	29.00
30.00	Has existing debt been replaced prior to its			debt? If ves.	see	N	30.00
	instructions.			, , , , , , , , , , , , , , , , ,			
31.00	Has debt been recalled before scheduled matur	rity without i	ssuance of new of	debt? If yes,	see	N	31.00
	instructions.						
	Purchased Services						
32.00	Have changes or new agreements occurred in pa arrangements with suppliers of services? If	atient care se	rvices furnished	d through coi	ntractual	N	32. 00
33. 00	If line 32 is yes, were the requirements of 9			r to competi	tive hidding? If	N	33. 00
00.00	no, see instructions.	000. 2100.2 ap	pri ou por turini	g to compet.	ervo braariigi ii		00.00
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facili	ity under an a	rrangement with	provi der-bas	sed physi ci ans?	Y	34. 00
	If yes, see instructions.						05.00
35. 00	If line 34 is yes, were there new agreements			ts with the p	orovi der-based	N	35. 00
	physicians during the cost reporting period?	TT yes, see t	nstructions.		Y/N	Date	
					1. 00	2. 00	
	Home Office Costs					2.00	
36.00	Were home office costs claimed on the cost re				N		36. 00
37. 00	If line 36 is yes, has a home office cost sta	atement been p	repared by the h	nome office?	N		37. 00
	If yes, see instructions.						
38. 00					N		38. 00
39. 00	the provider? If yes, enter in column 2 the i If line 36 is yes, did the provider render so				. N		39. 00
37.00	see instructions.	ervices to oth	lei chain compone	ents: II yes,	, IN		37.00
40. 00	If line 36 is yes, did the provider render so	ervices to the	home office? I	If ves. see	N		40. 00
	instructions.			<u> </u>			
			1. (	00	2.	00	
41 00	Cost Report Preparer Contact Information	o /nooi +!	CTACEV		THOMAC		41 00
41.00	Enter the first name, last name and the title		STACEY		THOMAS		41. 00
	held by the cost report preparer in columns respectively.	i, Z, anu 3,					
42. 00	Enter the employer/company name of the cost i	report	STACEY THOMAS				42. 00
00	preparer.	-1					.2.00
43.00	Enter the telephone number and email address		260-432-8870		STHOMAS797@AOL	. COM	43. 00
	report preparer in columns 1 and 2, respectiv	vel y.					

Provider CCN: 151300

				9/30/2014 10:	58 am_
		Part B			
		Date			
		4. 00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R	09/02/2014			16. 00
	Report only? If either column 1 or 3 is yes,				
	enter the paid-through date of the PS&R				
	Report used in columns 2 and 4 (see				
47.00	instructions)				47.00
17. 00	Was the cost report prepared using the PS&R				17. 00
	Report for totals and the provider's records for allocation? If either column 1 or 3 is				
	yes, enter the paid-through date in columns				
	2 and 4. (see instructions)				
18. 00					18. 00
	made to PS&R Report data for additional				
	claims that have been billed but are not				
	included on the PS&R Report used to file				
	this cost report? If yes, see instructions.				
19. 00	If line 16 or 17 is yes, were adjustments				19. 00
	made to PS&R Report data for corrections of				
	other PS&R Report information? If yes, see				
20.00	instructions.				20.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe				20. 00
	the other adjustments:				
21. 00	Was the cost report prepared only using the				21. 00
21.00	provider's records? If yes, see				21.00
	instructions.				
			3. 00		
	Cost Report Preparer Contact Information				
41. 00			REIMB MGR		41. 00
	held by the cost report preparer in columns 1	, 2, and 3,			
40.00	respecti vel y.				40.00
42. 00	Enter the employer/company name of the cost r	report			42. 00
43. 00	preparer.	of the cost			43. 00
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respective				43.00
	Treport preparer in corumns rand 2, respectiv	very.	I	1	ı

Health Financial Systems COMMUNITY
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

					Ţ	o 04/30/2014	Date/Time Prep 9/30/2014 10:	
							I/P Days / 0/P	o am
							Visits / Trips	
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Available	CAH Hours	Title V	
		1. 00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 150	21, 831. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			25	9, 150	21, 831. 00	0	7. 00
	beds) (see instructions)			_				
8.00	INTENSIVE CARE UNIT	31. 00		(			0	8. 00
9.00	CORONARY CARE UNIT	32. 00		(	1	0.00	1	9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00		(	1	0. 00		10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		(	) 0	0.00	0	11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						_	12. 00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			25	9, 150	21, 831. 00	1	14.00
15. 00	CAH visits						0	15.00
16.00	SUBPROVIDER - I PF			_				16.00
17. 00	SUBPROVI DER - I RF	41. 00		(	1		0	17. 00
18.00	SUBPROVI DER	42. 00		(	0		0	18.00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE	404.00						21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )							23. 00
24. 00	HOSPI CE	00.00						24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC	00.40						25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00	1				0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		0.5			0	26. 25
27. 00	Total (sum of lines 14-26)			25	9			27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32. 00	Labor & delivery days (see instructions)			(	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
22 00	outpatient days (see instructions)							33. 00
33.00	LTCH non-covered days		l		1	l	l l	JJ. 00

33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151300

Peri od: Worksheet S-3 From 05/01/2013 Part I To 04/30/2014 Date/Time Prepared:

9/30/2014 10:58 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 382 134 710 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) 120 2 00 3.00 HMO IPF Subprovider 0 0 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 377 0 377 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 C 17 6.00 7.00 Total Adults and Peds. (exclude observation 759 134 1, 104 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 0 8.00 CORONARY CARE UNIT 9.00 0 C 0 9.00 10.00 BURN INTENSIVE CARE UNIT 0 C 0 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 0 0 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 45 151 13.00 14.00 Total (see instructions) 759 179 1, 255 0.00 106.02 14.00 CAH visits 15.00 0 0 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 0.00 17.00 0 C 0 0.00 17.00 18.00 SUBPROVI DER 0 0 0.00 0.00 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 0 0 0.00 0.00 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24 00 HOSPICE (non-distinct part) 24. 10 0 0 24.10 25. 00 CMHC - CMHC 25.00 25. 10 CMHC - CORF 0 0.00 0.00 25. 10 RURAL HEALTH CLINIC 0 26.00 0.00 0 0.00 Ω 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 106.02 27.00 Observation Bed Days 28.00 0 412 28.00 29 00 Ambul ance Trips 0 29 00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 0 0 32.00 Ω 32.00 Total ancillary labor & delivery room 32.01 outpatient days (see instructions)

LTCH non-covered days

Health Financial Systems COMMUNITY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 151300

Peri od: Worksheet S-3
From 05/01/2013 Part I
To 04/30/2014 Date/Time Prepared: 9/30/2014 10:58 am 9/30/2014

						9/30/2014 10:	58 am
	·	Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11.00	12. 00	13.00	14.00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and			0 131	34	310	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)			41			2. 00
3. 00	HMO IPF Subprovider						3. 00
4.00	HMO I RF Subprovi der						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGI CAL INTENSI 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		0 131	34	310	ł
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF				_	_	16. 00
17. 00	SUBPROVI DER - I RF	0. 00		0	0	0	17. 00
18. 00	SUBPROVI DER	0. 00		0	0	0	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0.00					25. 10
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	I I		I	I		33. 00

Heal th	Financial Systems COMMUNITY HOSPITAL OF	BREMEN		In Lie	eu of Form CMS-2	2552-10
		rovi der	CCN: 151300	Peri od:	Worksheet S-10	0
				From 05/01/2013	D . (T' D	
				To 04/30/2014	Date/Time Prep 9/30/2014 10:	
					1. 00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ed by lir	ne 202 column	1 8)	0. 471564	1. 00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		333, 660	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?  If line 3 is "yes", does line 2 include all DSH or supplemental p	aumanta t	From Modicole	10	N	3. 00 4. 00
4. 00 5. 00	If line 4 is "no", then enter DSH or supplemental payments from M		iioni wedicaid	l f	0	5. 00
6.00	Medical d charges	eui cai u			2, 444, 336	
7. 00	Medicaid cost (line 1 times line 6)				1, 152, 661	7. 00
8. 00	Difference between net revenue and costs for Medicaid program (li	ne 7 minu	us sum of lir	nes 2 and 5: if	819, 001	8.00
	< zero then enter zero)				·	
	State Children's Health Insurance Program (SCHIP) (see instruction	ns for ea	ach line)			
9.00	Net revenue from stand-alone SCHIP				0	9. 00
10. 00	Stand-alone SCHIP charges				0	10. 00
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0	
12. 00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 mi	inus line 9;	if < zero then	0	12. 00
	<pre>enter zero) Other state or local government indigent care program (see instru</pre>	ctions fo	or oach line)			
13. 00	Net revenue from state or local indigent care program (Not includ				49, 451	13. 00
14. 00	Charges for patients covered under state or local indigent care p				204, 008	
00	10)	. 09. a (.			201,000	00
15.00	State or local indigent care program cost (line 1 times line 14)				96, 203	15. 00
16.00	Difference between net revenue and costs for state or local indig	ent care	program (lir	ne 15 minus line	46, 752	16. 00
	13; if < zero then enter zero)					
47.00	Uncompensated care (see instructions for each line)	. , .				47.00
17. 00	Private grants, donations, or endowment income restricted to fund				0	17. 00
18. 00 19. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, SCHIP and state and local			oc (cum of lines	865, 753	18. 00 19. 00
19.00	8, 12 and 16)	rnar gent	care program	is (suii oi iiiles	605, 755	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
20.00	T-1-1 :-: 1:	+ 6.11	1.00	2. 00	3. 00	20.00
20. 00	Total initial obligation of patients approved for charity care (a charges excluding non-reimbursable cost centers) for the entire f		82, 90	787, 541	870, 509	20. 00
21. 00	Cost of initial obligation of patients approved for charity care		39, 12	371, 376	410, 501	21. 00
21.00	times line 20)	(11110 1	07, 12	071,070	110,001	21.00
22.00	Partial payment by patients approved for charity care			0 0	0	22. 00
23. 00	Cost of charity care (line 21 minus line 22)		39, 12	25 371, 376	410, 501	23. 00
					4.00	
24. 00	Does the amount in line 20 column 2 include charges for patient d	avs bevor	nd a Length o	of stav limit	1. 00 N	24. 00
	imposed on patients covered by Medicaid or other indigent care pr		a . ogtii (	,	''	55
25. 00	If line 24 is "yes," charges for patient days beyond an indigent		ogram's Lengt	h of stay limit	0	25. 00
26. 00	Total bad debt expense for the entire hospital complex (see instr	uctions)			626, 232	
27. 00	Medicare bad debts for the entire hospital complex (see instructi	,			50, 856	
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line		,		575, 376	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expen	se (line	1 times line	28)	271, 327	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	20)			681, 828	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	30)			1, 547, 581	31.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	<u>COMMUNITY HOSPITA</u> OF EXPENSES		CCN: 151300 F	Peri od:	u of Form CMS-: Worksheet A	
00	Since the same that the same t			F	rom 05/01/2013		
					o 04/30/2014	Date/Time Pre 9/30/2014 10:	
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
	00100 NEW CAP REL COSTS-BLDG & FIXT		0	C	1, 854, 492	1, 854, 492	1.0
	00200 NEW CAP REL COSTS-MVBLE EQUIP		0			0	2.0
1	00300 OTHER CAPITAL RELATED COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	77, 454	24, 138	101, 592	1, 408, 235	1, 509, 827	3. C
1	00500 ADMINISTRATIVE & GENERAL	955, 263	5, 252, 417	6, 207, 680		2, 619, 975	5.0
	00700 OPERATION OF PLANT	175, 666	143, 111	318, 777		646, 453	7.0
1	00701 OPERATION OF PLANT	0	0	C	O	0	7.0
	00800 LAUNDRY & LINEN SERVICE	0	118, 248			118, 248	8. C
	00900 HOUSEKEEPI NG	142, 804	21, 716			164, 520	9.0
	01000 DI ETARY	207, 794	234, 703			61, 449	
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	215, 157	13, 760	0 228, 917	,	381, 048 228, 917	
	01600 MEDICAL RECORDS & LIBRARY	207, 775	100, 280	308, 055		308, 055	
-	NPATIENT ROUTINE SERVICE COST CENTERS						]
	D3000 ADULTS & PEDIATRICS	690, 858	158, 657	849, 515	-35, 162	814, 353	30. C
	03100 INTENSIVE CARE UNIT	0	0	C	0	0	31.0
	03200 CORONARY CARE UNIT	0	0	C		0	32.0
	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0			0	33. C
	04100 SUBPROVIDER - IRF	0	0			0	41.0
	04200 SUBPROVI DER	o o	0		ol ol	0	42. 0
	04300 NURSERY	0	0	d	5, 845	5, 845	1
	ANCILLARY SERVICE COST CENTERS						
	O5000 OPERATING ROOM	602, 398	1, 370, 690	1, 973, 088		1, 545, 271	50.0
	D5200 DELIVERY ROOM & LABOR ROOM	0	0	704 (00	, , , , ,	7, 603	
	D5400  RADI OLOGY-DI AGNOSTI C D5700  CT   SCAN	405, 416 45, 414	329, 207 314, 198	734, 623 359, 612		734, 596 353, 417	54. 0 57. 0
1	D5800 MAGNETIC RESONANCE IMAGING (MRI)	51, 173	246, 556			290, 855	1
	05900 CARDI AC CATHETERI ZATI ON	0	2 10, 000	277,727	0, 0, 1	270,000	59.0
	06000 LABORATORY	510, 990	733, 312	1, 244, 302	2 0	1, 244, 302	60.0
	D6001 BLOOD LABORATORY	0	0	C	o	0	60.0
	06500 RESPI RATORY THERAPY	0	18, 413	· ·		17, 800	
	06600 PHYSI CAL THERAPY	286, 429	15, 740	302, 169	-4, 886	297, 283	
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		589	0 589	67. C
	06900 ELECTROCARDI OLOGY	0	52, 682	52, 682		52, 682	
	06902 SLEEP LAB	0	33, 996			33, 996	1
00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	o	0	70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	102, 770	32, 181	134, 951	478, 481	613, 432	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	400 040	'l "	0	
	07300 DRUGS CHARGED TO PATIENTS DUTPATIENT SERVICE COST CENTERS	217, 080	275, 263	492, 343	8 632	492, 975	/ 3. C
	D8800 RURAL HEALTH CLINIC	0	0	C	ol	0	88. 0
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	d	Ö	0	89. 0
00	09000 CLI NI C	0	0	C	o	0	90.0
	09100 EMERGENCY	942, 827	811, 833	1, 754, 660	-11, 576	1, 743, 084	
	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.0
	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	O	0	C	ol	0	95. 0
	09910 CORF	0	0			0	
. 00	10100 HOME HEALTH AGENCY	O	Ö	Ċ	_		101. 0
	SPECIAL PURPOSE COST CENTERS						
. 00	10900 PANCREAS ACQUISITION	0	0	C	0		109. 0
	11000   NTESTINAL ACQUISITION	0	0	C	이		110. C
	11100  SLET ACQUISITION 08600 OTHER ORGAN ACQUISITION	0	0				111.0
	08600 OTHER ORGAN ACQUISITION 11300 INTEREST EXPENSE		0				112. C
. 00	SUBTOTALS (SUM OF LINES 1-117)	5, 837, 268	10, 301, 101	16, 138, 369	2, 698	16, 141, 067	
	NONREI MBURSABLE COST CENTERS	0,007,200	10, 001, 101	10, 100, 307	2,070	10, 141, 007	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 0
. 00	19200 PHYSICIANS' PRIVATE OFFICES	42, 455	45, 883			85, 640	
. 00	TOTAL (SUM OF LINES 118-199)	5, 879, 723	10, 346, 984	16, 226, 707	이	16, 226, 707	200. 0

Provider CCN: 151300

Peri od: From 05/01/2013 To 04/30/2014 Worksheet A Date/Time Prepared: 9/30/2014 10:58 am

				9/30/2014 10: 5	8 am_
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS		T		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-39, 090		1	1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0			2. 00
3.00	00300 OTHER CAPITAL RELATED COSTS	0			3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	.,		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-752, 948			5. 00
7.00	00700 OPERATION OF PLANT	-4, 925		1	7. 00
7. 01	00701 OPERATION OF PLANT	0	1		7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	118, 248		8. 00
9.00	00900 HOUSEKEEPI NG	-2, 137	162, 383		9.00
10.00		-8, 559		·	10.00
11.00		-143, 595		·	11.00
13.00	1 1	0	,		13. 00 16. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-3, 487	304, 568		16.00
30. 00		-6, 600	807, 753		30. 00
31. 00	l l	-0,000		1	31.00
32. 00		0	1		32. 00
33. 00	1 1	0			33. 00
34. 00		0	0	1	34. 00
41. 00		0			41. 00
42. 00	1 1	0	1	1	42. 00
43. 00	l i	0		1	43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS		5,010		10.00
50.00		-543, 919	1, 001, 352		50.00
52. 00		0	7, 603	1	52.00
54.00		-3, 285		1	54.00
57.00		0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	290, 855		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		59.00
60.00	06000 LABORATORY	0	1, 244, 302		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
65.00	06500 RESPIRATORY THERAPY	0	17, 800		65.00
66. 00		0	297, 283		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	67.00
68. 00		0	589		68. 00
69. 00		0			69. 00
69. 02		0	1,		69. 02
70. 00		0	1	·	70. 00
71. 00	l l	-25, 282		l l	71. 00
72. 00		0			72.00
73. 00		0	492, 975		73. 00
00 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC		1 0		00 00
88. 00 89. 00	l i	0	1	1	88. 00 89. 00
90.00	1 1	0	0	1	90.00
91.00	1 1	-1, 171, 749	571, 335		91.00
92. 00		-1, 1/1, /47	371,333		92.00
72.00	OTHER REIMBURSABLE COST CENTERS	L			72.00
95 00	09500 AMBULANCE SERVICES	0	0		95. 00
	09910 CORF	0			99. 10
	010100 HOME HEALTH AGENCY	0		i i	101. 00
	SPECIAL PURPOSE COST CENTERS				
109.00	0 10900 PANCREAS ACQUISITION	0	0	1	109. 00
	0 11000 I NTESTI NAL ACQUI SI TI ON	0	Ō		110. 00
111.00	0 11100 I SLET ACQUISITION	0	0		111. 00
	0 08600 OTHER ORGAN ACQUISITION	0	0		112. 00
113.00	0 11300 INTEREST EXPENSE	0	0		113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2, 705, 576	13, 435, 491		118. 00
	NONREI MBURSABLE COST CENTERS				
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	l	190. 00
	0 19200 PHYSICIANS' PRIVATE OFFICES	0			192. 00
200.00	O TOTAL (SUM OF LINES 118-199)	-2, 705, 576	13, 521, 131		200. 00

Peri od: Worksheet A-6 From 05/01/2013 Date/Time Prepared: 0/20/2014 10:58 am

Cost Center						lo	04/30/201	4 Date/lime Prepared: 9/30/2014 10:58 am
1.00			Increases					1. 30, 2011 10. 30 dill
A - UNASSIGNED COSTS   EMPLOYEE BENEFITS DEPARTMENT   7.00								
1.00   EMPLOYEE BENEFITS DEPARTMENT   4.00   0   1.408,235   2.00   OPERATION OF PLANT   7.00   0   0   1.212,200   3.00   NeW CAP REL COSTS-BLDG & 1.00   0   1.212,200   3.00   NEW CAP REL COSTS-BLDG & 1.00   0   2.948,111			3. 00	4.00	5. 00			
2.00   OPERATION OF PLANT   7.00   0   327,676   3.00   NEW CAP REL COSTS-BLDG & 1.00   0   1,212,200								
New Cap Rel Costs-blog & 1,00	1.00		4.00	0	1, 408, 235			1.00
FIXT	2.00	OPERATION OF PLANT	7. 00	0	327, 676			2.00
TOTALS	3.00	NEW CAP REL COSTS-BLDG &	1.00	0	1, 212, 200			3.00
B - NURSING   1.00   DELIVERY ROOM & LABOR ROOM   52.00   5,302   2,301   1.00   1.0		FI XT						
1.00		TOTALS		0	2, 948, 111			
2.00		B - NURSING						
RESPIRATORY THERAPY	1.00	DELIVERY ROOM & LABOR ROOM	52.00	5, 302	2, 301			1. 00
TOTALS  C - CAFETERIA COSTS  C - CAFETERIA 11.00 178,938 202,110  TOTALS 178,938 202,110  D - INTEREST  NEW CAP REL COSTS-BLDG & 1.00 0 642,292  E - SPEECH PURCHASED SVC  1.00 SPEECH PATHOLOGY 68.00 0 589  TOTALS 0 589  TOTALS 0 0 478,481  PATIENTS  DRUGS CHARGED TO PATIENTS 73.00 0 632 3.00 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00	NURSERY	43.00	4, 076	1, 769			2.00
C - CAFETERI A COSTS   TOTALS   TOTAL	3.00	RESPI RATORY THERAPY	65.00	4, 292	1, 863			3.00
1.00 CAFETERIA 11.00 178, 938 202, 110 TOTALS 178, 938 202, 110 D - INTEREST  1.00 NEW CAP REL COSTS-BLDG & 1.00 0 642, 292 E - SPEECH PURCHASED SVC  1.00 SPEECH PATHOLOGY 68.00 0 589 F - CHARGABLE SUPPLIES  1.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 478, 481 PATIENTS 73.00 0 632 2.00 DRUGS CHARGED TO PATIENTS 73.00 0 0 632 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		TOTALS		13, 670	5, 933			
1.00 CAFETERIA 11.00 178, 938 202, 110 TOTALS 178, 938 202, 110 D - INTEREST  1.00 NEW CAP REL COSTS-BLDG & 1.00 0 642, 292 E - SPEECH PURCHASED SVC  1.00 SPEECH PATHOLOGY 68.00 0 589 F - CHARGABLE SUPPLIES  1.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 478, 481 PATIENTS 73.00 0 632 2.00 DRUGS CHARGED TO PATIENTS 73.00 0 0 632 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		C - CAFETERIA COSTS	<u> </u>	· · ·				
TOTALS	1.00		11, 00	178, 938	202, 110			1. 00
D - INTEREST								
1.00   NEW CAP REL COSTS-BLDG &   1.00   0   642, 292				,				
FIXT   TOTALS	1 00		1 00	0	642 292			1. 00
TOTALS				٩	0 12/ 272			
E - SPEECH PURCHASED SVC  SPEECH PATHOLOGY 68.00 0 589 TOTALS 0 0 589  F - CHARGABLE SUPPLIES  1. 00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 478, 481 PATI ENTS 2. 00 DRUGS CHARGED TO PATI ENTS 73.00 0 632 3. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					642. 292			
1. 00   SPECH PATHOLOGY   68. 00   0   589   1. 00   1. 00   589   1. 00   1.				-1	,			
TOTALS  F - CHARGABLE SUPPLIES  1. 00 MEDICAL SUPPLIES CHARGED TO 71. 00 0 478, 481 1.00 PATIENTS  2. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 632 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00		68, 00	0	589			1. 00
F - CHARGABLE SUPPLIES  1. 00 MEDICAL SUPPLIES CHARGED TO 71. 00 0 478, 481  2. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 632  3. 00 4. 00 0 0 0 0 33. 00 44. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	00		=	<del> </del>				
1. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 478, 481 2. 0					337			
PATI ENTS DRUGS CHARGED TO PATI ENTS  73.00 0.00 0.00 0.00 3.0 4.00 5.00 6.00 7.00 8.00 TOTALS G - YELLOW PAGES TOTALS DRUGS CHARGED TO PATI ENTS 73.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	1 00		71 00	0	478 481			1. 00
2. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 632 2. 0	1.00		71.00	٩	170, 101			1. 60
3. 00 4. 00 4. 00 5. 00 6. 00 7. 00 8. 00 TOTALS G - YELLOW PAGES 1. 00 ADMI NI STRATI VE & GENERAL TOTALS TOTALS TOTALS 0 0 2,698 TOTALS 0 2,698 TOTALS 0 2,698 TOTALS 0 2,698	2 00		73 00	0	632			2.00
4. 00		SHOOD CHARGES TO TALLE		0	0			3.00
5. 00				0	0			4.00
6. 00					o o			5. 00
7. 00 8. 00 0. 00 0 0 0 0 0 0 0 0 0 0 0 0				0	0			6. 00
8. 00				0	0			7. 00
TOTALS 0 479, 113  G - YELLOW PAGES  1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 2, 698  TOTALS 0 2, 698				0	0			8. 00
G - YELLOW PAGES  1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 2, 698 1 TOTALS 0 2, 698	0.00	TOTALS — — — —		<del></del>				0.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 2, 698 TOTALS 0 2, 698				<u> </u>	4/7, 113			
TOTALS 0 2,698	1 00		5 00		2 600			1. 00
	1.00		— — <del>5.00</del> —	;;				1.00
200. 00 paralle rotar. The eases   192, 008  4, 280, 840  500.	E00 00			102 409				E00.00
	300. UC	goranu 10tar. Tricreases		192, 008	4, 200, 840			500.00

RECLASSI FI CATIONS

TOTALS

500.00 Grand Total: Decreases

Provider CCN: 151300

2, 698

4, 280, 846

Peri od: Worksheet A-6
From 05/01/2013

500.00

04/30/2014 Date/Time Prepared: 9/30/2014 10:58 am Decreases Cost Center 0ther Wkst. A-7 Ref. Li ne # Sal ary 10. 00 6.00 7.00 8.00 9.00 A - UNASSIGNED COSTS 1.00 ADMINISTRATIVE & GENERAL 5.00 0 2, 948, 111 0 1.00 0.00 0 0 2.00 2.00 3.00 0.00 9 3.00 TOTALS 0 2, 948, 111 B - NURSING ADULTS & PEDIATRICS 1.00 30.00 13, 670 5. 933 0 1.00 2.00 2.00 0 0.00 3.00 0.00 0 0 3.00 5, 933 TOTALS 13, 670 C - CAFETERIA COSTS
DI ETARY 1.00 178, 938 202, 110 10.00 0 1.00 TOTALS 178, 938 202, 110 D - INTEREST ADMINISTRATIVE & GENERAL 642, 292 1.00 5.00 0 10 1.00 TOTALS 642, 292 E - SPEECH PURCHASED SVC PHYSICAL THERAPY 66.00 1.00 0 589 0 1.00 589 TOTALS - CHARGABLE SUPPLIES 1.00 ADULTS & PEDIATRICS 30.00 15, 559 1.00 0 427, 817 0 2.00 OPERATING ROOM 50.00 2.00 3.00 RADI OLOGY-DI AGNOSTI C 54.00 0 27 0 3.00 4.00 CT SCAN 57.00 0 6, 195 0 4.00 MAGNETIC RESONANCE IMAGING 5.00 58.00 o 6, 874 0 5.00 (MRI) 6.00 RESPÍRATORY THERAPY 0 65.00 0 6, 768 6.00 PHYSICAL THERAPY 7.00 66.00 0 4, 297 0 7.00 8.00 **EMERGENCY** 91.00 11, 576 8.00 0 TOTALS 479, 113 G - YELLOW PAGES PHYSICIANS' PRIVATE OFFICES 1.00 192.00 2, 698 0 1.00

192, 608

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 151300 Peri od: Worksheet A-7 From 05/01/2013 Part I Date/Time Prepared: 04/30/2014 9/30/2014 10:58 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 440, 039 0 1.00 0 2.00 Land Improvements 0 2.00 0 3. 00 3.00 Buildings and Fixtures 17, 285, 369 454, 737 454, 737 0 Building Improvements 0 4.00 0 4.00 5.00 Fixed Equipment 0 0 5.00 0 6.00 Movable Equipment 6, 252, 977 625, 237 625, 237 0 6.00 0 7.00 HIT designated Assets 7.00 0 0 8.00 Subtotal (sum of lines 1-7) 23, 978, 385 1,079,974 1, 079, 974 0 8.00 9.00 Reconciling Items -927, 240 794, 434 0 794, 434 0 9.00 Total (line 8 minus line 9) 285, 540 24, 905, 625 10.00 10.00 285, 540 0 0 Endi ng Bal ance Fully Depreciated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 440,039 1.00 2.00 Land Improvements 0 2.00 3.00 Buildings and Fixtures 17, 740, 106 0 3.00 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 6, 878, 214 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 0 8.00 25, 058, 359 8.00 9.00 Reconciling Items -132, 806 9.00 10.00 Total (line 8 minus line 9)

25, 191, 165

0

Heal th	Financial Systems (	COMMUNITY HOSPI	TAL OF BREMEN		In Lieu of Form CMS-2552-10			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151300	Peri od:	Worksheet A-7		
					From 05/01/2013 To 04/30/2014		nared:	
					10 04/30/2014	9/30/2014 10:		
SUMMARY OF CAPITAL								
			1	1 .	T			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	,		
			10.00	44.00	instructions)			
	DART II. DECONOLILATION OF AMOUNTS FROM WORK	9.00	10.00	11.00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	MN 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1. 00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00	
3.00   Total (sum of lines 1-2)   0   0   0   0								
		SUMMARY 0	F CAPITAL					
	Cost Center Description		Total (1) (sum					
		Capi tal -Relate						
		d Costs (see	through 14)					
		instructions)						
		14.00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	MN 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0				1. 00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2. 00	
3.00	Total (sum of lines 1-2)	0	0				3. 00	
		•	•	•		•	•	

Heal th	n Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 05/01/2013 To 04/30/2014		pared:
		COM	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	38 alli
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		0 1.000000	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0. 000000		
3.00	Total (sum of lines 1-2)	0	0		0 1.000000		3. 00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6.00	7. 00	8. 00	9. 00	10. 00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS			0 4 407 454	/10.010	4 00
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	0		0 1, 197, 154	618, 248	ł
2. 00 3. 00	NEW CAP REL COSTS-MVBLE EQUIP	0			0 1 107 154	(10.240	
3.00	Total (sum of lines 1-2)	0	<u> </u>	<u>l</u> JMMARY OF CAPI	0 1, 197, 154	618, 248	3.00
			50	JIMIMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	•				Capi tal -Relate		
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		1	1			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0		1	0	1, 815, 402	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	-		0	0	2.00
3. 00	Total (sum of lines 1-2)	0	U I	11	0 0	1, 815, 402	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 151300 | Period: | Worksheet A-From 05/01/2013 | To 04/30/2014 | Date/Time Pr

				'.	o 04/30/2014	Date/Time Prep 9/30/2014 10:5	pared:
				Expense Classification on To/From Which the Amount is		973072014 10.3	o alli
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	O	2. 00
3. 00	Investment income - other (chapter 2)	В		NEW CAP REL COSTS-BLDG & FLXT	1. 00	10	
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)	В	-46, 512	ADMINISTRATIVE & GENERAL	5. 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)		0		0. 00	O	7. 00
8.00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -1, 722, 268		0. 00	O O	
11. 00	Sale of scrap, waste, etc. (chapter 23)	В	-3, 285	RADI OLOGY-DI AGNOSTI C	54.00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12. 00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	0 -143, 595	CAFETERI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee and others		0		0.00	0	
16. 00	Sale of medical and surgical supplies to other than patients	В	-25, 282	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	16. 00
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and abstracts	В	-3, 487	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19. 00
20. 00 21. 00	Vending machines Income from imposition of interest, finance or penalty charges (chapter 21)	В	0 -17, 809	ADMINISTRATIVE & GENERAL	0. 00 5. 00	0	
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	, , ,	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00			0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14)		0		0.00	0	32.00

					o 04/30/2014	Date/Time Prep 9/30/2014 10:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					T		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
33. 00	MEALS ON WHEELS	В	·	DI ETARY	10.00		00.00
34. 00	HAF PROVIDER ASSESSMENT	A	·	ADMINISTRATIVE & GENERAL	5. 00		34. 00
35. 00	INVOICE PENALTIES	Α	·	ADMINISTRATIVE & GENERAL	5. 00		35. 00
36. 00	RECRUI TI NG/MD SUPPORT	A	·	ADMINISTRATIVE & GENERAL	5. 00		36. 00
37.00	LOBBYING EXP IN DUES	A		ADMINISTRATIVE & GENERAL	5. 00	0	37. 00
38. 00	PLYMOUTH ST CLINIC DEPR	A	-15, 046	NEW CAP REL COSTS-BLDG &	1.00	9	38. 00
				FI XT			
39. 00			0		0.00	ol	39. 00
40.00	MISC INCOME	В	-72, 092	ADMINISTRATIVE & GENERAL	5. 00	o	40. 00
41.00	PLYMOUTH ST MAINTENANCE	A	-4, 925	OPERATION OF PLANT	7. 00	o	41.00
42.00	PLYMOUTH ST HOUSEKEEPING	Α	-2, 137	HOUSEKEEPI NG	9. 00	0	42. 00
43.00			0		0.00	0	43.00
44.00			0		0.00	ol	44. 00
45.00			0		0.00	l o	45.00
50.00	TOTAL (sum of lines 1 thru 49)		-2, 705, 576				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
Identifier   Remuneration   Component   Component   Identifier   Remuneration   Component   Component   Identifier   Ide	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1.00   2.00   3.00   4.00   5.00   6.00   7.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1. 00         50. 00 AGGREGATE - OPERATI NG ROOM         543, 919         543, 919         0         0         0           2. 00         91. 00 AGGREGATE - EMERGENCY         1, 171, 749         1, 171, 749         0         0         0           3. 00         60. 00 AGGREGATE - LABORATORY         21, 600         0         21, 600         0         0           4. 00         30. 00 AGGREGATE - ADULTS & PEDI ATRI CS         6, 600         6, 600         0         0         0         0         0           5. 00         0. 00         0         0         0         0         0         0         0         0           6. 00         0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00     91. 00     AGGREGATE - EMERGENCY     1, 171, 749     1, 171, 749     0     0     0       3. 00     60. 00     AGGREGATE - LABORATORY     21, 600     0     21, 600     0     0       4. 00     30. 00     AGGREGATE - ADULTS & 6, 600     6, 600     0     0     0     0       5. 00     0. 00     0     0     0     0     0     0       6. 00     0     0     0     0     0     0       0     0     0     0     0     0       0     0     0     0     0     0       0     0     0     0     0     0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
3. 00 60. 00 AGGREGATE-LABORATORY 21, 600 0 21, 600 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
4. 00 30. 00 AGGREGATE-ADULTS & 6, 600 6, 600 0 0 0 0 0 0 0 0 0 0 0 0 0	4. 00 5. 00 6. 00 7. 00
5. 00	5. 00 6. 00 7. 00
5. 00     0. 00       6. 00     0. 00	6. 00 7. 00
6.00 0.00 0 0 0	6. 00 7. 00
	7. 00
7.00 0.00 0 0 0	8.00
8.00 0.00 0 0 0	
9.00 0.00 0 0 0	9. 00
	10.00
1/110/000 1/110/000	00. 00
Identifier Limit Unadjusted RCE Memberships & Component of Malpractice Limit Continuing Share of col. Insurance	
Education 12	
1.00 2.00 8.00 9.00 12.00 13.00 14.00	
1. 00 50. 00 AGGREGATE - OPERATING ROOM 0 0 0 0	1. 00
2.00 91.00 AGGREGATE-EMERGENCY 0 0 0 0	2. 00
3. 00 60. 00 AGGREGATE-LABORATORY 0 0 0 0	3. 00
4.00 30.00 AGGREGATE-ADULTS & 0 0 0 0	4. 00
PEDI ATRI CS	
5.00 0.00 0 0 0 0	5.00
6.00 0.00 0 0 0 0	6.00
7.00 0.00 0 0 0 0	7.00
8.00   0.00   0 0 0 0	8.00
9.00   0.00   0 0 0 0	9. 00
	10.00
	00.00
Wkst. A Line # Cost Center/Physician Provider Adjusted RCE RCE Adjustment	
Identifier   Component   Limit   Disallowance	
Share of col.	
1.00 2.00 15.00 16.00 17.00 18.00	
1. 00	1. 00
2. 00 91. 00 AGGREGATE-EMERGENCY 0 0 1, 171, 749	2. 00
3. 00   60. 00 AGGREGATE-LABORATORY   0   0   0   0	3. 00
4. 00   30. 00 AGGREGATE-LADULTS & 0 0 6, 600	4. 00
PEDI ATRI CS	4.00
5.00 0.00 0 0 0	5. 00
6.00 0.00 0 0 0 0	6. 00
7.00 0 0.00 0 0 0 0	7. 00
8.00 0.00 0 0 0 0	8. 00
9.00 0.00 0 0 0 0	9. 00
	10. 00
200. 00   0   0   1, 722, 268   2	

		COMMUNITY HOSPITA		00N 454555		u of Form CMS-2				
	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151300	Peri od: From 05/01/2013 To 04/30/2014	Worksheet A-8 Parts I-VI Date/Time Pre 9/30/2014 10:	pared:			
					Speech Pathology	Cost	Jo alli			
	PART I - GENERAL INFORMATION					1. 00				
1. 00	Total number of weeks worked (excluding aides	s) (see instructi	ons)			4	1.00			
2.00	Line 1 multiplied by 15 hours per week					60	2. 00			
3.00	Number of unduplicated days in which supervis					10				
4. 00	Number of unduplicated days in which therapy nor therapist was on provider site (see inst		provider si	te but neith	er supervisor	0	4. 00			
5. 00	Number of unduplicated offsite visits - super	rvisors or therap	ists (see ins	structions)		0	5.00			
6. 00	Number of unduplicated offsite visits - there	apy assistants (i	nclude only \	visits made l		0	6. 00			
	assistant and on which supervisor and/or the	rapist was not pr	esent during	the visit(s	)) (see					
7. 00	instructions) Standard travel expense rate					9. 77	7. 00			
8. 00	Optional travel expense rate per mile					0.00				
			Therapi sts	Assi stants		Trai nees				
0.00	T	1.00	2.00	3. 00	4. 00	5. 00	0.00			
9. 00 10. 00	Total hours worked AHSEA (see instructions)	0. 00 0. 00	9. 07 19. 52	0. 0.		0. 00 0. 00	1			
11. 00	Standard travel allowance (columns 1 and 2,	9. 76	9. 76	0.		0.00	11.00			
	one-half of column 2, line 10; column 3,									
12 00	one-half of column 3, line 10) Number of travel hours (provider site)	0	0				12 00			
12. 00 12. 01	Number of travel hours (offsite)	0	0		0		12. 00 12. 01			
13. 00	Number of miles driven (provider site)	o o	Ö		Ö		13. 00			
13. 01	Number of miles driven (offsite)	0	0		0		13. 01			
						1 00				
	Part II - SALARY EQUIVALENCY COMPUTATION					1. 00				
14.00	Supervisors (column 1, line 9 times column 1,	line 10)				0	14. 00			
15. 00	Therapists (column 2, line 9 times column 2,					177				
16. 00 17. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a		tory thorany	or lines 14	14 for all	0 177				
17.00	others)	id 15 for respira	tory therapy	or rines 14	-10 101 411	177	17.00			
18.00	Aides (column 4, line 9 times column 4, line					0				
	Trainees (column 5, line 9 times column 5, li			47 140	6 11 11 )	0				
20. 00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory					ol ogy or	20.00			
	occupational therapy, line 9, is greater than									
04 00	the amount from line 20. Otherwise complete				4 10 11 0	40.54	04 00			
21. 00	Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3,			n or columns	I and 2, line 9	19. 51	21.00			
22. 00	Weighted allowance excluding aides and trained					1, 171	22. 00			
23. 00	Total salary equivalency (see instructions)					1, 171	23. 00			
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	VANCE AND TRAVEL	EXPENSE COMPL	JIAIION - PRO	OVIDER SITE		-			
24. 00	Therapists (line 3 times column 2, line 11)					98	24. 00			
25. 00	Assistants (line 4 times column 3, line 11)					0				
26. 00	Subtotal (line 24 for respiratory therapy or					98	1			
27. 00	Standard travel expense (line 7 times line 3 others)	for respiratory	tnerapy or su	um or lines .	3 and 4 for all	98	27. 00			
28. 00	Total standard travel allowance and standard	travel expense a	t the provide	er site (sum	of lines 26 and	196	28. 00			
	27)	-					1			
29. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of the su		2 line 12 )		T	0	29. 00			
30.00	Assistants (column 3, line 10 times column 3,		2, 11116 12 )			0	1			
31.00	Subtotal (line 29 for respiratory therapy or	•	and 30 for al	I others)		0	31.00			
32. 00	Optional travel expense (line 8 times columns	s 1 and 2, line 1	3 for respira	atory therap	y or sum of	0	32. 00			
33. 00	columns 1-3, line 13 for all others) Standard travel allowance and standard travel	evnense (line 1	8)			0	33.00			
34. 00										
35. 00	Optional travel allowance and optional travel			•		0				
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				VICES OUTSIDE PRO	VI DER SITE	1			
	Standard Travel Expense						34 00			
36 00	Theranists (line 5 times column 2 line 11)				1	11				
36. 00 37. 00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)					0	1			

	LE COST DETERMINATION FOR THERAPY SERVICES F SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151300	Period: From 05/01/2013 To 04/30/2014		pared:	
					Speech Pathology	Cost		
						1. 00		
6. 00 Op	otional travel allowance and optional travel			nd 43 – see ir		0	46. 0	
		Therapists	Assi stants	Ai des	Trai nees	Total		
PA	RT V - OVERTIME COMPUTATION	1. 00	2. 00	3. 00	4. 00	5. 00		
7. 00 Ov pe ec cc	vertime hours worked during reporting eriod (if column 5, line 47, is zero or qual to or greater than 2,080, do not omplete lines 48-55 and enter zero in each olumn of line 56)	0. 00	0.00	0.0	0.00	0.00	47.0	
	vertime rate (see instructions)	0. 00	0.00	0.0	0.00		48. 0	
	otal overtime (including base and overtime	0. 00	0. 00	0.0	0.00		49. 0	
	lowance) (multiply line 47 times line 48)							
	ALCULATION OF LIMIT ercentage of overtime hours by category	0, 00	0.00	0.0	0, 00	0.00	50.0	
(c	divide the hours in each column on line 47 y the total overtime worked - column 5, ne 47)	3. 33	5, 65		0.00	0.00	00.0	
1. 00 Al	location of provider's standard work year one full-time employee times the	0. 00	0.00	0.0	0.00	0. 00	51.0	
	ercentages on line 50) (see instructions) TERMINATION OF OVERTIME ALLOWANCE							
2. 00 Ac	djusted hourly salary equivalency amount	19. 52	0.00	0.0	0.00		52.0	
	see instructions) vertime cost limitation (line 51 times line	О	0	)	0 0		53.0	
4. 00 Ma	2) aximum overtime cost (enter the lesser of	0	0	)	0 0		54.0	
	ne 49 or line 53) ortion of overtime already included in	0	0		0 0		55.0	
ho	ourly computation at the AHSEA (multiply ne 47 times line 52)							
6. 00 Ov	vertime allowance (line 54 minus line 55 - f negative enter zero) ( Enter in column 5	0	0		0 0	0	56. 0	
th	ne sum of columns 1, 3, and 4 for							
	espiratory therapy and columns 1 through 3 or all others.)							
						1.00		
	ntt VI - COMPUTATION OF THERAPY LIMITATION A alary equivalency amount (from line 23)	ND EXCESS COST	ADJUSTMENT			1, 171	57. C	
	ravel allowance and expense - provider site	(from lines 33.	34. or 35))			1, 1, 1	1	
9. 00 Tr	ravel allowance and expense - Offsite servic			b)		0	1	
	vertime allowance (from column 5, line 56)					0		
1	quipment cost (see instructions)					0		
	upplies (see instructions) otal allowance (sum of lines 57-62)					0 1, 171	1	
1	otal cost of outside supplier services (from	vour records)				589	1	
5. 00 Ex	ccess over limitation (line 64 minus line 63		enter zero)			0		
	NE 33 CALCULATION  ne 26 = line 24 for respiratory therapy or	sum of lines 24	l and 25 for a	all others		98	1 100. (	
					others		100. 0	
00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27  LINE 34 CALCULATION								
	ne 27 = line 7 times line 3 for respiratory				others		101. C	
01. 00 Li	01.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 01.02 Line 34 = sum of lines 27 and 31							
01. 00 Li 01. 01 Li	ne 34 = sum of lines 27 and 31						101. C	
01. 00 Li 01. 01 Li 01. 02 Li LI	NE 35 CALCULATION	cum of Lines of	) and 20 for -	ll others		^	102.0	
01. 00 Li 01. 01 Li 01. 02 Li LI 02. 00 Li 02. 01 Li					ımns 1-3, line		102. 0 102. 0	

Health Financial Systems COMMUNITY HOSPITAL OF BREMEN In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 151300 Peri od: Worksheet B From 05/01/2013 Part I 04/30/2014 Date/Time Prepared: 9/30/2014 10:58 am CAPITAL RELATED COSTS Cost Center Description Net Expenses NEW BLDG & NEW MVBLE **EMPLOYEE** Subtotal for Cost FIXT **FOULP BENEFLTS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 1, 815, 402 1, 815, 402 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 0 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1,509,827 6, 789 0 1, 516, 616 4.00 00500 ADMINISTRATIVE & GENERAL 0 5 00 1 867 027 151, 435 249, 692 2 268 154 5 00 00700 OPERATION OF PLANT 7.00 641, 528 327, 645 0 45, 916 1,015,089 7.00 7.01 00701 OPERATION OF PLANT 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 118, 248 0 124, 713 8.00 6.465 0 00900 HOUSEKEEPI NG 0 9 00 11, 109 37.327 210, 819 9 00 162, 383 10.00 01000 DI ETARY 52,890 37, 117 0 7, 542 97, 549 10.00 01100 CAFETERI A 0 46, 771 321, 135 11.00 237, 453 36, 911 11.00 01300 NURSING ADMINISTRATION 228, 917 11, 726 0 56, 238 13.00 13.00 296, 881 0 01600 MEDICAL RECORDS & LIBRARY 54, 309 16.00 304, 568 19, 455 378, 332 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 807, 753 368, 022 177,005 1, 352, 780 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 0 C 0 0 32 00 03200 CORONARY CARE UNIT 0 C 0 0 0 32 00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 Ω 0 0 0 34.00 04100 SUBPROVIDER - IRF 41.00 0 0 0 41.00 C 0 04200 SUBPROVI DER O 42.00 Λ 42.00 04300 NURSERY 0 43.00 5,845 8,581 1,065 15, 491 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 1,001,352 1, 404, 462 50.00 245, 653 0 157, 457 05200 DELIVERY ROOM & LABOR ROOM 52.00 7,603 0 1, 386 8, 989 52.00 05400 RADI OLOGY-DI AGNOSTI C 731, 311 105, 969 954, 332 54.00 117, 052 54.00 57.00 05700 CT SCAN 353, 417 0 11, 870 365, 287 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 290, 855 13, 376 304, 231 58.00 r 05900 CARDIAC CATHETERIZATION 59.00 59.00 60.00 06000 LABORATORY 1, 244, 302 70, 825 0 133, 564 1, 448, 691 60.00 06001 BLOOD LABORATORY 0 60 01 Ω 60.01 65.00 06500 RESPIRATORY THERAPY 17.800 1.122 18, 922 65.00 06600 PHYSI CAL THERAPY 0 66.00 297, 283 82, 756 74,868 454, 907 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 Ω 06800 SPEECH PATHOLOGY 0 589 68.00 0 589 68.00 69.00 06900 ELECTROCARDI OLOGY 52,682 2, 116 0 0 54, 798 69.00 69.02 06902 SLEEP LAB 33, 996 13, 195 0 0 47, 191 69.02 07000 ELECTROENCEPHALOGRAPHY 0 70 00 0 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 588, 150 62, 478 26, 862 677, 490 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 492, 975 0 56, 741 573, 197 73.00 23, 481 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 C 0 90.00 09000 CLI NI C 0 90.00 0 0 1, 018, 022 09100 EMERGENCY 91.00 571, 335 200, 248 246, 439 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 0 0 0 99 10 09910 CORE 0 99. 10 0 Ω 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 109. 00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 0 0 0 111.00 C 112.00 08600 OTHER ORGAN ACQUISITION 0 0 0 0 112.00 113. 00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 13, 435, 491 1, 803, 059 0 1, 505, 519 13, 412, 051 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 12, 343 12, 343 190. 00 0

85.640

1, 815, 402

13, 521, 131

0

0

0

11.097

1, 516, 616

96, 737 192. 00

13, 521, 131 202. 00

0 200.00

0 201.00

200.00

201.00

202.00

192.00 19200 PHYSICIANS' PRIVATE OFFICES

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151300

| Period: | Worksheet B | From 05/01/2013 | Part | | Part | | To 04/30/2014 | Date/Time Prepared: | 9/30/2014 | 10: 58 am

						9/30/2014 10:	58 am_
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	PLANT	PLANT	LINEN SERVICE	0.00	
	OFNEDAL CEDIUSE COCT OFNITEDO	5. 00	7. 00	7. 01	8. 00	9. 00	
1 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT	T		T			1 00
1. 00 2. 00	00200 NEW CAP REL COSTS-BLDG & FIXT						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	2, 268, 154					5. 00
7. 00	00700 OPERATION OF PLANT	204, 601	1, 219, 690				7. 00
7. 00	00701 OPERATION OF PLANT	204,001	1, 217, 070	o o			7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	25, 137	5, 931	,	155, 781		8. 00
9.00	00900 HOUSEKEEPING	42, 493	10, 191		12, 025	275, 528	1
10. 00	01000 DI ETARY	19, 662	34, 050		403	7, 795	1
11. 00	01100 CAFETERI A	64, 728	33, 862		461	7, 752	
13. 00	01300 NURSING ADMINISTRATION	59, 839			0	2, 463	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	76, 257	17, 847		_	4, 086	1
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	707207	177017		<u> </u>	1,7000	1
30. 00	03000 ADULTS & PEDIATRICS	272, 666	337, 619	0	44, 306	77, 290	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0	1	,	0	1
32. 00	03200 CORONARY CARE UNIT	0	O	o	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	o	0	o	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	o	0	0	0	34.00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY	3, 122	7, 872	0	237	1, 802	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000  OPERATI NG ROOM	283, 083	225, 357	0	47, 035	51, 590	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 812	0	1		0	
54.00	05400  RADI OLOGY-DI AGNOSTI C	192, 355	107, 381	0	15, 263	24, 582	54. 00
57. 00	05700 CT SCAN	73, 627	0	0	0	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	61, 321	0	0	0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60. 00	06000 LABORATORY	292, 002	64, 973	1	0	14, 874	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	
65. 00	06500 RESPI RATORY THERAPY	3, 814	0	0	0	0	
66. 00	06600 PHYSI CAL THERAPY	91, 691	75, 919	0	9, 513	17, 380	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	
68. 00	06800 SPEECH PATHOLOGY	119	1 041	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	11, 045	1, 941		561	444	1
69. 02	06902 SLEEP LAB	9, 512	12, 105	1	338	2, 771	1
70.00	07000 ELECTROENCEPHALOGRAPHY	124 555	0 57 217	1	0	12 121	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	136, 555	57, 317		0	13, 121	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	115, 534	21, 541	,	0	0 4, 931	1
73.00	OUTPATIENT SERVICE COST CENTERS	115, 554	21, 541		U U	4, 731	73.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
90. 00	09000 CLINIC	0			0	0	1
91. 00	09100 EMERGENCY	205, 193	183, 704		23, 301	42, 055	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	200, 170	100, 701		20, 001	12,000	92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
	09910 CORF	0	O	o	0	0	1
	10100 HOME HEALTH AGENCY	0	O	o	0	0	101.00
	SPECIAL PURPOSE COST CENTERS	•		•			1
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100   SLET ACQUISITION	0	0	0	0	0	111. 00
112.00	08600 OTHER ORGAN ACQUISITION	0	0	0	0	0	112. 00
113.00	11300 INTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2, 246, 168	1, 208, 367	0	153, 752	272, 936	118. 00
	NONREI MBURSABLE COST CENTERS						]
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 488		0	0	2, 592	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	19, 498	0	0	2, 029	0	192. 00
200.00	Cross Foot Adjustments			1			200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	2, 268, 154	1, 219, 690	) 0	155, 781	275, 528	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

 OF BREMEN
 In Lieu of Form CMS-2552-10

 Provider CCN: 151300
 Period: From 05/01/2013 Part I To 04/30/2014 Date/Time Prepared: 9/30/2014 10:58 am

					04/30/2014	9/30/2014 10:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS & LI BRARY	Subtotal	
		10.00	11. 00	13. 00	16. 00	24. 00	
GENE	RAL SERVICE COST CENTERS						
	NEW CAP REL COSTS-BLDG & FIXT						1. 00
	NEW CAP REL COSTS-MVBLE EQUIP						2. 00
	OO EMPLOYEE BENEFITS DEPARTMENT						4. 00
	OO ADMINISTRATIVE & GENERAL						5. 00
	OO OPERATION OF PLANT						7. 00
	01 OPERATION OF PLANT						7. 01
	DO LAUNDRY & LINEN SERVICE						8.00
	00 HOUSEKEEPI NG 00 DI ETARY	150 450					9.00
	00 CAFETERI A	159, 459 0	427, 938				10. 00 11. 00
•	OO NURSI NG ADMI NI STRATI ON	0	17, 993				13.00
•	00 MEDICAL RECORDS & LIBRARY	o	38, 585		515, 107		16.00
	ATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	00,000	<u> </u>	0.07.07		10.00
	00 ADULTS & PEDIATRICS	159, 459	63, 395	132, 762	49, 030	2, 489, 307	30.00
31.00 0310	00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 0320	OO CORONARY CARE UNIT	0	0	0	0	0	32. 00
	00 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
	OO SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
	00 SUBPROVI DER - I RF	0	0	0	0	0	41.00
	00 SUBPROVI DER	0	1 000	2 057	2 700	0 27 000	42.00
	DO NURSERY LLARY SERVICE COST CENTERS	0	1, 890	3, 957	2, 709	37, 080	43.00
	OO OPERATING ROOM	0	64, 615	135, 316	99, 413	2, 310, 871	50.00
	DO DELIVERY ROOM & LABOR ROOM	0	2, 456	I	2, 843	21, 552	52. 00
	OO RADI OLOGY-DI AGNOSTI C	o	45, 689		46, 239	1, 385, 841	1
	OO CT SCAN	0	6, 281	0	54, 847	500, 042	
58. 00 0580	OO MAGNETIC RESONANCE IMAGING (MRI)	0	5, 832	0	21, 567	392, 951	58. 00
59.00 0590	OO CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
	DO LABORATORY	0	73, 933	0	120, 786	2, 015, 259	1
	01 BLOOD LABORATORY	0	0	0	0	0	60. 01
	00 RESPI RATORY THERAPY	0	1, 987		351	29, 209	65. 00
•	00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY	0	24, 931	0	24, 017	698, 358 0	66. 00 67. 00
•	00 SPEECH PATHOLOGY	0	0		75	783	1
	00 ELECTROCARDI OLOGY	0	0		10, 880	79, 669	
•	02 SLEEP LAB	0	0	Ö	2, 349	74, 266	
	OO ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00 0710	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17, 105	0	23, 914	925, 502	71. 00
	OO IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	DO DRUGS CHARGED TO PATIENTS	0	12, 334	0	23, 932	751, 469	73. 00
	PATIENT SERVICE COST CENTERS				ما		00.00
	DO RURAL HEALTH CLINIC DO FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
	00 CLINIC	0	0		0	0	90.00
	OO EMERGENCY	0	50, 912	106, 620	32, 155	1, 661, 962	1
1	OO OBSERVATION BEDS (NON-DISTINCT PART)	Ĭ	00, 7.12	100,020	027 100	1,001,702	92.00
	R REIMBURSABLE COST CENTERS	•		,	<u>'</u>		
	00 AMBULANCE SERVICES	0	0	0	0	0	
99. 10 0991		0	0	_	0	0	
	OO HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	CIAL PURPOSE COST CENTERS	0			ما		100.00
	DO PANCREAS ACQUISITION DO INTESTINAL ACQUISITION	0	0	0	0		109. 00 110. 00
	00 ISLET ACQUISITION	0	0		0		111.00
	OO OTHER ORGAN ACQUISITION	0	0		0		112. 00
	00 INTEREST EXPENSE	Ĭ	· ·			· ·	113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	159, 459	427, 938	387, 933	515, 107	13, 374, 121	
	REIMBURSABLE COST CENTERS						
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	OO PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	118, 264	
200.00	Cross Foot Adjustments		_	]			200.00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118-201)	0 159, 459	0 427, 938	0 387, 933	0  515, 107	0 13, 521, 131	201.00
202.00		109, 409	421, 938	307, 733	313, 107	13, 021, 131	1202. UU

| Peri od: | Worksheet B | From 05/01/2013 | Part | | To 04/30/2014 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 151300

				То	04/30/2014	Date/Time Prepared: 9/30/2014 10:58 am
	Cost Center Description	Intern &	Total			77 307 2014 10: 30 dill
		Residents Cost & Post				
		Stepdown				
		Adjustments	07.00			
	GENERAL SERVICE COST CENTERS	25. 00	26. 00			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1. 00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					2.00
5. 00	00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00	00700 OPERATION OF PLANT					7. 00
7. 01 8. 00	OO701   OPERATION OF PLANT   OO800   LAUNDRY & LINEN SERVICE					7. 01
9. 00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON					11. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS		2, 489, 307			30.00
31. 00	03100   NTENSI VE CARE UNI T		2, 467, 307			31.00
32. 00	03200 CORONARY CARE UNIT	0	0			32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0			33. 00 34. 00
41. 00	04100 SUBPROVI DER - I RF		o			41. 00
42. 00	04200 SUBPROVI DER	0	0			42.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	<u> </u>	37, 080			43. 00
50. 00	05000 OPERATING ROOM	0	2, 310, 871			50.00
52. 00 54. 00	05200   DELIVERY ROOM & LABOR ROOM   05400   RADIOLOGY-DIAGNOSTIC	0	21, 552 1, 385, 841			52. 00 54. 00
57. 00	05700 CT SCAN	0	500, 042			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	392, 951			58. 00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	0	0 2, 015, 259			59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	o o	0			60. 01
65. 00	06500 RESPIRATORY THERAPY	0	29, 209			65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		698, 358 0			66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	783			68. 00
69. 00 69. 02	06900 ELECTROCARDI OLOGY 06902 SLEEP LAB	0	79, 669 74, 266			69. 00 69. 02
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	74, 200			70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	925, 502			71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0 751, 469			72. 00 73. 00
, 0. 00	OUTPATIENT SERVICE COST CENTERS	,	70.17.10.7			7 0 1 0 0
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			88. 00   89. 00
	09000 CLINIC		0			90.00
	09100 EMERGENCY	0	1, 661, 962			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0				92. 00
	09500 AMBULANCE SERVICES	0	0			95. 00
	09910 CORF	0	0			99. 10 101. 00
101.00	10100   HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	<u> </u>	O <sub> </sub>			101.00
	10900 PANCREAS ACQUISITION	0	0			109. 00
	11000   INTESTINAL ACQUISITION   11100   ISLET ACQUISITION	0	0			110. 00 111. 00
	08600 OTHER ORGAN ACQUISITION	o o	ő			112. 00
	11300   INTEREST EXPENSE		12 274 121			113.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)   NONREIMBURSABLE COST CENTERS	0	13, 374, 121			118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28, 746			190. 00
192. 00 200. 00	19200   PHYSICIANS' PRIVATE OFFICES   Cross Foot Adjustments	0	118, 264 0			192. 00 200. 00
201.00	Negative Cost Centers		0			201. 00
202.00	TOTAL (sum lines 118-201)	0	13, 521, 131			202. 00

Provi der CCN: 151300

Peri od:

ALLOCATION OF CAPITAL RELATED COSTS

From 05/01/2013 Part II 04/30/2014 Date/Time Prepared: 9/30/2014 10:58 am CAPITAL RELATED COSTS Cost Center Description Directly NEW BLDG & NEW MVBLE Subtotal **EMPLOYEE** Assigned New FIXT **FOULP BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 0 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 6, 789 6, 789 6, 789 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 0 0 0 151, 435 151, 435 1, 118 5.00 00700 OPERATION OF PLANT 0 206 7 00 327, 645 327, 645 7 00 00701 OPERATION OF PLANT 7.01 0 0 7.01 6, 465 8.00 00800 LAUNDRY & LINEN SERVICE 6, 465 0 8.00 11, 109 00900 HOUSEKEEPI NG 0 0 0 11, 109 9.00 9 00 167 01000 DI ETARY 0 10.00 37, 117 37, 117 34 10.00 11.00 01100 CAFETERI A 36, 911 36, 911 209 11.00 01300 NURSING ADMINISTRATION 0 0 13.00 11, 726 11, 726 252 13.00 01600 MEDICAL RECORDS & LIBRARY 0 19, 455 0 16.00 16.00 19 455 243 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 368, 022 0 368, 022 792 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 0 0 31.00 0 0 03200 CORONARY CARE UNIT 32.00 32 00 Ω 0 0 33.00 03300 BURN INTENSIVE CARE UNIT C 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 0 34.00 0 04100 SUBPROVI DER - I RF 0 0 0 41.00 41.00 0 04200 SUBPROVI DER 0 42.00 42 00 0 0 04300 NURSERY 43.00 8,581 8,581 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 705 50.00 245, 653 0 245, 653 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 52 00 0 05400 RADI OLOGY-DI AGNOSTI C 117, 052 0 117, 052 474 54.00 54.00 57.00 05700 CT SCAN 0 53 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 000000000000 0 58.00 60 58.00 0 05900 CARDIAC CATHETERIZATION 0 59.00 Λ 59.00 06000 LABORATORY 598 60.00 70,825 70, 825 60.00 60.01 06001 BLOOD LABORATORY 0 Ω 60.01 06500 RESPIRATORY THERAPY 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 82, 756 82, 756 335 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 0 Ω 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 0 06900 ELECTROCARDI OLOGY 69.00 2, 116 2, 116 0 69.00 69.02 06902 SLEEP LAB 13, 195 0 13, 195 0 69.02 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71 00 120 71.00 62, 478 62, 478 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 23, 481 23, 481 254 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 0 0 90.00 09000 CLI NI C 0 90.00 0 91 00 09100 EMERGENCY 200, 248 0 200, 248 1, 103 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0 0 0 0 95.00 0 99. 10 09910 CORF 0 0 o 99. 10 Ω 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 109. 00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 Ω 0 111.00 11100 | SLET ACQUISITION 0 0 0 0 111.00 112.00 08600 OTHER ORGAN ACQUISITION 0 0 0 0 112.00 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 6, 739 118.00 0 1,803,059 0 1, 803, 059 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 12. 343 0 12. 343 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 50 192. 00 0 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 1, 815, 402 0 1, 815, 402 6, 789 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151300

				'	0 04/30/2014	9/30/2014 10:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	PLANT	PLANT	LINEN SERVICE		
	T	5. 00	7. 00	7. 01	8. 00	9. 00	
4 00	GENERAL SERVI CE COST CENTERS			T	I	I	4 00
1.00	00100 NEW CAP REL COSTS BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	152, 553					4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	13, 762	341, 613				7.00
7. 00	00700 OPERATION OF PLANT	13, 702	341,013				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 691	1, 661	Ί "	9, 817		8.00
9. 00	00900 HOUSEKEEPING	2, 858	2, 854	1	758	17, 746	9. 00
10. 00	01000 DI ETARY	1, 322	9, 537	1	25	502	1
11. 00	01100 CAFETERI A	4, 354	9, 484			499	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	4, 025	3, 013			159	13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	5, 129	4, 999	1	_	263	1
	INPATIENT ROUTINE SERVICE COST CENTERS		.,	_	_		
30.00	03000 ADULTS & PEDIATRICS	18, 340	94, 562	2 0	2, 792	4, 978	30.00
31.00	03100 INTENSIVE CARE UNIT	0	O	) c	0	0	31.00
32.00	03200 CORONARY CARE UNIT	0	0	) c	0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	) c	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100 SUBPROVI DER - I RF	0	0	) c	0	0	41. 00
42.00	04200 SUBPROVI DER	0	0	) c	0	0	42. 00
43.00	04300 NURSERY	210	2, 205	[ C	15	116	43. 00
	ANCILLARY SERVICE COST CENTERS				1		
50. 00	05000 OPERATI NG ROOM	19, 040	63, 118	1		3, 323	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	122	0	0		0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	12, 938	30, 075	1	962	1, 583	
57. 00	05700 CT SCAN	4, 952	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	4, 124	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	10.100		0	0	59.00
60.00	06000 LABORATORY	19, 636	18, 198	1	0	958	60.00
60. 01	06001 BLOOD LABORATORY	257	0		0	0	60. 01
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		21 244	'l ~	400	0	65.00
67. 00	06700 OCCUPATIONAL THERAPY	6, 167	21, 264		600	1, 119 0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0			0		68.00
69. 00	06900 ELECTROCARDI OLOGY	743	544	Ί "	35	29	69.00
69. 02	06902 SLEEP LAB	640	3, 390		21	178	69. 02
70. 00	07000 ELECTROENCEPHALOGRAPHY	040	3, 370		0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 185	16, 053		0	845	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	10,000	ol o	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	7, 771	6, 033	1	0	318	1
70.00	OUTPATIENT SERVICE COST CENTERS	.,	0,000	,1		0.0	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	O	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	o	) c	0	0	89. 00
90.00	09000 CLI NI C	0	o	) c	0	0	90.00
91.00	09100 EMERGENCY	13, 801	51, 452	2 0	1, 468	2, 709	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	
	09910 CORF	0	0	0	0	0	99. 10
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS	-			_		
	10900 PANCREAS ACQUISITION	0	0	) C	0		109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	_		110. 00
	11100 ISLET ACQUISITION	0	0	0	0	•	111. 00
	08600 OTHER ORGAN ACQUISITION	0	0	0	0	0	112. 00
	11300 INTEREST EXPENSE			_			113. 00
118.00		151, 075	338, 442	2  C	9, 689	17, 579	118. 00
100 00	NONREI MBURSABLE COST CENTERS	4	0.474	_	_		100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	167	3, 171				190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	1, 311	0	0	128	l 0	192. 00
200.00		_	_	,	_	_	200.00
201.00		152 552	241 412		0 017		201.00
202.00	TOTAL (sum lines 118-201)	152, 553	341, 613	B  C	9, 817	17,746	202. 00

Provi der CCN: 151300

Peri od:

In Lieu of Form CMS-2552-10
Worksheet B

From 05/01/2013 Part II 04/30/2014 Date/Time Prepared: 9/30/2014 10:58 am Cost Center Description DI ETARY CAFETERI A NURSI NG MEDI CAL Subtotal ADMI NI STRATI ON RECORDS & LI BRARY 10.00 11.00 13.00 24.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 7.01 00701 OPERATION OF PLANT 7.01 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 48, 537 10.00 01100 CAFETERI A 51.486 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 0 2, 165 21, 340 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 4,642 34, 731 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 7, 303 556, 260 30.00 30.00 48, 537 7,627 3, 307 31.00 03100 INTENSIVE CARE UNIT C 0 0 31.00 03200 CORONARY CARE UNIT 32.00 32.00 0 0 0 0 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 C 0 Ω 34 00 41.00 04100 SUBPROVI DER - I RF 0 C 0 0 0 41.00 04200 SUBPROVI DER 0 42.00 C 0 42.00 11, 760 04300 NURSERY 227 218 183 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 7,774 7, 444 6, 705 356, 727 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 295 283 192 917 52.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 5 497 3 119 171 700 54 00 0 57.00 05700 CT SCAN 756 0 3,699 9, 460 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 702 0 1, 455 6, 341 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 59.00 0 06000 LABORATORY 60.00 8, 896 0 8, 134 127, 245 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 06500 RESPIRATORY THERAPY 65.00 00000000 239 227 24 752 65.00 66 00 06600 PHYSI CAL THERAPY 2 999 116, 860 66 00 C 1,620 06700 OCCUPATIONAL THERAPY 0 67.00 0 Λ 67.00 06800 SPEECH PATHOLOGY 0 5 13 68.00 68.00 C 69.00 06900 ELECTROCARDI OLOGY 734 4, 201 69.00 06902 SLEEP LAB O 69 02 158 17, 582 69 02 C 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 2.058 1, 613 92, 352 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 40<u>, 955</u> 0 0 73.00 1.484 1,614 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 0 0 0 90.00 90 00 09000 CLI NI C 0 0 91.00 09100 EMERGENCY 0 6, 125 5,865 2, 169 284, 940 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 95 00 09500 AMBULANCE SERVICES 0 n 0 0 99. 10 09910 CORF 0 0 0 99.10 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0  $\cap$ O 0 0 109, 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 111.00 0 C 0 0 112.00 08600 OTHER ORGAN ACQUISITION 0 0 O 0 112.00 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 118.00 48, 537 51, 486 21, 340 34, 731 1, 798, 065 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 15, 848 190, 00 1, 489 192. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 200.00 Cross Foot Adjustments 0 200. 00 Negative Cost Centers 0 201.00 201.00

51, 486

21, 340

34.731

1, 815, 402 202. 00

48.537

TOTAL (sum lines 118-201)

202.00

| Peri od: | Worksheet B | From 05/01/2013 | Part II | To 04/30/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 151300

				То	04/30/2014	Date/Time Prepared: 9/30/2014 10:58 am
	Cost Center Description	Intern &	Total			77 307 2014 10: 30 dill
		Residents Cost & Post				
		Stepdown				
		Adjustments				
	GENERAL SERVICE COST CENTERS	25. 00	26. 00			
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 7. 00	OO5OO   ADMINISTRATIVE & GENERAL   OO7OO   OPERATION OF PLANT					5. 00 7. 00
7. 01	00701 OPERATION OF PLANT					7. 01
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					13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
30. 00	O3000 ADULTS & PEDIATRICS		556, 260			30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0			31.00
32. 00	03200 CORONARY CARE UNIT	0	O			32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0			33. 00
34. 00 41. 00	03400   SURGICAL INTENSIVE CARE UNIT   04100   SUBPROVIDER - IRF	0	0			34. 00 41. 00
42. 00	04200 SUBPROVI DER	0	0			42. 00
43.00	04300 NURSERY	0	11, 760			43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS		25/ 727			F0.00
50. 00 52. 00	05000   OPERATING ROOM   05200   DELIVERY ROOM & LABOR ROOM	0	356, 727 917			50. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	171, 700			54. 00
57. 00	05700 CT SCAN	0	9, 460			57. 00
58. 00 59. 00	05800   MAGNETIC RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	0	6, 341 0			58. 00 59. 00
60. 00	06000 LABORATORY	0	127, 245			60.00
60. 01	06001 BLOOD LABORATORY	0	o			60. 01
65. 00	06500 RESPI RATORY THERAPY	0	752			65. 00
66. 00 67. 00	O6600   PHYSI CAL THERAPY   O6700   OCCUPATI ONAL THERAPY		116, 860 0			66.00
68. 00	06800 SPEECH PATHOLOGY	O	13			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	4, 201			69. 00
69. 02 70. 00	06902 SLEEP LAB 07000 ELECTROENCEPHALOGRAPHY	0	17, 582 0			69. 02 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	92, 352			71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	40, 955			73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	O	0			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	O	o			89. 00
	09000 CLI NI C	0	0			90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	284, 940			91.00
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>				72.00
	09500 AMBULANCE SERVICES	0	0			95. 00
	09910 CORF	0	0			99. 10 101. 00
101.00	10100  HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	<u> </u>	U			101.00
109.00	10900 PANCREAS ACQUISITION	0	0			109. 00
	11000   NTESTINAL ACQUISITION	0	0			110. 00
	11100  SLET ACQUISITION  08600 OTHER ORGAN ACQUISITION	0	0			111. 00 112. 00
	11300 INTEREST EXPENSE					113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1, 798, 065			118. 00
100.00	NONREI MBURSABLE COST CENTERS		15 040			100.00
	19000  GIFT, FLOWER, COFFEE SHOP & CANTEEN   19200  PHYSICIANS' PRIVATE OFFICES		15, 848 1, 489			190. 00 192. 00
200.00			0			200. 00
201.00		0	0			201. 00
202.00	TOTAL (sum lines 118-201)	0	1, 815, 402			202. 00

Health Financial Systems COMMUNITY HOSPITAL OF BREMEN In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 151300 Peri od: Worksheet B-1 From 05/01/2013 04/30/2014 Date/Time Prepared: 9/30/2014 10:58 am CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliation ADMINISTRATIVE **FOULP** BENEFITS & GENERAL FIXT (SQUARE (ACCUM. (SQUARE DEPARTMENT FEET) FEET) (GROSS COST) SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 61.774 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 61, 774 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 231 231 5, 802, 269 00500 ADMINISTRATIVE & GENERAL 955, 263 5 00 5 153 -2, 268, 154 11 252 977 5 153 00700 OPERATION OF PLANT 7.00 11, 149 11, 149 175, 666 1,015,089 7.01 00701 OPERATION OF PLANT 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 220 220 0 124, 713 C 0 00900 HOUSEKEEPI NG 9 00 378 142.804 210, 819 378 10.00 01000 DI ETARY 1, 263 1, 263 28, 856 0 97, 549 01100 CAFETERI A 178, 938 11.00 1, 256 1, 256 321, 135 01300 NURSING ADMINISTRATION 399 399 215, 157 0 13.00 296, 881 01600 MEDICAL RECORDS & LIBRARY 16.00 662 662 207, 775 378, 332 NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 12, 523 12, 523 677, 188 1, 352, 780 0 03100 INTENSIVE CARE UNIT 31.00 0 0 0 32 00 03200 CORONARY CARE UNIT 0 C 0 0 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 Ω 0 0 O 04100 SUBPROVIDER - IRF o 41.00 0 0 C 0 04200 SUBPROVI DER 42.00 0 Λ 0 Λ

Health Financial Systems	COMMUNITY HOSPIT	AL OF BREMEN		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 05/01/2013 o 04/30/2014	Date/Time Pre 9/30/2014 10:	
	CAPITAL RELA	ATED COSTS				
Cost Center Description	NEW BLDG & FLXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1. 00	2. 00	4.00	5A	5. 00	
205.00 Unit cost multiplier (Wkst. B, Part			0. 001170		0. 013557	205. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151300

Peri od: Worksheet B-1 From 05/01/2013 To 04/30/2014 Date/Time Prepared: 9/30/2014 10:58 am

In Lieu of Form CMS-2552-10

			''	0 04/30/2014	9/30/2014 10:	
Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT	PLANT	LINEN SERVICE	(SQUARE	(MEALS	
	(SQUARE	(SQ FT	(POUNDS OF LAUNDRY)	FEET)	SERVED)	
	FEET) 7. 00	PLYMOUTH ST) 7.01	8. 00	9. 00	10. 00	
GENERAL SERVICE COST CENTERS	7.00	7.01	0.00	7. 00	10.00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00   00500   ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 OPERATION OF PLANT	45, 241					7. 00
7. 01   00701   0PERATI ON OF PLANT	0	0				7. 01
8. 00 00800 LAUNDRY & LINEN SERVICE	220	0	21, 648			8. 00
9. 00   00900   HOUSEKEEPI NG	378	0	1, 671	44, 643	100	9.00
10. 00   01000 DI ETARY	1, 263	0	56	1, 263	100	1
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	1, 256 399	0	64	1, 256 399	0	11. 00 13. 00
16. 00   01600   MEDICAL RECORDS & LI BRARY	662	0	0	662	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	002	U		002	0	10.00
30. 00 03000 ADULTS & PEDIATRICS	12, 523	0	6, 157	12, 523	100	30.00
31. 00   03100   NTENSI VE CARE UNI T	0	0	0, 137	12, 323	0	31.00
32. 00   03200   CORONARY CARE UNIT	0	Ö	0	0	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	o	0	o	0	33. 00
34.00 03400 SURGI CAL INTENSI VE CARE UNIT	0	o	0	o	0	34. 00
41. 00   04100   SUBPROVI DER -   I RF	0	0	0	0	0	41.00
42. 00   04200   SUBPROVI DER	0	0	0	0	0	42.00
43. 00   04300 NURSERY	292	0	33	292	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	8, 359	0	6, 536	8, 359	0	50. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	43	0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 983	0	2, 121	3, 983	0	54. 00
57.00   05700   CT   SCAN	0	0	0	0	0	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00   06000   LABORATORY	2, 410	0	0	2, 410	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	2, 816	0	1, 322	2, 816	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	72	0	78	72	0	69.00
69. 02   06902   SLEEP LAB	449	0	47	449	0	69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	2 12(	0	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	2, 126	0	0	2, 126	0	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0 799	0	0	799	0	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS	199	U		799	0	73.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	n	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00   09000   CLINI C	0	O.	0	0	0	90.00
91. 00   09100   EMERGENCY	6, 814	o O	3, 238	6, 814	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 2		0, 200	2, 2		92.00
OTHER REIMBURSABLE COST CENTERS				<u>'</u>		
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
99. 10   09910   CORF	0	0	0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0		111. 00
112.00 08600 OTHER ORGAN ACQUISITION	0	0	0	0	0	112. 00
113. 00 11300 I NTEREST EXPENSE		_				113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	44, 821	0	21, 366	44, 223	100	118. 00
NONREI MBURSABLE COST CENTERS	100			400		100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	420	0	_	420		190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 200.00  Cross Foot Adjustments	0	U	282	o	0	192. 00 200. 00
200.00   Cross Foot Adjustments 201.00   Negative Cost Centers						200.00
202.00 Regative cost centers 202.00 Cost to be allocated (per Wkst. B,	1, 219, 690		155, 781	275, 528	159, 459	
Part I)	1, 217, 090		100, 781	210,028	137, 439	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	26. 959837	0. 000000	7. 196092	6. 171807	1, 594. 590000	203 00
204.00 Cost to be allocated (per Wkst. B,	341, 613		9, 817	17, 746		204. 00
Part II)	371,013		,, 517	17, 740	40, 337	
205.00 Unit cost multiplier (Wkst. B, Part	7. 550960	0. 000000	0. 453483	0. 397509	485. 370000	205. 00
			•	•		

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151300

Peri od: Worksheet B-1 From 05/01/2013 To 04/30/2014 Date/Time Pre

Date/Time Prepared: 9/30/2014 10:58 am Cost Center Description CAFETERI A NURSI NG MEDI CAL RECORDS & (FTE HRS) ADMI NI STRATI ON LI BRARY (DI RECT (GROSS NRSING HRS) CHARGES) 11.00 13.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00701 OPERATION OF PLANT 7.01 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 131, 570 11.00 13.00 01300 NURSING ADMINISTRATION 5, 532 56, 953 13.00 01600 MEDICAL RECORDS & LIBRARY 11,863 28, 361, 208 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 19, 491 19, 491 2, 699, 587 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 0 03200 CORONARY CARE UNIT 0 32 00 0 32 00 Ω 03300 BURN INTENSIVE CARE UNIT 33.00 C 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34.00 34.00 04100 SUBPROVIDER - IRF 41.00 0 0 41.00 0 04200 SUBPROVI DER 42 00 O 42 00 0 04300 NURSERY 43.00 581 581 149, 184 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 19,866 19, 866 5, 473, 665 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 52 00 755 755 156, 563 54.00 05400 RADI OLOGY-DI AGNOSTI C 14,047 2, 545, 922 54.00 05700 CT SCAN 1, 931 3, 019, 879 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 1, 793 58.00 0 1, 187, 453 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 Ω 59.00 60.00 06000 LABORATORY 22, 731 0 6, 649, 824 60.00 06001 BLOOD LABORATORY 60.01 60.01 65.00 06500 RESPIRATORY THERAPY 19.350 611 607 65.00 06600 PHYSI CAL THERAPY 66.00 7.665 C 1, 322, 365 66 00 06700 OCCUPATIONAL THERAPY 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 0 4, 155 68.00 06900 ELECTROCARDI OLOGY 599, 040 69.00 0 69.00 69.02 06902 SLEEP LAB 0 129, 360 69.02 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 5.259 1, 316, 710 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS Λ 72.00  $\cap$ 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 792 1, 317, 701 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 0 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 r 0 89.00 90.00 09000 CLI NI C 90.00 91.00 09100 EMERGENCY 15, 653 1, 770, 450 91.00 15, 653 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 С 95.00 99. 10 09910 CORF 0 0 99. 10 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 C 109.00 110.00 11000 INTESTINAL ACQUISITION 0 C 0 110 00 111.00 11100 | SLET ACQUISITION 0 C 0 111.00 112.00 08600 OTHER ORGAN ACQUISITION 0 0 112.00 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 131, 570 56, 953 28, 361, 208 118.00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 Cross Foot Adjustments 200.00 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 427, 938 387, 933 515, 107 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 6.811459 0.018162 3. 252550 203.00 204.00 Cost to be allocated (per Wkst. B, 51, 486 21, 340 34, 731 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.391320 0.374695 0.001225 205.00 11)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 151300

					9/30/2014 10:	58 am
		Ti tl	e XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
·	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 489, 307		2, 489, 307	O	0	30.00
31. 00   03100   INTENSIVE CARE UNIT	_,,		_,,	o	0	31. 00
32. 00 03200 CORONARY CARE UNIT	0				0	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0				0	33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0			0	Ö	34.00
41. 00   04100   SUBPROVI DER -   RF					0	41.00
42. 00   04200   SUBPROVI DER   1 KF	0			0	0	42.00
	_		27 000	0	0	43.00
	37, 080		37, 080	U U	0	43.00
ANCILLARY SERVICE COST CENTERS	0.040.074	I	0.040.074			F0 00
50. 00 05000 OPERATING ROOM	2, 310, 871		2, 310, 871	0	0	
52.00   05200   DELIVERY ROOM & LABOR ROOM	21, 552		21, 552		0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 385, 841		1, 385, 841	0	0	54.00
57. 00   05700   CT   SCAN	500, 042		500, 042	0	0	
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	392, 951		392, 951	0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0		0	0	0	59. 00
60. 00   06000   LABORATORY	2, 015, 259		2, 015, 259	0	0	60.00
60. 01   06001   BLOOD LABORATORY	0		0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	29, 209	0	29, 209	0	0	65.00
66. 00   06600 PHYSI CAL THERAPY	698, 358	0	698, 358	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	o	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	783	0	783	o	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	79, 669		79, 669	ol	0	69. 00
69. 02   06902   SLEEP LAB	74, 266	l	74, 266		0	69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		1 0	ام	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	925, 502		925, 502	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	720,002		,20,002	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	751, 469		751, 469	Ö	0	73.00
OUTPATIENT SERVICE COST CENTERS	731, 407		731, 407	<u> </u>		75.00
88. 00 08800 RURAL HEALTH CLINIC	1 0		1 0	O	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				0	0	
90. 00   009000   CLINI C				0	0	90.00
91. 00   09100   EMERGENCY	1		1 (/1 0/2	U		
	1, 661, 962		1, 661, 962	U	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	684, 184		684, 184		0	92. 00
OTHER REIMBURSABLE COST CENTERS	_	Γ	1 _			
95. 00 09500 AMBULANCE SERVI CES	0		0	0	0	
99. 10  09910 CORF	0		0		0	
101.00 10100 HOME HEALTH AGENCY	0		0		0	101. 00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0		0			109. 00
110.00 11000 INTESTINAL ACQUISITION	0		0			110. 00
111.00 11100 ISLET ACQUISITION	0		0			111. 00
112.00 08600 OTHER ORGAN ACQUISITION	0		0		0	112. 00
113.00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	14, 058, 305	0	14, 058, 305	ol	0	200. 00
201.00 Less Observation Beds	684, 184		684, 184		0	201. 00
202.00 Total (see instructions)	13, 374, 121	0				202. 00
1 (		'		, 91	Ü	

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Peri od: Worksheet C From 05/01/2013 Part I To 04/30/2014 Date/Time Prepared: 9/30/2014 10:58 am Provider CCN: 151300

						9/30/2014 10:	58 am
			Ti tl	e XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'	'	•	+ col. 7)	Ratio	Inpati ent	
				' ' ' ' ' '		Ratio	
		6. 00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30. 00	03000 ADULTS & PEDIATRICS	2, 114, 104		2, 114, 104			30.00
31. 00	03100   NTENSI VE CARE UNIT	2, 114, 104		2, 114, 104			31.00
		0					
32.00	03200 CORONARY CARE UNIT	0		0			32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0		0			33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0			34. 00
41.00	04100 SUBPROVI DER - I RF	0		0			41. 00
42.00	04200 SUBPROVI DER	0		0			42.00
43.00	04300 NURSERY	149, 184		149, 184			43.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	1, 100, 546	4, 373, 119	5, 473, 665	0. 422180	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	156, 563		156, 563	0. 137657	0.000000	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	67, 983	2, 477, 939			0. 000000	
57. 00	05700 CT SCAN	107, 776	2, 912, 103			0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	25, 797	1, 161, 656			0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	25, 777	1, 101, 050	1		0. 000000	
		457 101	ŭ	· -			
60.00	06000 LABORATORY	457, 191	6, 192, 633	6, 649, 824		0. 000000	
60. 01	06001 BLOOD LABORATORY	0	0	0	0. 000000	0. 000000	
65.00	06500 RESPI RATORY THERAPY	1, 892	17, 458			0. 000000	
66.00	06600 PHYSI CAL THERAPY	385, 155	937, 210	1, 322, 365		0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0.000000	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	3, 507	648	4, 155	0. 188448	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	60, 230	538, 810	599, 040	0. 132994	0.000000	69. 00
69. 02	06902 SLEEP LAB	o	129, 360	129, 360	0. 574103	0.000000	69. 02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	. 0	. 0	0.000000	0.000000	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	633, 527	683, 183	1, 316, 710		0. 000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	000, 027	000, 100	1,010,710	0. 000000	0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	479, 149	838, 552	1, 317, 701		0. 000000	
73.00	OUTPATIENT SERVICE COST CENTERS	4/9, 149	030, 332	1, 317, 701	0.370200	0.000000	/3.00
00.00				J			00.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	_			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	· ·			89. 00
90.00	09000 CLI NI C	0	0	0		0. 000000	90.00
91. 00	09100 EMERGENCY	42, 890	1, 727, 560			0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 224	579, 259	585, 483	1. 168580	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
99. 10	09910 CORF	0	0	0			99. 10
101.00	10100 HOME HEALTH AGENCY	o	0	0			101.00
	SPECIAL PURPOSE COST CENTERS			,			1
109.00	10900 PANCREAS ACQUISITION	0	0	0			109. 00
	11000   NTESTINAL ACQUISITION		0	•			110.00
	11100   SLET ACQUISITION		0	Ö			111.00
	08600 OTHER ORGAN ACQUISITION		0				112.00
	11300 I NTEREST EXPENSE		0	Ī			113. 00
200.00		E 701 710	22 E40 400	20 241 200			
	,	5, 791, 718	22, 569, 490	28, 361, 208			200.00
201.00		F 701 710	22 5/0 422	20 2/1 222			201. 00
202.00	Total (see instructions)	5, 791, 718	22, 569, 490	28, 361, 208			202. 00

		T' 11 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		9/30/2014 10: 5	8 am_
	l	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 INTENSIVE CARE UNIT					31.00
32. 00   03200   CORONARY CARE UNIT					32.00
33.00 03300 BURN INTENSIVE CARE UNIT					33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
41. 00   04100   SUBPROVI DER - I RF					41.00
42. 00   04200   SUBPROVI DER					42.00
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
57. 00   05700 CT SCAN	0. 000000			l l	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			l l	58. 00
59. 00 05900 CARDIAC CATHETERIZATION	0.000000			l l	59. 00
60. 00   06000   LABORATORY	0. 000000			l l	60.00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	0. 000000			l l	60. 00
l I	0. 000000			l l	
				l l	65. 00
66. 00 06600 PHYSI CAL THERAPY	0.000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000			I	67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 000000			l l	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 000000			l l	69. 00
69. 02   06902   SLEEP LAB	0. 000000			l l	69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			l l	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			l l	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC				1	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
90. 00  09000   CLI NI C	0. 000000				90.00
91. 00   09100   EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
99. 10   09910   CORF					99. 10
101.00 10100 HOME HEALTH AGENCY				1	101. 00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION				l l	109. 00
110.00 11000 INTESTINAL ACQUISITION				l l	110. 00
111.00 11100 ISLET ACQUISITION					111. 00
112.00 08600 OTHER ORGAN ACQUISITION					112. 00
113.00 11300 I NTEREST EXPENSE					113. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds				I	201. 00
202.00 Total (see instructions)				2	202. 00

Heal th	Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	eu of Form CMS-2	2552-10
	TATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 05/01/2013 To 04/30/2014		pared: 58 am
			Ti 1	tle XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1, 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 489, 307		2, 489, 30	7 0	2, 489, 307	30.00
31.00	03100 INTENSIVE CARE UNIT	0			0 0	0	31.00
32.00	03200 CORONARY CARE UNIT	0			0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0			0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0			0	0	34.00
41.00	04100 SUBPROVI DER - I RF	0			0	0	41.00
42.00	04200 SUBPROVI DER	0			0	0	42. 00
43.00	04300 NURSERY	37, 080		37, 08	0	37, 080	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 310, 871		2, 310, 87	1 0	2, 310, 871	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	21, 552		21, 55	2 0	21, 552	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 385, 841		1, 385, 84	1 0	1, 385, 841	54.00
57.00	05700 CT SCAN	500, 042		500, 04	2 0	500, 042	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	392, 951		392, 95	1 0	392, 951	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0			0	0	59. 00
60.00	06000 LABORATORY	2, 015, 259		2, 015, 25	9 0	2, 015, 259	60.00

Health Financial Systems

COMMUNITY HOSPITAL OF BREMEN

In Lieu of Form CMS-2552-10

Provider CCN: 151300

Period:
From 05/01/2013
To 04/30/2014

Part I
Date/Time Prepared:
9/30/2014 10:58 am

Charges

Cost Center Description

Inpatient

Outpatient

Outpatient

Total (col. 6
+ col. 7)

Ratio

In Lieu of Form CMS-2552-10

Worksheet C
Part I
Date/Time Prepared:
9/30/2014 10:58 am

Cost

TEFRA
Inpatient
Ratio

			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	, , , , , , , , , , , , , , , , , , ,			+ col. 7)	Ratio	Inpati ent	
				<u> </u>		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
1	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00 0	3000 ADULTS & PEDIATRICS	2, 114, 104		2, 114, 104			30. 00
31.00 0	03100 INTENSIVE CARE UNIT	0		0			31.00
32.00 0	3200 CORONARY CARE UNIT	0		0			32.00
33.00 0	3300 BURN INTENSIVE CARE UNIT	0		0			33. 00
34.00 0	3400 SURGICAL INTENSIVE CARE UNIT	0		0			34.00
41.00 0	04100 SUBPROVI DER - I RF	0		0			41.00
42.00 0	04200 SUBPROVI DER	0		0			42.00
	04300 NURSERY	149, 184		149, 184			43.00
	NCILLARY SERVICE COST CENTERS						
50.00 0	05000 OPERATING ROOM	1, 100, 546	4, 373, 119	5, 473, 665	0. 422180	0. 000000	50.00
	05200 DELIVERY ROOM & LABOR ROOM	156, 563	0	156, 563	0. 137657	0. 000000	52.00
54.00 0	05400 RADI OLOGY-DI AGNOSTI C	67, 983	2, 477, 939	2, 545, 922	0. 544338	0.000000	54.00
57.00 0	05700 CT SCAN	107, 776	2, 912, 103	3, 019, 879	0. 165583	0.000000	57. 00
58.00 0	05800 MAGNETIC RESONANCE IMAGING (MRI)	25, 797	1, 161, 656	1, 187, 453	0. 330919	0.000000	58. 00
59.00 0	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0. 000000	0. 000000	59. 00
60.00 0	06000 LABORATORY	457, 191	6, 192, 633	6, 649, 824	0. 303054	0. 000000	60.00
60. 01 0	06001 BLOOD LABORATORY	0	0	0	0. 000000	0.000000	60. 01
65.00 0	06500 RESPI RATORY THERAPY	1, 892	17, 458		1. 509509	0.000000	65. 00
66.00 0	06600 PHYSI CAL THERAPY	385, 155	937, 210	1, 322, 365	0. 528113	0.000000	66. 00
67.00 0	06700 OCCUPATI ONAL THERAPY	0	0		0.000000	0.000000	67. 00
68.00 0	06800 SPEECH PATHOLOGY	3, 507	648	4, 155	0. 188448	0.000000	68. 00
69.00 0	06900 ELECTROCARDI OLOGY	60, 230	538, 810	599, 040	0. 132994	0.000000	69. 00
	06902 SLEEP LAB	0	129, 360	129, 360	0. 574103	0.000000	69. 02
70.00 0	77000 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70. 00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	633, 527	683, 183	1, 316, 710	0. 702890	0. 000000	71. 00
72.00 0	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0. 000000	0.000000	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	479, 149	838, 552	1, 317, 701	0. 570288	0.000000	73. 00
0	UTPATIENT SERVICE COST CENTERS						
88. 00 0	08800 RURAL HEALTH CLINIC	0	0	0	0.000000	0. 000000	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	0. 000000	0. 000000	89. 00
90.00 0	99000 CLI NI C	0	0	0	0.000000	0.000000	90.00
91.00 0	9100 EMERGENCY	42, 890	1, 727, 560	1, 770, 450	0. 938723	0.000000	91.00
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 224	579, 259	585, 483	1. 168580	0. 000000	92.00
	THER REIMBURSABLE COST CENTERS						
95.00 0	9500 AMBULANCE SERVICES	0	0	0	0. 000000	0.000000	95. 00
99. 10 0	9910 CORF	0	0	0			99. 10
101.001	0100 HOME HEALTH AGENCY	0	0	0			101. 00
S	PECIAL PURPOSE COST CENTERS						
109.001	0900 PANCREAS ACQUISITION	0	0	0			109. 00
110.001	1000 INTESTINAL ACQUISITION	0	0	0			110. 00
	1100 I SLET ACQUISITION	0	0	0			111. 00
	08600 OTHER ORGAN ACQUISITION	0	0	0			112. 00
113.001	1300 I NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	5, 791, 718	22, 569, 490	28, 361, 208			200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	5, 791, 718	22, 569, 490	28, 361, 208			202. 00

				9/30/2014 10:58 am
		Title XIX	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
32. 00   03200   CORONARY CARE UNI T				32.00
33. 00 03300 BURN INTENSIVE CARE UNIT				33.00
34. 00   03400   SURGI CAL INTENSI VE CARE UNIT				34.00
41. 00   04100   SUBPROVI DER -   RF				41.00
42. 00 04200 SUBPROVI DER				42.00
43. 00   04300   NURSERY				43.00
ANCILLARY SERVICE COST CENTERS	0.000000			50.00
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
57. 00   05700   CT SCAN	0.000000			57. 00
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI)	0.000000			58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0.000000			59.00
60. 00   06000   LABORATORY	0.000000			60.00
60. 01 06001 BLOOD LABORATORY	0.000000			60. 01
65. 00 06500 RESPIRATORY THERAPY	0.000000			65. 00
66. 00   06600   PHYSI CAL THERAPY	0.000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0.000000			68. 00
69. 00   06900   ELECTROCARDI OLOGY	0.000000			69. 00
69. 02   06902   SLEEP LAB 70. 00   07000   ELECTROENCEPHALOGRAPHY	0.000000			69. 02
	0.000000			70.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000 0. 000000			71. 00 72. 00
				•
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0. 000000			73. 00
	0. 000000			88. 00
	1			
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER 90. 00   09000   CLINIC	0. 000000 0. 000000			89. 00 90. 00
91. 00   09100   EMERGENCY	0. 000000			91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	0.00000			72.00
95. 00 09500 AMBULANCE SERVI CES	0. 000000			95. 00
99. 10   09910 CORF	0.00000			99. 10
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				101.00
109. 00 10900 PANCREAS ACQUISITION				109. 00
110. 00 11000   NTESTI NAL ACQUI SI TI ON				110.00
111. 00 11100   SLET ACQUISITION				111.00
112. 00 08600 OTHER ORGAN ACQUISITION				112.00
113. 00 11300   NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
111111111111111111111111111111111111111	i I			1202.00

				' '	0 17 007 201 1	9/30/2014 10:	
			Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
	·	(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
			ĺ	col . 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 310, 871	356, 727	1, 954, 144	0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	21, 552	917	20, 635	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 385, 841	171, 700	1, 214, 141	0	0	54.00
57.00	05700 CT SCAN	500, 042	9, 460	490, 582	0	0	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	392, 951	6, 341		0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
	06000 LABORATORY	2, 015, 259	127, 245		0	0	60.00
	06001 BLOOD LABORATORY	2,010,207	127,210	1, 000, 011	0	0	60. 01
	06500 RESPIRATORY THERAPY	29, 209	752	28, 457	0	0	65. 00
	06600 PHYSI CAL THERAPY	698, 358	l e		0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	070, 330	110,000	0 301, 470	0	0	67. 00
	06800 SPEECH PATHOLOGY	783	13		0	0	68.00
					0	0	
	06900 ELECTROCARDI OLOGY	79, 669			0		69. 00
	06902 SLEEP LAB	74, 266	17, 582		0	0	69. 02
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	925, 502	92, 352		0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	751, 469	40, 955	710, 514	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	0	0	1	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
	09000 CLI NI C	0	0	0	0	0	90. 00
91.00	09100 EMERGENCY	1, 661, 962	284, 940	1, 377, 022	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	684, 184	204, 259	479, 925	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
99. 10	09910 CORF	0	0	0	0	0	99. 10
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00	11100   SLET ACQUISITION	0	0	0	0	0	111. 00
112.00	08600 OTHER ORGAN ACQUISITION	0	0	o	0	0	112. 00
113.00	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	11, 531, 918	1, 434, 304	10, 097, 614	0	0	200. 00
201.00	, ,	684, 184			0		201. 00
202. 00		10, 847, 734	· ·		0		202. 00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		.,,	1, 211, 007	<u> </u>		

					9/30/2014 10:	58 am
			le XIX	Hospi tal	Cost	
Cost Center Description	Cost Net of	Total Charges				
	Capital and		Cost to Charge			
	Operating Cost	Part I, column	Ratio (col. 6			
	Reduction	8)	/ col . 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	2, 310, 871	5, 473, 665	0. 422180			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	21, 552	156, 563	0. 137657			52.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	1, 385, 841	2, 545, 922	0. 544338			54.00
57. 00  05700 CT SCAN	500, 042	3, 019, 879	0. 165583			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	392, 951	1, 187, 453	0. 330919			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0.000000			59. 00
60. 00 06000 LABORATORY	2, 015, 259	6, 649, 824				60.00
60. 01   06001   BLOOD   LABORATORY	0	0	0.000000			60. 01
65. 00 06500 RESPIRATORY THERAPY	29, 209	19, 350				65.00
66. 00   06600   PHYSI CAL THERAPY	698, 358					66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	783	4, 155				68.00
69. 00 06900 ELECTROCARDI OLOGY	79, 669					69. 00
69. 02   06902   SLEEP LAB	74, 266					69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	7 1, 200	127,000	I .			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	925, 502	1				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	725, 502	1, 310, 710	I			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	751, 469	1				73. 00
OUTPATIENT SERVICE COST CENTERS	731, 407	1, 317, 701	0.370200			73.00
88. 00 08800 RURAL HEALTH CLINIC	1 0		0.000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0.000000			89. 00
90. 00   09000   CLINIC			0.000000			90.00
91. 00   09100   EMERGENCY	1, 661, 962	1, 770, 450				91.00
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	684, 184	585, 483	1. 168580			92. 00
			0.000000			05.00
95. 00   09500   AMBULANCE SERVI CES 99. 10   09910   CORF	0	•				95. 00 99. 10
	0 0					
101. 00 10100 HOME HEALTH AGENCY	1 0	0	0.000000			101. 00
SPECIAL PURPOSE COST CENTERS		1	0.000000			100.00
109. 00 10900 PANCREAS ACQUISITION	0	0				109. 00
110. 00 11000   INTESTINAL ACQUISITION	0	0	0.000000			110.00
111. 00 11100   SLET ACQUISITION	0	0	0.000000			111. 00
112. 00 08600 OTHER ORGAN ACQUISITION	0	0	0.000000			112.00
113. 00 11300   INTEREST EXPENSE						113. 00
200.00 Subtotal (sum of lines 50 thru 199)	11, 531, 918					200. 00
201.00 Less Observation Beds	684, 184					201. 00
202.00   Total (line 200 minus line 201)	10, 847, 734	26, 097, 920	1			202. 00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES			Provi der	CCN: 151300	Peri od: From 05/01/2013 To 04/30/2014	Worksheet C Part I Date/Time Pre	
				т:	tle V	Hooni tal	9/30/2014 10: Cost	58 am
				- 11	lie v	Hospi tal Costs	COST	
	Cost Center Description	Total Cost	Thor	apy Limit	Total Costs		Total Costs	
	cost center bescriptron	(from Wkst. B,	mer	Adj.	l lotal costs	Di sal I owance	TOTAL COSTS	
		Part I, col.		Auj .		Di Sai i Owance		
		26)						
		1.00		2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>			
30.00	03000 ADULTS & PEDIATRICS	2, 489, 307			2, 489, 30	07	2, 489, 307	30.00
31.00	03100 INTENSIVE CARE UNIT	0				0 0	0	31.00
32.00	03200 CORONARY CARE UNIT	0				0 0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0				0 0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0				0 0	0	34.00
41.00	04100 SUBPROVI DER - I RF	0				0 0	0	41.00
42.00	04200 SUBPROVI DER	0				0 0	0	42.00
43.00	04300 NURSERY	37, 080			37, 08	30 0	37, 080	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	2, 310, 871			2, 310, 87	71 0	2, 310, 871	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	21, 552			21, 5		21, 552	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 385, 841			1, 385, 84	41 0	1, 385, 841	54.00
57.00	05700 CT SCAN	500, 042			500, 04	42 0	500, 042	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	392, 951			392, 95	51 0	392, 951	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0				0 0	0	59. 00
60.00	06000 LABORATORY	2, 015, 259			2, 015, 25	59 0	2, 015, 259	
60. 01	06001 BLOOD LABORATORY	0				0 0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	29, 209		0	29, 20	09	29, 209	65. 00
66.00	06600 PHYSI CAL THERAPY	698, 358		0	698, 35	58 0	698, 358	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0		0		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	783		0	78	33 0	783	68. 00
69. 00	06900 ELECTROCARDI OLOGY	79, 669			79, 60	59 0	79, 669	69. 00
69. 02	06902 SLEEP LAB	74, 266			74, 20	66 0	74, 266	
70.00	07000 ELECTROENCEPHALOGRAPHY	0				0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	925, 502			925, 50	02	925, 502	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0				0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	751, 469			751, 40	59 0	751, 469	73. 00
	OUTPATIENT SERVICE COST CENTERS	, , ,						
88. 00	08800 RURAL HEALTH CLINIC	0				0 0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	0	89. 00
90.00	09000 CLI NI C	0				0 0	0	
91. 00	09100 EMERGENCY	1, 661, 962			1, 661, 90		1, 661, 962	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	684, 184			684, 18	34	684, 184	92. 00
05.00	OTHER REIMBURSABLE COST CENTERS				ı			05.00
95.00	09500 AMBULANCE SERVICES	0				0 0	0	
99. 10	09910 CORF	0				0	0	
101.00	10100 HOME HEALTH AGENCY	0				0	0	101. 00
100.00	SPECIAL PURPOSE COST CENTERS				I	0		100 00
	10900 PANCREAS ACQUISITION					ŭ		109.00
	11000 INTESTINAL ACQUISITION  11100 ISLET ACQUISITION					0	0	110. 00 111. 00
	08600 OTHER ORGAN ACQUISITION						-	112.00
	11300 INTEREST EXPENSE						U	113. 00
200.00	1	14 058 305		0	14 058 30	05	14 058 305	

14, 058, 305

13, 374, 121

684, 184

14, 058, 305

13, 374, 121

684, 184

14, 058, 305 200. 00 684, 184 201. 00 13, 374, 121 202. 00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Heal th Financial Systems

COMMUNITY HOSPITAL OF BREMEN

In Lieu of Form CMS-2552-10

Provider CCN: 151300

Period:
From 05/01/2013
To 04/30/2014

Part I
Date/Time Prepared:
9/30/2014 10:58 am

Title V

Hospital

Cost

Cost

Charges

Cost Center Description

Inpatient

Outpatient

Total (col. 6 Cost or Other Hopatient

Part of Description

TEFRA

In Lieu of Form CMS-2552-10

Worksheet C
Part I
Date/Time Prepared:
9/30/2014 10:58 am

Total (col. 6 Cost or Other Hopatient)

Part of Description

Ratio

			l I	tie v	ноѕрі таі	Lost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	F			+ col. 7)	Ratio	Inpatient	
				' ' ' ' ' ' '	nati o	Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INDATIONE DOUTING CODYLOG COCT CONTEDC	6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
	03000 ADULTS & PEDIATRICS	2, 114, 104		2, 114, 10	4		30. 00
	03100 INTENSIVE CARE UNIT	0			O		31.00
32.00	03200 CORONARY CARE UNIT	0			)		32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	l ol			o		33.00
	03400 SURGICAL INTENSIVE CARE UNIT			1	)		34.00
	04100 SUBPROVI DER - I RF				<u></u>		41.00
					2		
	04200 SUBPROVI DER	440.404					42.00
	04300 NURSERY	149, 184		149, 18	4		43. 00
	ANCILLARY SERVICE COST CENTERS	, ,					1
	05000 OPERATING ROOM	1, 100, 546	4, 373, 119	5, 473, 66			
52.00	05200 DELIVERY ROOM & LABOR ROOM	156, 563	0	156, 56	0. 137657	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	67, 983	2, 477, 939	2, 545, 92	0. 544338	0.000000	54.00
57. 00	05700 CT SCAN	107, 776	2, 912, 103				
	05800 MAGNETIC RESONANCE IMAGING (MRI)	25, 797	1, 161, 656				
	05900 CARDI AC CATHETERI ZATI ON	25,777	1, 101, 030		0. 000000		
		457 404	( 400 (00				
	06000 LABORATORY	457, 191	6, 192, 633	6, 649, 82			
	06001 BLOOD LABORATORY	0	0	1	0. 000000		
	06500 RESPI RATORY THERAPY	1, 892	17, 458	19, 35			
66.00	06600 PHYSI CAL THERAPY	385, 155	937, 210	1, 322, 36	0. 528113	0.000000	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	o	0		0. 000000	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	3, 507	648	4, 15	0. 188448	0.000000	68. 00
	06900 ELECTROCARDI OLOGY	60, 230	538, 810	·			
	06902 SLEEP LAB	00,200	129, 360	1			1
	07000 ELECTROENCEPHALOGRAPHY		127, 300		0. 000000		
		(22 527	ŭ				1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	633, 527	683, 183	1, 316, 71			
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0. 000000		1
	07300 DRUGS CHARGED TO PATIENTS	479, 149	838, 552	1, 317, 70	0. 570288	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0.000000	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	ol	0		0. 000000		
	09000 CLINIC	ا	0	•	0. 000000		
	09100 EMERGENCY	42, 890	1, 727, 560	1			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 224	579, 259				
		0, 224	379, 239	303, 40	1. 100000	0.00000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	0		0. 000000	0. 000000	
	09910 CORF	0	0		O		99. 10
101.00	10100 HOME HEALTH AGENCY	0	0		)		101. 00
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0	0		)		109. 00
110.00	11000 INTESTINAL ACQUISITION	ol	0		)		110.00
	11100   SLET ACQUISITION	ام	0	•	Ď		111.00
	08600 OTHER ORGAN ACQUISITION		0				112.00
		١	U	1	1		
	11300 INTEREST EXPENSE	F 704 710	00 5/0 100	00.0/4.00			113.00
200.00	Subtotal (see instructions)	5, 791, 718	22, 569, 490	28, 361, 20	3		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	5, 791, 718	22, 569, 490	28, 361, 20	3		202. 00
		· '		•	*		•

				9/30/2014 10:58 am
		Ti tle V	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 INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
33.00 03300 BURN INTENSIVE CARE UNIT				33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T				34.00
41. 00   04100   SUBPROVI DER -   RF				41.00
42. 00   04200   SUBPROVI DER				42.00
43. 00   04300   NURSERY				43.00
				43.00
ANCILLARY SERVICE COST CENTERS	0.000000			F0.00
50. 00 05000 OPERATING ROOM	0.000000			50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0. 000000			52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57. 00  05700   CT   SCAN	0. 000000			57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00  06000  LABORATORY	0. 000000			60.00
60. 01   06001   BLOOD LABORATORY	0. 000000			60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
69. 02   06902   SLEEP LAB	0. 000000			69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATIENT SERVICE COST CENTERS	0. 000000			73.00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.00
90. 00   09000   CLI NI C	0. 000000			90.00
91. 00   09100   EMERGENCY	0. 000000			91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	0.000000			92.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
99. 10   09910 CORF	0.000000			99. 10
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				101.00
109. 00 10900 PANCREAS ACQUISITION				109. 00
110. 00 11000   NTESTINAL ACQUISITION				110.00
				111.00
111. 00 11100 I SLET ACQUI SI TI ON				
112. 00 08600 OTHER ORGAN ACQUISITION				112.00
113. 00 11300   INTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202. 00

Heal th	Health Financial Systems COMMUNITY HOSPITAL OF BREMEN In Lieu of Form CMS-2552							2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS P			Provi der		Period: From 05/01/2013 To 04/30/2014	Worksheet D Part II Date/Time Pre 9/30/2014 10:		
				Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description Capital Total		l Charges	Ratio of Cost	Inpatient	Capital Costs		
			(from	n Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part	I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.		8)	2)			
		26)						
		1. 00		2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	356, 727		5, 473, 665	0. 06517	2 234, 465	15, 281	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	917		156, 563	0. 00585	7 4, 766	28	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	171, 700		2, 545, 922	0. 06744	1 26, 068	1, 758	54.00
57.00	05700 CT SCAN	9, 460		3, 019, 879	0. 00313	33, 591	105	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	6, 341		1, 187, 453	0. 00534	0 10, 484	56	58. 00

Health Financial Systems	OF BREMEN	u of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 151300	Peri od: From 05/01/2013 To 04/30/2014	Worksheet D Part IV Date/Time Prepared: 9/30/2014 10:58 am
		Title XVIII	Hospi tal	Cost

					0 04/30/2014	9/30/2014 10:58 am	
			Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost	9	
						4)	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0			0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0			0	0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0			0	0	54.00
	05700 CT SCAN	0			0	0	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0			0	0	59. 00
	06000 LABORATORY	0			0	0	60.00
	06001 BLOOD LABORATORY	0			0	0	60. 01
	06500 RESPIRATORY THERAPY	0			0	0	65. 00
	06600 PHYSI CAL THERAPY	0			0	0	66.00
	06700 OCCUPATI ONAL THERAPY					0	67. 00
	06800 SPEECH PATHOLOGY	0			0	0	68. 00
	06900 ELECTROCARDI OLOGY					0	69. 00
	06902 SLEEP LAB					0	69. 02
	07000 ELECTROENCEPHALOGRAPHY					0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS					0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		1	<u> </u>	) 0	0	73. 00
88. 00	08800 RURAL HEALTH CLINIC			1	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER					0	89.00
	09000 CLINIC					0	90.00
	09100 EMERGENCY					0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS		ή	1	,		1 /2.00
95 00	09500 AMBULANCE SERVICES						95. 00
200.00		0		d	0	n	200.00
200.00	1 1.0.00 (1.1.00 00 177)	1	1	1	.,	ı ~	1200.00

Heal th	Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		S Provi der		Period: From 05/01/2013 To 04/30/2014	Date/Time Pre 9/30/2014 10:	
				e XVIII	Hospi tal	Cost	
	Cost Center Description	Total	Total Charges	Ratio of Cos		Inpati ent	
			(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col . 5 ÷ col		Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4) 6. 00	7.00	8.00	7) 9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	6.00	7. 00	8.00	9.00	10.00	
50. 00	05000 OPERATING ROOM	1	5, 473, 665	0.00000	0.00000	234, 465	50.00
50.00	05200 DELIVERY ROOM & LABOR ROOM	0	156, 563	1		4, 766	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 545, 922	1		26, 068	1
57. 00	05700 CT SCAN	0	3, 019, 879	1		33, 591	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1, 187, 453	1		10, 484	
59. 00	05900 CARDIAC CATHETERIZATION	0	1, 107, 433	0.00000		10, 484	1
60. 00	06000 LABORATORY	0	6, 649, 824			156, 995	
60. 01	06001 BLOOD LABORATORY	0	0,047,025	0.00000		130, 773	
65. 00	06500 RESPIRATORY THERAPY	0	19, 350			344	1
66. 00	06600 PHYSI CAL THERAPY	0	1, 322, 365			83, 010	
67. 00	06700 OCCUPATI ONAL THERAPY	0	1,022,000	1		00,010	1
68. 00	06800 SPEECH PATHOLOGY	0	4, 155	1		1, 429	
69. 00	06900 ELECTROCARDI OLOGY	0	599, 040			17, 199	
69. 02	06902 SLEEP LAB	0	129, 360	•		0	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	127,000	0.00000		_	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 316, 710	1		209, 339	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	(	0.00000		0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 317, 701	1		216, 201	73. 00
	OUTPATIENT SERVICE COST CENTERS		.,,,,,,,,	.,			1
88. 00	08800 RURAL HEALTH CLINIC	0	(	0.00000	0.000000	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ì	0.00000		0	
90.00	09000 CLI NI C	0		0.00000		0	90.00
91. 00	09100 EMERGENCY	0	1, 770, 450	1		414	91.00
91.00	0 / 100 EMERGENOT						71.00

994, 305 200. 00

95.00

26, 097, 920

Health Financial Systems	COMMUNITY HOSPITAL (	In Lieu	u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 151300	From 05/01/2013	Worksheet D Part IV Date/Time Prepared:

					9/30/2014 10:	58 am
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9	)		
	x col. 10)		x col. 12)			
	11. 00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0	C	)	0		50. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	C	)	0		52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	C	)	0		54. 00
57.00  05700 CT SCAN	0	C	)	0		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	)	0		58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	C	)	0		59. 00
60. 00   06000   LABORATORY	0	C	)	0		60.00
60. 01  06001  BL00D LABORATORY	0	C	)	0		60. 01
65. 00   06500   RESPI RATORY THERAPY	0	C		0		65. 00
66. 00   06600   PHYSI CAL THERAPY	0	C		0		66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0	C		0		67. 00
68. 00   06800   SPEECH PATHOLOGY	0	C		0		68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	C	)	0		69. 00
69. 02  06902   SLEEP LAB	0	C		0		69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   RURAL HEALTH CLINIC	0	C	)	0		88. 00
89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	C	)	0		89. 00
90. 00  09000   CLI NI C	0	C	)	0		90.00
91. 00   09100   EMERGENCY	0	C	)	0		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	)	0		92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50-199)	0	C	P	0		200. 00

Health Financial Systems	COMMUNITY HOSPITAL OF BR			OF BREMEN	REMEN In Lieu of For		
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE	COST	Provider CCN:	151300	Peri od: From 05/01/2013	

					From 05/01/2013 To 04/30/2014	Part V Date/Time Pre	pared:
						9/30/2014 10:	58 am
			Ti tl	e XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2.00	3. 00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	0. 422180	C	1,		0	00.00
	5200 DELIVERY ROOM & LABOR ROOM	0. 137657	C	1	0	0	
	5400 RADI OLOGY-DI AGNOSTI C	0. 544338	C	535, 72		0	
	5700 CT SCAN	0. 165583	C	902, 32		0	57. 00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 330919	l .	338, 33	3 0	0	58. 00
59. 00 0	5900 CARDI AC CATHETERI ZATI ON	0. 000000	C	)	0	0	59. 00
60.00	6000 LABORATORY	0. 303054	C	2, 403, 74	9 0	0	60. 00
60. 01 0	6001 BLOOD LABORATORY	0. 000000	C	)	0	0	60. 01
65.00 0	6500 RESPI RATORY THERAPY	1. 509509	C	1 ., 00.		0	65. 00
66.00 0	6600 PHYSI CAL THERAPY	0. 528113	C	319, 680	0	0	66.00
67. 00 0	6700 OCCUPATIONAL THERAPY	0. 000000	C		0	0	67.00
68. 00 0	6800 SPEECH PATHOLOGY	0. 188448	C	648	8 0	0	68. 00
69. 00 0	6900 ELECTROCARDI OLOGY	0. 132994	C	152, 68	6 0	0	69. 00
69. 02 0	6902 SLEEP LAB	0. 574103	C	49, 55	5 0	0	69. 02
70. 00 0	7000 ELECTROENCEPHALOGRAPHY	0. 000000	l c	)	0	0	70.00
71. 00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 702890	l	154, 03	9 0	0	71.00
72. 00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	l c		0	0	72. 00
73. 00 0	7300 DRUGS CHARGED TO PATIENTS	0. 570288	l c	423, 43	2 0	0	73. 00
Ol	UTPATIENT SERVICE COST CENTERS				*		1
88. 00 0	8800 RURAL HEALTH CLINIC	0.000000				0	88. 00
89. 00 0	8900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
	9000 CLI NI C	0. 000000	l c	)	0	0	90.00
91, 00 0	9100 EMERGENCY	0. 938723	l	478, 68	8 0	0	91.00
92. 00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 168580	l e			0	92.00
	THER REIMBURSABLE COST CENTERS						
	9500 AMBULANCE SERVICES	0. 000000			O		95.00
200.00	Subtotal (see instructions)		l c	7, 021, 89	8 0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program		]		0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		l c	7, 021, 89	8 0	0	202. 00
	,	II.					

				10 04/30/2014	9/30/2014 10:	
		Ti tl	e XVIII	Hospi tal	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	412, 393	0				50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	291, 613	0				54.00
57. 00   05700   CT   SCAN	149, 410	0				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	111, 961	0				58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0				59. 00
60. 00   06000   LABORATORY	728, 466	0				60.00
60. 01   06001   BLOOD LABORATORY	0	0				60. 01
65. 00 06500 RESPIRATORY THERAPY	11, 424	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	168, 827	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00   06800   SPEECH PATHOLOGY	122	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	20, 306	0				69. 00
69. 02   06902   SLEEP LAB	28, 450	0				69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	108, 272	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	241, 478	0				73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00   09000   CLI NI C	0	0				90. 00
91. 00 09100 EMERGENCY	449, 355	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	325, 632	0				92.00
OTHER REIMBURSABLE COST CENTERS		•				
95. 00 09500 AMBULANCE SERVI CES	0					95. 00
200.00 Subtotal (see instructions)	3, 047, 709	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	3, 047, 709	0				202. 00
· · · · · · · · · · · · · · · · · · ·	•	•	•			•

Health Financial Systems	COMMUNITY HOSPITAL OF BREMEN					In Lieu of Form CMS-2552-1			
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE	COST	Provi der	CCN:	151300		od: 05/01/2013	Worksheet D Part V
				Component	CCN:	15Z300	To	04/30/2014	Date/Time Prepared:

		Component	CCN: 15Z300   T	To 04/30/2014	Date/Time Pre 9/30/2014 10:	
		Ti tl	e XVIII S	wing Beds - SNF		00 4
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000 OPERATING ROOM	0. 422180			이	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 137657		(	이	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 544338	l .	(	0	0	
57. 00  05700   CT SCAN	0. 165583		(	0	0	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 330919	0	(	0	0	58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	(	ol ol	0	59. 00
60. 00   06000   LABORATORY	0. 303054	0	(	ol ol	0	60.00
60. 01   06001   BLOOD LABORATORY	0. 000000	0	(	ol ol	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	1. 509509	0	(	ol ol	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 528113	0	(	o o	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	(	o o	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 188448	0	(	ol ol	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 132994	0	(	ol ol	0	69. 00
69. 02   06902   SLEEP LAB	0. 574103	0	(	ol ol	0	69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		ol ol	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 702890	0		ol ol	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		ol ol	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 570288	0		ol ol	0	73. 00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 00   09000   CLI NI C	0. 000000	0		ol ol	0	90. 00
91. 00 09100 EMERGENCY	0. 938723	0		ol ol	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 168580	0		ol ol	0	92.00
OTHER REIMBURSABLE COST CENTERS	,			<u>'</u>		
95. 00 09500 AMBULANCE SERVI CES	0. 000000					95. 00
200.00 Subtotal (see instructions)		0		ol ol	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				ol ol		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0		ol	0	202. 00
	•	•	•			

Health Financial Systems	COMMUNITY HOSPITAL OF BREMEN	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER H	EALTH SERVICES AND VACCINE COST Provider CCN: 151300	Peri od: Worksheet D From 05/01/2013 Part V
	Component CCN: 15Z300	To 04/30/2014 Date/Time Prepared: 9/30/2014 10:58 am

			Compone	ent CCN: 15Z300	To 04/30/2014	Date/Time Pre 9/30/2014 10:	pared: 58 am
			Ti	tle XVIII	Swing Beds - SNF		
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Services No	t			
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins				
		(see inst.)	(see inst.)	_			
	ANGLE LABOR OF BUILDING CONT. OF MITTERS	6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS	1	1				
	05000 OPERATING ROOM	0		0			50.00
	05200 DELIVERY ROOM & LABOR ROOM	0		0			52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0		0			54.00
	05700 CT SCAN	0		0			57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0			58. 00
	05900 CARDI AC CATHETERI ZATI ON	0		0			59. 00
	06000 LABORATORY	0		0			60.00
	06001 BLOOD LABORATORY	0		0			60. 01
	06500 RESPI RATORY THERAPY	0		0			65. 00
	06600 PHYSI CAL THERAPY	0		0			66. 00
	06700 OCCUPATI ONAL THERAPY	0		0			67. 00
	06800 SPEECH PATHOLOGY	0		0			68. 00
	06900 ELECTROCARDI OLOGY	0		0			69. 00
	06902 SLEEP LAB	0		0			69. 02
	07000 ELECTROENCEPHALOGRAPHY	0		0			70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0			71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0			72. 00
	07300 DRUGS CHARGED TO PATIENTS	0		0			73. 00
	OUTPATIENT SERVICE COST CENTERS		ı				00.00
	08800 RURAL HEALTH CLINIC	0		0			88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0					89. 00
	09000 CLI NI C	0					90.00
	09100 EMERGENCY	0		0			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0			92. 00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES						95. 00
200.00		0		0			200. 00
200.00	Subtotal (see instructions) Less PBP Clinic Lab. Services-Program			U <sub>I</sub>			200.00
201.00			1				201.00
202. 00	Only Charges Net Charges (line 200 +/- line 201)			o			202. 00
202.00	inct ondinges (Time 200 +/ - Time 201)	1	T	O <sub>I</sub>			1202.00

Health Financial Systems	COMMUNITY HOSPITAL C	OF BREMEN	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151300	Peri od:	Worksheet D

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST		CCN: 151300	Peri od: From 05/01/2013 To 04/30/2014	Worksheet D Part V Date/Time Pre 9/30/2014 10:	
			Ti t	le XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Servi ces (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATING ROOM	0. 422180	375, 467	I	0 0	158, 515	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 422160	375, 467		0 0	130, 313	•
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 137637	_		0	96, 796	1
57. 00	05700 CT SCAN	0. 165583				32, 825	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 330919			0	23, 326	•
59. 00	05900 CARDIAC CATHETERIZATION	0. 000000			0	23, 320	1
60.00	06000 LABORATORY	0. 303054	330, 201		0	100, 069	
60. 00	06001 BLOOD LABORATORY	0. 000000			0	100,089	60.00
65. 00	06500 RESPIRATORY THERAPY	1. 509509	5, 692		0	8, 592	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 528113	52, 042			27, 484	1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000				27, 404	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 188448				0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 132994	16, 722			2, 224	
69. 02	06902 SLEEP LAB	0. 132444				2, 224	69. 02
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 702890				34, 110	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 702870		1	0 0	34,110	•
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 570288		1	0 0	34, 942	
73.00	OUTPATIENT SERVICE COST CENTERS	0. 370200	01, 270		0 0	34, 742	73.00
88. 00	08800 RURAL HEALTH CLINIC	0. 000000		I		0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				,	89. 00
90.00	09000 CLINIC	0. 000000			0 0	,	90.00
91. 00	09100 EMERGENCY	0. 938723			0 0	215, 103	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 168580			0 0	110, 771	92.00
,2,00	OTHER REIMBURSABLE COST CENTERS	11 100000	,,,,,,		<u> </u>	1.0,77	72.00
95.00	09500 AMBULANCE SERVI CES	0. 000000	0		0		95. 00
200.00			1, 660, 409		0 0	844, 757	
201.00			, 555, 151		0 0		201. 00
	Only Charges						
202.00			1, 660, 409		0 0	844, 757	202. 00

				10 04/30/2014	Date/IIMe Prepar   9/30/2014 10:58	
		Ti t	tle XIX	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0	(	)			0. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	(	)		52	2. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	C				4. 00
57. 00   05700   CT   SCAN	0	(			57	7. 00
58.00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0	C			58	8. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	C			59	9. 00
60. 00   06000   LABORATORY	0	C			60	0. 00
60. 01   06001   BLOOD   LABORATORY	0	l			60	0. 01
65. 00 06500 RESPIRATORY THERAPY	0	l c			65	5. 00
66. 00 06600 PHYSI CAL THERAPY	0	l c			66	6. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1 0	ol		67	7. 00
68. 00 06800 SPEECH PATHOLOGY	0		ol		68	8. 00
69. 00 06900 ELECTROCARDI OLOGY	0		ol		69	9. 00
69. 02   06902   SLEEP LAB	0		ol		69	9. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	l	ol		70	0. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					1. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	l d			72	2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	l d				3. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	C			88	8. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l c			89	9. 00
90. 00 09000 CLI NI C	0		ol		90	0. 00
91. 00 09100 EMERGENCY	0		ol		91	1. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		ol		92	2. 00
OTHER REIMBURSABLE COST CENTERS	,	•				
95. 00 09500 AMBULANCE SERVI CES	0				95	5. 00
200.00 Subtotal (see instructions)	0				200	0. 00
201.00 Less PBP Clinic Lab. Services-Program	0					1. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	C			202	2. 00
	•				,	

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS			Period: From 05/01/2013 To 04/30/2014	Date/Time Pre 9/30/2014 10:	epared: 58 am
		Ti	tle V	Hospi tal	Cost	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Total Patient Days	Per Diem (col. 3 / col. 4)	
	Part II, col. 26)		(col . 1 - col 2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	556, 260	139, 901	416, 35	9 1, 122	371.09	
31. 00   I NTENSI VE CARE UNI T	0			0	0. 00	
32. 00 CORONARY CARE UNIT	0			0	0.00	
33.00 BURN INTENSIVE CARE UNIT	0			0	0. 00	
34.00 SURGICAL INTENSIVE CARE UNIT	0			0	0.00	
41. 00   SUBPROVI DER - I RF	0	0		0	0.00	
42. 00 SUBPROVI DER	0	0		0	0.00	
43. 00 NURSERY	11, 760		11, 76	0 151	77. 88	
200.00 Total (lines 30-199)	568, 020		428, 11	9 1, 273		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	1			
LABATI ENT. DOUTLAGE OFFILIAGE COOT, OFFITEDO	6. 00	7. 00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	0	0	?			30.00
31. 00   INTENSIVE CARE UNIT	0		?			31.00
32. 00 CORONARY CARE UNIT	0	0	2			32. 00
33.00 BURN INTENSIVE CARE UNIT	0	0	<u>'</u>			33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	2			34.00
41. 00 SUBPROVI DER - I RF	0		<u>'</u>			41.00
42. 00 SUBPROVI DER	0	0	1			42. 00
43. 00 NURSERY	0	0	1			43. 00
200.00 Total (lines 30-199)	0	0	7			200.00

	COMMUNITY HOSPI					u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	P	rovi der		Peri od: From 05/01/2013	Worksheet D Part II	
					To 04/30/2014	Date/Time Pre 9/30/2014 10:	
			Ti	tle V	Hospi tal	Cost	JO alli
Cost Center Description	Capi tal	Total		Ratio of Cos		Capital Costs	
	Related Cost				Program	(column 3 x	
	(from Wkst. B,			(col . 1 ÷ col		column 4)	
	Part II, col.	1	3)	2)			
	26)			<b>_</b>			
	1.00	2.	00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATING ROOM	356, 727	5,	473, 665	0. 06517	72 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	917	1	156, 563	0. 00585	57 0	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	171, 700	2,	545, 922	0.06744	11 0	0	54.00
57. 00   05700   CT   SCAN	9, 460	3,	019, 879	0. 00313	33 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	6, 341	1,	187, 453	0. 00534	10 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0	0.00000	00	0	59.00
60. 00   06000   LABORATORY	127, 245	6,	649, 824	0. 01913	35 0	0	60.00
60. 01   06001   BL00D   LABORATORY	0		0	0.00000	00	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	752		19, 350	0. 03886	53 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	116, 860	1,	322, 365	0. 08837	72 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		0	0.00000	00	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	13		4, 155	0. 00312	29 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	4, 201		599, 040	0.0070	13 0	0	69. 00
69. 02   06902   SLEEP LAB	17, 582		129, 360	0. 1359	15 0	0	69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		. 0	0. 00000	00 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	92, 352	1,	316, 710	0. 07013	88 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		. 0	0. 00000	00 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	40, 955	1,	317, 701	0. 03108	31 0	0	73. 00
OUTPATIENT SERVICE COST CENTERS				•	<u>'</u>		
88. 00 08800 RURAL HEALTH CLINIC	0		0	0.00000	00 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0.00000	00	0	89. 00
00.00.000000000000000000000000000000000		J	0	0 0000	0	1 ^	1 00 00

0

1, 770, 450

26, 097, 920

585, 483

284, 940

204, 259

1, 434, 304

0.000000

0. 160942

0. 348873

0

91.00

95. 00 0 200. 00

0 90.00

0

0 92.00

90. 00 | 099000 FEDERALLY QUALIFIED HEALTH CENTER
90. 00 | 099000 CLINIC
91. 00 | 09100 EMERGENCY
92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 | 09500 AMBULANCE SERVICES
200. 00 | Total (lines 50-199)

Health Financial Systems	COMMUNITY HOSPITAL	OF BREMEN	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT	ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provi der CCN: 151300	Period:	Worksheet D

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST	rs Provi der		Period: From 05/01/2013	Worksheet D Part III	
				Го 04/30/2014	Date/Time Pre	pared:
			+1 - 1/	11: +-1	9/30/2014 10:	58 am_
Cost Center Description	Nursing School		tle V All Other	Hospi tal	Cost Total Costs	
cost center bescription	Nursing school	Cost	Medical	Swing-Bed Adjustment	(sum of cols.	
			Education Cost		1 through 3,	
			Luucation cos	instructions)	minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
31. 00 03100 INTENSIVE CARE UNIT	o	0			0	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0			0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	o	0			0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	o	0			0	34.00
41. 00   04100   SUBPROVI DER - I RF	o	0		0	0	41. 00
42. 00   04200   SUBPROVI DER	o	0	(	0	0	42. 00
43. 00   04300   NURSERY	o	0	(		0	43.00
200.00 Total (lines 30-199)	0	0	(		0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
	/ 00	7.00	0.00	col . 8)		
INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00		
30. 00 03000 ADULTS & PEDIATRICS	1, 122	0.00	1	0		30.00
31. 00   03100   NTENSIVE CARE UNIT	1, 122	0.00				31. 00
32. 00   03200   CORONARY CARE UNIT	0	0.00				32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0.00				33. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0	0.00				34. 00
41. 00   04100   SUBPROVI DER -   RF	0	0.00		0		41. 00
42. 00   04200   SUBPROVI DER		0.00		ol o	ĺ	42. 00
43. 00   04300   NURSERY	151	0. 00		0		43. 00
200.00 Total (lines 30-199)	1, 273		1	o o		200. 00

Health Financial Systems COMMUNITY HOSPITAL OF BREMEN In L	eu of Form CMS-2552-10
Heal th Financial Systems Common in Hospital of Bremen The	
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS  Provider CCN: 151300   Period: From 05/01/20   To 04/30/20	
Title V Hospital	Cost
Cost Center Description  Non Physician Nursing School Allied Health Medical Cost  Cost  Allied Health Medical Education Co	Total Cost (sum of col 1 t through col.
1.00 2.00 3.00 4.00  ANCILLARY SERVICE COST CENTERS	5.00

ANCI LLARY SERVICE COST CENTERS		Cost Center Description	Anesthetist Cost	Nursi <sup>'</sup> ng School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
50.00   05000   OPERATING ROOM   0   0   0   0   0   0   0   0   0			1. 00	2. 00	3. 00	4. 00	5. 00	
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   52.00								
54.00   05400   RADI OLOGY-DI AGNOSTI C			0	0	0	0	0	
57.00   05700   CT SCAN   0   0   0   0   0   0   0   57.00			0	0	0	0	0	
S8.00   O5800   MAGNETIC RESONANCE I MAGING (MRI)   O   O   O   O   O   O   O   O   O			0	0	0	0	0	
S9.00   CARDIAC CATHETERIZATION   O   O   O   O   O   O   O   O   O			0	0	0	0	0	
60. 00			0	0	0	0	0	
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0 60. 01 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67.			0	0	0	0	0	
65. 00   06500   RESPIRATORY THERAPY   0   0   0   0   0   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   0   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   69. 02   06902   SLEEP LAB   0   0   0   0   0   0   69. 02   06902   SLEEP LAB   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   88. 00   08800   RURAL HEALTH CLINI C   0   0   0   0   89. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0   0   0   0   90. 00   09000   CLINI C   0   0   0   0   91. 00   09100   MERGERCY   0   0   0   0   92. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART)   0   0   0   0   95. 00   09500   AMBULANCE SERVI CES			0	0	0	0	0	
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 66. 00 67. 00 670. 00 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0	0	
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDIOLOGY   0   0   0   0   0   0   0   0   69. 00   69. 00   69. 00   0   0   0   0   0   0   0   0   0			0	0	0	0	0	
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   69. 00   69. 02   06902   SLEEP LAB   0   0   0   0   0   0   69. 02   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   001794TI ENT SERVI CE COST CENTERS  88. 00   08800   RURAL HEALTH CLINI C   0   0   0   0   0   89. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0   0   0   0   0   90. 00   09100   CLINI C   0   0   0   0   0   91. 00   09100   EMERGENCY   0   0   0   0   0   92. 00   07500   DRUGS CENTERS			0	0	0	0	0	
69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   0   0   0   0   69. 00   69. 00   69. 00   0   0   0   0   69. 00   69. 00   0   0   0   0   69. 00   69. 00   69. 00   0   0   0   0   0   0   0   0   0			0	0	0	0	0	
69. 02 06902 SLEEP LAB 0 0 0 0 0 0 0 69.02 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 001794TI ENT SERVI CE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 0 89. 00 90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0	0	
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   70. 00   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   71. 00   072. 00   072. 00   072. 00   073. 00   0			0	0	0	0	0	
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0    0UTPATI ENT SERVI CE COST CENTERS   0   0   0   0   0   0    88. 00   08800   RURAL HEALTH CLINI C   0   0   0   0   0   0    89. 00   08900   EDERALLY QUALI FIED HEALTH CENTER   0   0   0   0   0    90. 00   09000   CLI NI C   0   0   0   0   0    91. 00   09100   EMERGENCY   0   0   0   0   0    92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   0    0THER REI MBURSABLE COST CENTERS   95. 00			0	0	0	0	0	
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0    OUTPATIENT SERVICE COST CENTERS  88. 00   08800   RURAL HEALTH CLINIC   0   0   0   0   0   88. 00    89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   89. 00    90. 00   09000   CLINIC   0   0   0   0   0   0   0    91. 00   09100   EMERGENCY   0   0   0   0   0   0   0    92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0    OTHER REIMBURSABLE COST CENTERS  95. 00   09500   AMBULANCE SERVICES   95. 00	70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
73. 00			0	0	0	0	0	71. 00
SERVICE COST CENTERS			0	0	0	0	0	
88. 00   08800   RURAL HEALTH CLINIC   0 0 0 0 0 0 88. 00 89. 00 89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0 0 0 0 0 0 0 89. 00 90. 00 90. 00   091. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 92. 00   091. 00   091	73.00		0	0	0	0	0	73. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 90. 00 09000 CLI NI C 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00			,					
90. 00   09000   CLI NI C   0   0   0   0   0   90. 00   91. 00   91. 00   91. 00   92. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   0   0   0   92. 00   07   07   07   07   07   07   07			0	0	0	0	0	
91. 00   09100   EMERGENCY   0   0   0   0   0   91. 00   92. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   92. 00   00   00   00   00   00   00   00			0	0	0	0	0	89. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	90.00	09000 CLI NI C	0	0	0	0	0	90.00
OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 95. 00	91. 00	09100 EMERGENCY	0	0	0	0	0	91. 00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00		0	C	0	0	0	92. 00
		OTHER REIMBURSABLE COST CENTERS						
200 00   Total (Lines 50-199)								
250.50    151.01 (11105 50 177)   0  0  0  0  0 250.50	200.00	Total (lines 50-199)	0	0	0	0	0	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS   THROUGH COSTS   Provider CCN: 151300   Prov	552-10
Total Outpatient Cost Center Description	
Outpatient Cost (sum of Sum of	
Cost (sum of col . 2, 3 and 4)   Part I, col . (col . 5 ÷ col . to Charges (col . 6 ÷ col . 7)	
Col . 2, 3 and   8)   7)   (col . 6 ÷ col .   7)   (	
ANCILLARY SERVICE COST CENTERS     ANCILLARY SERV	
ANCILLARY SERVICE COST CENTERS	
ANCILLARY SERVICE COST CENTERS	
50. 00         05000         OPERATI NG ROOM         0         5, 473, 665         0.000000         0.000000         0.000000           52. 00         05200         DELI VERY ROOM & LABOR ROOM         0         156, 563         0.000000         0.000000         0.000000           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         2, 545, 922         0.000000         0.000000         0.000000           57. 00         05700         CT SCAN         0         3, 019, 879         0.000000         0.000000         0.000000           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0         1, 187, 453         0.000000         0.000000         0.000000           59. 00         05900         CARDI AC CATHETERI ZATI ON         0         0.000000         0.000000         0.000000	
52. 00         05200         DELI VERY ROOM & LABOR ROOM         0         156, 563         0.000000         0.000000         0.000000           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         2,545, 922         0.000000         0.000000         0.000000           57. 00         05700         CT SCAN         0         3,019,879         0.000000         0.000000         0.000000           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0         1,187,453         0.000000         0.000000         0.000000           59. 00         05900         CARDI AC CATHETERI ZATI ON         0         0         0.000000         0.000000         0.000000	50. 00
54. 00     05400     RADI OLOGY-DI AGNOSTI C     0     2,545,922     0.000000     0.000000     0.000000       57. 00     05700     CT SCAN     0     3,019,879     0.000000     0.000000     0.000000       58. 00     05800     MAGNETI C RESONANCE I MAGI NG (MRI)     0     1,187,453     0.000000     0.000000     0.000000       59. 00     05900     CARDI AC CATHETERI ZATI ON     0     0.000000     0.000000     0.000000	52. 00
57. 00     05700     CT SCAN     0     3,019,879     0.000000     0.000000     0.000000       58. 00     05800     MAGNETI C RESONANCE I MAGING (MRI)     0     1,187,453     0.000000     0.000000     0.000000       59. 00     05900     CARDI AC CATHETERI ZATI ON     0     0.000000     0.000000     0.000000	54. 00
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI) 0 1, 187, 453 0.000000 0.000000 0 0 0 0 0 0 0 0 0 0	57. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON   0   0. 000000   0. 000000   0	58. 00
	59. 00
60. 00   06000   LABORATORY   0   6, 649, 824   0. 000000   0. 000000   0	60.00
60. 01   06000   LABORATORY   0   0, 047, 024   0. 000000   0. 000000   0	60. 01
65. 00   06500   RESPI RATORY THERAPY 0 19, 350 0.000000 0.000000 0	65. 00
66. 00   06600   PHYSI CAL THERAPY	66. 00
67. 00   06700  0CCUPATI ONAL THERAPY	67. 00
68. 00   06800  SPEECH PATHOLOGY	68. 00
69. 00   06900   ELECTROCARDI OLOGY   0   599, 040   0. 000000   0. 000000	69. 00
69. 02   06902  SLEEP LAB	69. 02
70. 00   07000  ELECTROENCEPHALOGRAPHY	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 1,316,710 0.000000 0.000000 0	71. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0.000000   0.000000   0	72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   1,317,701   0.000000   0.000000	73. 00
OUTPATIENT SERVICE COST CENTERS	
88. 00   08800  RURAL HEALTH CLINIC   0   0.000000   0.000000   0	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0.000000   0.000000   0	89. 00
90. 00   09000   CLI NI C   0   0, 000000   0, 000000   0	90.00
91. 00 09100 EMERGENCY 0 1,770,450 0.000000 0.000000 0	91.00
92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)   0   585, 483   0.000000   0.000000   0	

95. 00 0 200. 00

26, 097, 920

Health Financial Systems		COMMUNITY H	OSPITAL (	OF BREMEN		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY	SERVICE OTHER	PASS	Provi der (	CCN: 151300	Peri od: From 05/01/2013 To 04/30/2014	Worksheet D Part IV Date/Time Prepared:

				10 04/30/201	9/30/2014 10	
			tle V	Hospi tal	Cost	
Cost Center Description		Outpatient	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col.	9		
	x col . 10)		x col. 12)			
ANOLULARY CERVILOE COCT CENTERS	11.00	12. 00	13.00			
ANCI LLARY SERVI CE COST CENTERS  50. 00 OPERATI NG ROOM			J			50.00
	0	(		0		
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	(		0		52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	(		0		54. 00
57. 00   05700   CT   SCAN	0	(		0		57. 00
58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI)	0	(		0		58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	(		0		59.00
60. 00   06000   LABORATORY	0	(		0		60. 00 60. 01
60. 01   06001   BLOOD LABORATORY 65. 00   06500   RESPI RATORY THERAPY	0	(		0		65. 00
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY		(		0		66.00
67. 00 06700 OCCUPATIONAL THERAPY		(		0		67.00
68. 00   06800   SPEECH PATHOLOGY		(		0		68.00
69. 00   06900   ELECTROCARDI OLOGY		(		0		69.00
69. 02   06900  ELECTROCARDI OLOGI 69. 02   06902  SLEEP LAB		(		0		69. 00
70. 00   07000  ELECTROENCEPHALOGRAPHY		(		0		70.00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS		(		0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		(		0		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	(		0		73. 00
OUTPATIENT SERVICE COST CENTERS	l U		4	U		73.00
88. 00 08800 RURAL HEALTH CLINIC	0	(		0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(		0		89. 00
90. 00   09000   CLI NI C	l ol	(		o		90.00
91. 00 09100 EMERGENCY	o	(		0		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	O	(		0		92. 00
OTHER REIMBURSABLE COST CENTERS	,					
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	O	(		0		200. 00

Health Financial Systems	COMMUNITY HOSPITAL OF BREMEN	In Lie	u of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 151300	Peri od: From 05/01/2013	Worksheet D-1	
		To 04/30/2014	Date/Time Prep 9/30/2014 10:5	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				

PART 1. ALL REPOLINGS CONTINUENTS  1.00   Impatient days (including private roun days and saing-bed days, excluding newtorn)   1.56   1.00			Title XVIII	Hospi tal	Cost	<del>50 a</del>
INSMITTER IDMS   INSMITTER IDMS   Inspite Individual perivate room days, and swing-bed days, excluding newborn)   1,516   1,00   1,516   1		Cost Center Description				
Impart Int Int No.   Impart and days (including private room days and swing-bed days, excluding needorm)   1,516   1,00   Impart and days (including private room days, excluding swing-bed and newborn days)   1,122   2,00   1		DADT I ALL DOUBLES COMPONENTS			1.00	
Impatient days (including private room days and swing-bed days, excluding newborn)						
1.122   2.00   Impatient days (including private room days, excluding swing-bed and neshborn days)   1.122   2.00   2.0	1 00		excluding newborn)		1 516	1 00
2.00   Private room days (excluding saing-bed and observation bed days)   1   1   2   2   3   4   4   5   5   6   4   4   4   5   6   6   6   6   6   6   6   6   6						
5.00 Total swing-hed SKF type inpartient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the co				vate room days,		
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if call-andar year, enter 0 on this line)  7.00 reporting period (if call-andar year, enter 0 on this line)  8.01 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if call-andar year, enter 0 on this line)  8.02 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if call-andar year, enter 0 on this line)  9.03 Total inpatient days including private room days) after December 31 of the cost reporting period (if call-andar year, enter 0 on this line)  10.04 SNF year inpatient days (and the private room days) after December 31 of the cost reporting period (if call-andar year, enter 0 on this line)  11.00 SNF year inpatient days applicable to this SNF year inpatient days applicable to the reporting period (if call-andar year, enter 0 on this line)  12.00 SNF year inpatient days applicable to this SNF year year year year year year year year		do not complete this line.				
reporting period (1° calendar year, enter 0 on this line) 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.0						
10   Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   7.00   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   7.00	5. 00		days) through December	r 31 of the cost	250	5. 00
reporting period (if Calendar year, either 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period to swing-bed NF type inpatient days (including private room days) after December 31 of the cost 17 8.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after 10.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days applicable to SNF type services applicable to servi	6 00		days) after December (	31 of the cost	127	6 00
10.00   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost   7.00   7.00   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost   7.80   7.00   Total inpatient days including private room days applicable to the Program (excluding swing-bed and   382   7.00   7.00   Total inpatient days including private room days applicable to the Program (excluding swing-bed and   382   7.00   7.00   \$sing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   250   10.00   \$\text{through December 31 of the cost reporting period (see Instructions)   1.00   \$\text{sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after   127   11.00   \$\text{compatible SNF type services applicable to title XVIII only (including private room days)   12.00   13.00   \$\text{sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   12.00   13.00   \$\text{Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   13.00   14.00   15.00	0.00		days) arter becember :	of the cost	127	0.00
10   10   10   10   10   10   10   10	7.00		days) through December	31 of the cost	0	7. 00
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10.00   Swings-bed SRF type inpatient days applicable to title XVIII only (including private room days)   250   10.00	8.00		days) after December 3°	1 of the cost	17	8. 00
newborn days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after private room days)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after private room days)  13.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)  14.00 Swing-bed NF type inpatient days applicable to title XV or XIX only (including private room days)  15.00 Swing-bed NF type inpatient days applicable to title XV or XIX only (including private room days)  16.00 Swing-bed NF type inpatient days applicable to title XV or XIX only (including private room days)  17.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  18.00 Nedically necessary private room days applicable to the Program (excluding swing-bed days)  18.00 Nursery days (title V or XIX only)  18.00 Nursery days (title V or XIX only)  18.00 Nursery days (title V or XIX only)  18.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line or exporting period with the private room of the private	0.00		the Drogram (eveluding	swing had and	202	0.00
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December 31 of the cost reporting period (if calendar year, enter 0 on this line)   12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   14. 00 Mcdically necessary private room days applicable to titles V or XIX only (including private room days)   15. 00 Total nursery days (title V or XIX only)   16. 00 Total nursery days (title V or XIX only)   17. 00 Total nursery days (title V or XIX only)   18. 00 Total nursery days (title V or XIX only)   19. 00 Total nursery days (title V		through December 31 of the cost reporting period (see instruction	ons)			
12.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   0   12.00	11. 00			oom days) after	127	11. 00
through December 31 of the cost reporting period  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Medically necessary private room days applicable (if calendar year, enter 0 on this line)  15. 00  16. 00 Total nursery days (title V or XIX only)  17. 00  18. 00 Total nursery days (title V or XIX only)  18. 00 Total nursery days (title V or XIX only)  19. 01 Total nursery days (title V or XIX only)  19. 01 Total nursery days (title V or XIX only)  19. 01 Total nursery days (title V or XIX only)  19. 01 Total nursery days (title V or XIX only)  19. 01 Total nursery days (title V or XIX only)  19. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting re	12 00			s recom days)	0	12 00
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after December' 31 of the cost reporting period (if calendar year, enter 0 on this line)   14,00   14,00   15.00   16 to 10   16 t	13. 00		only (including private	e room davs)	0	13. 00
15.00   Total nursery days (title V or XIX only)   0   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   17.00   17.00   17.00   17.00   18.00						
16. 00   Nursery days (title V or XIX only)   16. 00   17. 00   17. 00   18. 00			(excluding swing-bed of	days)	- 1	
SWING BED ADJUSTMENT  17. 00  18. 00 Ided care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line or rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line or reporting period or reporting period or reporting period (line or reporting period or reporting period or reporting period (line or reporting period or reporting period or reporting period (line or reporting period or reporting period or reporting period (line or reporting period or reporting period or reporting period (line or reporting period or reporting period (line or reporting period or reporting period (line or reporting period or reporting period (line or reporting period (line or reporting period or reporting period or reporting perio						
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reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19. 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost cost reporting period  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost cost reporting period  21. 00 Total general inpatient routine service cost (see instructions)  22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19)  26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30. 00 Average perivate room perid em charge (line 30 + line 4)  31. 00 Average periden private room cost differential (line 3 x line 35)  31. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35)  31. 00 Average periden private room cost differential (line 3 x line 35)  32. 00 Average periden private room cost differential (line 3 x line 35)  33. 00 Average periden private room cost differential (line 3 x line 35)  34. 00 Average periden private room cost	17. 00		through December 31 of	f the cost		17. 00
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22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average perivate room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 29 + line 3)  34.00 Average per diem private room cost differential (line 30 + line 4)  35.00 Average per diem private room cost differential (line 32 x line 31)  36.00 Private room cost differential direm 34 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 30)  38.00 Average per diem private room cost differential (line 3 x line 31)  38.00 Average per diem private room cost differential (line 3 x line 35)  38.00 Average per diem private room cost differential (line 3 x line 35)  39.00 Proyate general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		' ' '				
5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 v. line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 v. line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 v. line 20)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 v. line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)						
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ± line 28)  32.00 Average perivate room per diem charge (line 29 ± line 3)  33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 3 x line 35)  36.00 Private room cost differential djustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  37.00 Average per diem private room cost differential (line 3 x line 35)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22. 00		31 of the cost reporti	ing period (line	U	22.00
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 626,065 26.00  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 1,863,242 27.00  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00  29.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 31.00 32.00 Average private room per diem charge (line 29 + line 3) 0.00 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 0.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average linpatient routine service cost net of swing-bed cost and private room cost differential (line 1,863,242 2,7 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,660.65 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 40.00 40.00	23. 00	1	1 of the cost reporting	period (line 6	0	23. 00
7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20) 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 34 x line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242) Ceneral inpatient routine service cost provide room cost differential (line 1, 863, 242) Ceneral inpatient routine service cost provide room cost differential (line 1, 863, 242) Ceneral inpatient routine service cost provide room cost differential (line 1, 863, 242) Ceneral inpatient routine service cost provide room cost differential (line 1, 863, 242) Cenera		] 31	,			
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  30.00 Average private room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Average linpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  30.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  31.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  32.00 Aucontal inpatient routine service cost per diem (see instructions)  33.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  34.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24. 00		31 of the cost reportin	ng period (line	0	24. 00
x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room cost differential (line 34 x line 31)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)	25 00		of the cost reporting	poriod (line 9	0	25 00
26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30. 00 Average private room per diem charge (line 29 + line 3)  30. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  30. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25.00		of the cost reporting	perrou (Trile 6	U	23.00
28.00 Private room charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Algusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 28.00 29.00 20.00 20.00 20.00 31.00 20.00 32.00	26. 00				626, 065	26.00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 29.00  29.00 20.00  30.00 20.00  30.00 20.00  30.00 20.00  31.00  32.00 32.00  32	27. 00		ine 21 minus line 26)		1, 863, 242	27. 00
29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average pri vate room per diem charge (line 29 + line 3) 33.00 Average semi-pri vate room per diem charge (line 30 + line 4) 34.00 Average per diem pri vate room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem pri vate room cost differential (line 34 x line 31) 36.00 Pri vate room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 1, 863, 242) 37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary pri vate room cost applicable to the Program (line 14 x line 35)  0 29.00 30.00 30.00 31.00 32.00 32.00 32.00 34.00 35.00 36.00 37.00 Frogram general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				<u>,                                      </u>		
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.000 32.00 32.00 32.00 33.00 34.00 35.00 36.00 37.00 Frogram general inpatient routine service cost per diem (see instructions) 36.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		,	and observation bed cha	arges)		
31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi -private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.000 000 000 000 000 000 000 000 000						
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,				
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 .00 35.00 36.00 37.00 36.00 37.00 3						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 37.00 37.00 37.00 38.00 37.00	34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruct	tions)	0. 00	34.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 Adjusted General inpatient routine service cost (line 9 x line 38)  40.00 O Medically necessary private room cost applicable to the Program (line 14 x line 35)	35. 00		31)		0.00	35.00
27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,660.65 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		, , , , , , , , , , , , , , , , , , , ,				
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,660.65 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00		d private room cost dit	fferential (line	1, 863, 242	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,660.65 38.00  Program general inpatient routine service cost (line 9 x line 38)  634,368 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,660.65 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,660.65 38.00 49.00			TMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 634,368 39.00 40.00	38. 00				1, 660. 65	38. 00
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   634,368   41.00		1	•			
	41. 00	lotal Program general inpatient routine service cost (line 39 +	line 40)		634, 368	41. 00

Heal th	Financial Systems	COMMUNITY HOSPITAL	OF BREMEN		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CCN: 151300	Peri od: From 05/01/2013	Worksheet D-1	
					To 04/30/2014		
			Title	e XVIII	Hospi tal	9/30/2014 10: Cost	58 am_
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost Inpa	itient DaysL	col. 1 col. 1	÷	(col. 3 x col. 4)	
	I	1.00	2.00	3. 00	4.00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. C	0 0	0	42. 00
43.00	INTENSIVE CARE UNIT	0	0	0.0	0 0	0	43. 00
44. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0. C 0. C		0	44.00
45. 00 46. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0. 0		0	45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk			_		488, 183	•
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see	instruction	ns)		1, 122, 551	49. 00
50.00	Pass through costs applicable to Program inp	atient routine serv	ices (from	Wkst. D, sum	of Parts I and	0	50. 00
51. 00	<pre>                                    </pre>	ationt ancillary so	rvices (fro	om Wket D e	um of Darte II	0	51. 00
31.00	and IV)	attent and training se	ivices (iic	JIII WKSt. D, S	um or rarts ii		31.00
52. 00 53. 00	Total Program excludable cost (sum of lines	,	مريطة ممماية	ician anacth	atiot and	0	52.00
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		eu, non-pnys	sician anestri	etist, and		53. 00
E 4 00	TARGET AMOUNT AND LIMIT COMPUTATION						F 4 00
54. 00 55. 00	Program discharges Target amount per discharge					0.00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)					0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and target	amount (li	ne 56 minus	line 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period endi	ng 1996, up	odated and co	mpounded by the	0.00	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report undate	ed by the ma	arket hasket		0.00	60. 00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60 ente	er the Lesse	er of 50% of		0.00	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		ines 54 x 6	50), or 1% of	the target		
62.00	Relief payment (see instructions)	riisti ucti olis)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instructio	ons)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through December	31 of the	cost reporti	ng period (See	415, 163	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December 3	11 of the co	net renorting	narind (See	210, 903	65. 00
03.00	instructions) (title XVIII only)					210, 703	03.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 64 p	olus line 65	5)(title XVII	I only). For	626, 066	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through Dec	ember 31 of	the cost re	porting period	0	67. 00
68. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre>	e costs after Decem	her 31 of t	the cost repo	rting period	0	68. 00
	(line 13 x line 20)			•	rting perrou	Ĭ	00.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil						70. 00
71.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		70 ÷ line 2	2)			71.00
72. 00 73. 00	Medically necessary private room cost applic	,	ne 14 x lir	ne 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	•					74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service cos	sts (from wo	orksneet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from provi		*.		-	79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ıımıtation	(line 78 min	us line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in						83. 00 84. 00
85. 00	Utilization review - physician compensation						85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		jh 85)				86. 00
87. 00	Total observation bed days (see instructions					412	87. 00
88.00	, , , , , , , , , , , , , , , , , , , ,	•	ne 2)			1, 660. 64 684, 184	
07.00	Observation bed cost (line 87 x line 88) (se	c matructions)				1 004, 104	0 7. 00

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 05/01/2013 To 04/30/2014		
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	556, 260	1, 863, 242	0. 29854	4 684, 184	204, 259	90.00
91.00 Nursing School cost	0	1, 863, 242	0.00000	684, 184	0	91.00
92.00 Allied health cost	0	1, 863, 242	0.00000	684, 184	0	92.00
93 00 All other Medical Education	0	1 863 242	0 00000	684 184	0	93 00

Health Financial Systems	COMMUNITY HOSPITAL (	OF BREMEN	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 151300	Peri od: From 05/01/2013	Worksheet D-1	
			To 04/30/2014	Date/Time Pre 9/30/2014 10:	
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

		Title XIX	Hospi tal	Cost	<del>50 a</del>
	Cost Center Description	<u> </u>			
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		1, 516	1. 00
2.00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be			1, 122	2. 00
3.00	Private room days (excluding swing-bed and observation bed days		vate room days.	0	3. 00
	do not complete this line.	, you o y p		_	
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		710	4.00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	250	5.00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December 3	1 of the cost	127	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	Have) through December	31 of the cost	0	7. 00
7.00	reporting period	days) through becember	or the cost	O	7.00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 31	of the cost	17	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 ,			
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	134	9. 00
	newborn days)			_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		om days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII only		om dave) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ent		oni days) arter	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		room days)	0	12.00
	through December 31 of the cost reporting period	3 ( a.a		_	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
	after December 31 of the cost reporting period (if calendar yea				
14. 00	Medically necessary private room days applicable to the Program	(excluding swing-bed d	ays)	0	14. 00
15.00	Total nursery days (title V or XIX only)			151	
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			45	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of	the cost		17. 00
17.00	reporting period	thi odgir becember 31 or	the cost		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of t	he cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19.00
00.00	reporting period	C. D. I. 04 C.II.		0.00	00.00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	arter December 31 of th	e cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)			2, 489, 307	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	na period (line	2, 407, 307	22. 00
22.00	5 x line 17)	or or the dest report.		· ·	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	period (line 6	0	23.00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	g period (line	0	24. 00
25. 00	7 x line 19)	of the cost reporting	noriad (line 0	0	25. 00
23.00	Swing-bed cost applicable to NF type services after December 31 $\times$ line 20)	of the cost reporting	perrou (Trile o	U	23.00
26. 00	Total swing-bed cost (see instructions)			626, 065	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I	ne 21 minus line 26)		1, 863, 242	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	rges)		28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	ine 28)		0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruct	ions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line		10113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	/		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost dif	ferential (line	1, 863, 242	
	27 minus line 36)	· · · · · · · · · · · · · · · · · · ·			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS		,		
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 660. 65	
39.00	Program general inpatient routine service cost (line 9 x line 3	*		222, 527	39. 00
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	,		0 222, 527	40. 00 41. 00
71.00	Trotal Trogram general impatrent routine service cost (IIIIe 37 +	11110 40)	I	222, 521	+1.00

		COMMUNITY HOSPI			0011		eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi d	der		Period: From 05/01/2013	Worksheet D-1	
						To 04/30/2014	Date/Time Prep 9/30/2014 10:	
				Ti t	e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Innationt D	21/6	Average Per	Program Days	Program Cost (col. 3 x col.	
		impatrent costi	пратент в	ays	col. 2)	-	4)	
10.00	NUDGEDY (12 II V a VIV II )	1.00	2. 00	454	3. 00	4. 00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	37, 080		151	245. 5	6 45	11, 050	42.00
43.00	INTENSIVE CARE UNIT	0		0	0.0	0 0	0	43.00
44.00	CORONARY CARE UNIT	0		0	0.0			
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0		0	0. 0 0. 0		0	45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)							47. 00
	Cost Center Description						1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)				143, 623	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(	see instruc	tio	ns)		377, 200	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	atient routine	services (f	rom	Wkst D sum	of Parts I and	0	50.00
30. 00	[111)		•					30.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services	(fr	om Wkst. D, s	um of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)					o	52. 00
53. 00	Total Program inpatient operating cost exclu	ding capital re	lated, non-	phy:	sician anesth	etist, and	0	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54. 00	Program di scharges						0	54.00
	Target amount per discharge						0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	rget amount	(1)	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	· ·	Ü	,		ŕ	Ö	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 1996	, u	pdated and co	mpounded by the	0.00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by th	ne ma	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line						0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54	X	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	rnstructrons,					0	62.00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)				0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of	the	cost reporti	ng period (See	0	64. 00
<b>.</b>	instructions)(title XVIII only)		04 6 11					, F 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	its after Decemb	er 31 or th	ie c	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus lin	e 6	5)(title XVII	l only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 3	1 o	f the cost re	porting period	o	67. 00
	(line 12 x line 19)	· ·						
68. 00	Title V or XIX swing-bed NF inpatient routir (line 13 x line 20)	e costs after D	ecember 31	of	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + I	i ne	68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil							70. 00
71.00	Adjusted general inpatient routine service of	-			,			71.00
72. 00	Program routine service cost (line 9 x line							72. 00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv				ne 35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•		,	orksheet B, P	art II, column		75. 00
7/ 00	26, line 45)	no 2)						74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *						76. 00 77. 00
	Inpatient routine service cost (line 74 minu							78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp					us line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi		oot min tat	. 511	(			81. 00
82.00	Inpatient routine service cost limitation (I		•					82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		5)					83. 00 84. 00
85.00	Utilization review - physician compensation	(see instruction						85. 00
86. 00	Total Program inpatient operating costs (sum		rough 85)					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions						412	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)				1, 660. 64	88. 00
89 00	Observation bed cost (line 87 x line 88) (se	e instructions)					684, 184	89.00

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 05/01/2013 To 04/30/2014	Date/Time Prep 9/30/2014 10:	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	556, 260	1, 863, 242	0. 29854	4 684, 184	204, 259	90. 00
91.00 Nursing School cost	0	1, 863, 242	0.00000	0 684, 184	0	91.00
92.00 Allied health cost	0	1, 863, 242	0.00000	0 684, 184	0	92. 00
93.00 All other Medical Education	0	1, 863, 242	0. 00000	0 684, 184	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF BREMEN	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 151300	Peri od: From 05/01/2013	Worksheet D-1	
		To 04/30/2014	Date/Time Prep 9/30/2014 10:	
	Title V	Hospi tal	Cost	
Cost Center Description				

Dear 1, ALL DROUDER COMPONENTS  1.00  Impatient days (including private room days and seting-bed days, excluding newtorn) Impatient days (including private room days, excluding saing-bed and newtorn days) 1.10  Impatient days (including private room days, excluding saing-bed and newtorn days) 1.10  1.10			Ti tle V	Hospi tal	9/30/2014 10: Cost	30 alli
PART   F. ALL PROVIDER CORPONENTS		Cost Center Description				
IMPAILENT DAYS   1.00   Inpatient days (including private room days, excluding newborn)   1.516   1.00   Inpatient days (including private room days, excluding seling-bed and newborn days)   1.122   2.00		DADT I ALL DROW DED COMPONENTS			1. 00	
1.00 [Inpattient days (Including private room days, and swing-bed days, excluding newborn) 1.22 2.00 [Inpattient days (Including private room days, and on enwborn days) 1.22 2.00 [Inpattient days (excluding private room days, days and newborn days) 1.22 2.00 [Inpattient days (excluding private room days) 1.22 2.00 ] 2.00 [International days (excluding swing-bed and observation bed days) 1.22 2.00 ] 2.01 [International days (excluding swing-bed and observation bed days) 1.22 2.00 ] 2.02 [International days (excluding swing-bed and observation bed days) 1.22 2.00 ] 2.03 [International days (excluding private room days) 1.22 2.00 ] 2.04 [International days (excluding private room days) after December 31 of the cost reporting period (if Catendary year, enter 0 on this 1 ine) 1.22 2.00 ] 2.03 [International days and private room days (excluding private room days) after December 31 of the cost reporting period (if Catendary year, enter 0 on this 1 ine) 1.22 2.00 ] 2.04 [International days and private room days and days after December 31 of the cost reporting period (if Catendary year, enter 0 on this 1 ine) 1.22 2.00 ] 2.05 [International days and days (including private room days) after December 31 of the cost reporting period (if Catendary year, enter 0 on this 1 ine) 1.22 2.00 ] 2.05 [International days and days (including private room days) after December 31 of the cost reporting period (if Catendary year, enter 0 on this 1 ine) 1.22 2.00 [International days applicable to 11 it is XVIII only (including private room days) 3.22 2.00 [International days applicable to 11 it is XVIII only (including private room days) 3.23 2.00 [International days applicable to 11 it is XVIII only (including private room days) 3.24 2.00 [International days applicable to 11 it is XVIII only (including private room days) 3.24 2.00 [International days applicable to 11 it is XVIII only (including private room days) 3.24 2.00 [International days applicable to 11 it is XVIII only (including private room days) 3.25 2.00 [International days a						
Impatient days (including private room days, excluding swing-bed and newborn days)   1,122   2,00	1.00		excluding newborn)		1, 516	1.00
do not complete this line.  4. 00 Semi-private room days (sexcluding swing-bed and observation bed days) through December 31 of the cost 70 0 5.00 10 10 10 10 10 10 10 10 10 10 10 10 1		Inpatient days (including private room days, excluding swing-bed	d and newborn days)		-	
5.00. Total swing-bed SF type inpatient days (including private room days) through December 31 of the cost	3.00		). If you have only pri	vate room days,	0	3. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  7.00 reporting period (if callendar year, enter 0 on this line)  8.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  8.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  9.01 Total inpatient days including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  10.02 SNF type inpatient days (and total garden to the Program (excluding swing-bed and nowborn days) including private room days applicable to the Program (excluding swing-bed and nowborn days)  11.03 SNF type inpatient days applicable to the Program (excluding private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  12.00 SNF type inpatient days applicable to title SVI or XIX only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  13.00 SNF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.10 SNF type inpatient days applicable to the Program (excluding swing-bed days)  16.10 Number of the cost reporting period (if callendar year) and the private room days)  17.00 Medically necessary private room days applicable to services after December 31 of the cost reporting period (if callendar year) and the private room days)  18.00 Medical rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (if callendar year) and the private room days applicable to SNF type services after December 31 of the cost reporting period (if callendar yea	4 00		d==\		710	4 00
report in g period  1. Total synip-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1. Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1. Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1. Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  1. Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  1. Total inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  1. Total nursery days (title V or XIX only (including private room days) after December 31 of the cost reporting period (see instructions)  1. Total nursery days (title V or XIX only)				31 of the cost		
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   7.00	0.00		days) thi dagn become	01 01 1110 0031	Ŭ	0.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  11.00 Swing-bed NF type inpatient days applicable to titles XVIII only (including private room days) after December 31 of the cost reporting period in titles V or XIX only (including private room days)  12.00 Introdup December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Total nursery days (title V or XIX only)  14.00 Introduction of the cost reporting period (if calendar year, enter 0 on this line)  15.01 Total nursery days (title V or XIX only)  16.02 Nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  18.00 Nursery days (title V or XIX only)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days)  18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days)  18.00 Medicare rate for swing-bed NF services sphilable to services after December 31 of the cost reporting period (line 6 on the private room days applicable to SNF type services after December 31 of the cost reporting period (line 6 on the private room days applicable to SNF type services through December 31 of the cost reporting period (	6.00	Total swing-bed SNF type inpatient days (including private room	days) after December 3	31 of the cost	377	6. 00
reporting period  8. 00 Totals wing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed Swing-	7.00			04 6 11		7.00
10   10   10   10   10   10   10   10	7.00		days) through December	31 of the cost	0	7.00
reporting period (if calendar year, enter 0 on this line)  10. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after Swing-bed SNF type Inpatient days applicable to title SV or XIX only (including private room days)  13. 00 Swing-bed SNF type Inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Swing-bed SNF type Inpatient days applicable to titles V or XIX only (including private room days)  15. 00 Swing-bed SNF type Inpatient days applicable to titles V or XIX only (including private room days)  16. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  16. 00 Nursery days (title V or XIX only)  17. 00 SWING-BED ADUSTRIEND  18. 00 Medically necessary private room days applicable to services through December 31 of the cost reporting period  18. 00 Medicall care rate for swing-bed SNF services applicable to services after December 31 of the cost  18. 00 Medical care rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed SNF services through December 31 of the cost reporting period	8.00		davs) after December 31	of the cost	17	8. 00
newborn days)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to titlet XVIII only (including private room days) after becember 31 of the cost reporting period (see instructions)  12. 00 Swing-bed SNF type inpatient days applicable to titlet XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Nursery days (title V or XIX only)  17. 00 Nursery days (title V or XIX only)  18. 00 Nursery days (title V or XIX only)  19. 00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19. 00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19. 00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19. 00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line or period period negoting						
10.00   Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)   10.00   10.00   11.00   11.00   12.00   12.00   12.00   12.00   13.	9.00		the Program (excluding	swing-bed and	0	9. 00
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.01 Obsember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.02 Obsember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.03 Obsember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.04 Obsember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.05 Obsember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.06 Obsember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.07 Obsember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.08 Obsember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.09 Obsember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Obsember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Obsember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Obsember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Obsember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Obsember 31 of the cost reporting period (if calendar year)  1.00 Obsember 31 of the cost reporting period (if calendar year)  1.00 Obsember 31 of the cost reporting period (if calendar year)  1.00 Obsember 31 of the cost reporting period (if calendar year)  1.00 Obsember 31 of the cost reporting period (if calendar year)  1.00 Obsember 31 of the cost reporting period (if calendar year)  1.00 Obsember 31 of the cost reporting period (if calendar year)  1.00 Obsember 31 of the cost reporting period (if calendar year)  1.00 Obsembe	10 00		(including private re	om dava)	0	10 00
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through December 31 of the cost reporting period  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15. 15. 00  16. 00  17. 00 Total nursery days (title V or XIX only)  18. 15. 00  18. 00 Notes and the very days (title V or XIX only)  19. 10. 00  19. 00 Notes and the very days (title V or XIX only)  19. 00 Notes and the very days (title Volume the very days (title V or XIX only)  19. 00 Notes and the very days (title Volume the v						
3. 00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   14. 00   14. 00   14. 00   15. 00   15. 00   16. 00   17. 00   16. 00   17. 00   16. 00   17. 00   17. 00   17. 00   17. 00   18. 00   1	12. 00		only (including private	e room days)	0	12. 00
after December' 31 of the cost reporting period (if calendar year, enter 0 on this line)   14, 00   14, 00   15.00   10   10   10   10   10   10   10	13 00		only (including private	room days)	0	13 00
15. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 17. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 19	10.00				Ŭ	10.00
16. 00   Nursery days (title V or XIX only)   16. 00   17. 00   17. 00   18. 00   Modi Care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period or reporting reporting reporting reporting reporting reporting reporting period (line 6 or 22.00	14.00		(excluding swing-bed of	lays)	0	
SWING BED ADJUSTMENT  17. 00  18. 00  18. 00  18. 00  19. 00  10. 00  10. 01  10. 01  10. 01  10. 02  10. 00  10. 01  10. 01  10. 02  10. 00  10. 01  10. 01  10. 02  10. 00  10. 01  10. 01  10. 02  10. 00  10. 01  10. 02  10. 00  10. 01  10. 02  10. 00  10. 01  10. 02  10. 00  10. 01  10. 02  10. 02  10. 00  10. 01  10. 02						
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reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19. 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  20. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  20. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  21. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  22. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  23. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost reto f swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service cost reto f swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Swing-bed cost (see instructions)  30. 00 Swing-bed cost (see instructions)  30. 00 Swing-bed cost applicable to NF type service cost (rine 27 + line 28)  30. 00 Average private room contarges (excluding swing-bed charges)  30. 00 Average private room contarges (excluding swing-bed charges)  30. 00 Average private room contarges december 31	17 00		through December 31 of	the cost		17 00
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19.00   Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   20	18. 00		after December 31 of t	he cost		18. 00
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x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 626,065 26.00 Total swing-bed cost (see instructions) 7 (Seneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 1, 863,242 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 * line 28) 0.0000 31.00 General inpatient routine service cost/charge ratio (line 27 * line 28) 0.0000 31.00 32.00 Average private room per diem charge (line 30 * line 4) 0.00 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Avera	23. 00		of the cost reporting	period (line 6	0	23. 00
7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  27.00 private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  27.00 program general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 do			,	, ,		
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27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ± line 28)  Average private room per diem charge (line 29 ± line 3)  Average semi-private room per diem charge (line 30 ± line 4)  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 3 x line 35)  Private room cost differential adjustment (line 3 x line 35)  Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  O 39. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O 40. 00	23.00		or the cost reporting	perrou (rine o		25.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  0 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00  29.00  29.00  29.00  20.00  30.00	26.00	Total swing-bed cost (see instructions)			626, 065	26. 00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  32.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  28.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  28.00 Average per diem private roum cost applicable to the Program (line 14 x line 35)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	27. 00		ne 21 minus line 26)		1, 863, 242	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00 20.00 30.00 0.00 31.00 0.00 32.0	20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	and observation had obs	race)	0	20 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Oncomplete (line 27 ÷ line 28) 40.00 Semi-private room charge diem charge (line 27 ÷ line 28) 40.00 Semi-private room charge diem charge (line 27 ÷ line 28) 40.00 Semi-private room charge diem charge (line 27 ÷ line 28) 40.00 Semi-private room charge diem charge (line 30 + line 33) 40.00 Semi-private room charge (line 30 + line 31) 40.00 Semi-private room charge (line 30 + line 31) 40.00 Semi-private room charge (line 30 + line 31) 40.00 Semi-private room charge (line 30 + line 31) 40.00 Semi-private room charge (line 30 + line 31) 40.00 Semi-private room charge (line 30 + line 31) 40.00 Semi-private room charge (line 30 + line 31) 40.00 Semi-private room charge (line 30 + line 31) 40.00 Semi-private room charge (line 30 + line 31) 40.00 Semi-private room charge (line 30 + line 31) 40.00 Semi-private room charge (line 30 + line 31) 40.00 Semi-private room charge (line 30 + line 31) 40.00 Semi-private room charge (line 30 + line 31) 40.00 Semi-private room charge (line 30 + line 31) 40.00 Semi-private room charge (line 30 + li			and observation bed cha	ii ges)	_	
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  0 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			i ne 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  34.00 35.00 35.00 36.00 37.00 36.00 37.00						
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 863, 242)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 660.65  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			s lino 22)(soo instruct	i one)		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 37.0				.1 0115)		
27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,660.65 38.00  Program general inpatient routine service cost (line 9 x line 38)  0 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		9   ' '	- /			
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,660.65 38.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00	·	d private room cost dif	ferential (line	1, 863, 242	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,660.65 38.00  Program general inpatient routine service cost (line 9 x line 38)  0 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,660.65 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  38.00  40.00			TMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 39.00 40.00	38. 00				1, 660, 65	38, 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	*			
41.00  Total Program general inpatient routine service cost (line 39 + line 40)   0   41.00		, , , , , , , , , , , , , , , , , , , ,	•			
	41. 00	lotal Program general inpatient routine service cost (line 39 +	line 40)		0	41.00

	<u> </u>	COMMUNITY HOSPI			CON. 454000		eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		P	rovi der	CCN: 151300	Peri od: From 05/01/2013		
						To 04/30/2014	Date/Time Pre 9/30/2014 10:	
					tle V	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	1	tal ont Davs	Average Per		Program Cost (col. 3 x col.	
		impatrent cost	Праст	iii baya	col . 2)		4)	
12.00	MUDGEDY (+; +1 - V o VIV1.)	1.00		00	3.00	4.00	5. 00	12.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	37, 080	'	151	245.	56 0	)  0	42. 00
43.00	INTENSIVE CARE UNIT	0		C			0	43. 00
44. 00	CORONARY CARE UNIT	0	1	C				
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0 0	1	C				
	OTHER SPECIAL CARE (SPECIFY)							47. 00
	Cost Center Description						1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line	200)			1.00	48. 00
49. 00	Total Program inpatient costs (sum of lines			,	ons)		0	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	ationt routing	sorvi c	e (from	Wkst D su	of Parts L and	0	50.00
30.00	[111]	atrent routine	Sel VI C	55 (11011	i wkst. D, Sui	ii Oi Faits I ailu		30.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	ry serv	ces (fr	om Wkst. D,	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)					0	52.00
53. 00	Total Program inpatient operating cost exclu	ıding capital re	el ated,	non-phy	sician anestl	netist, and	0	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)						-
54. 00	Program discharges						0	54.00
	Target amount per discharge						0.00	1
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and to	argot a	nount (I	ino 56 minus	lino 52)	0 0	
58. 00	Bonus payment (see instructions)	ing cost and ta	arget a	ilouit (i	The 50 millios	111le 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng	1996, L	updated and co	ompounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost renort ur	ndated	ov the m	narket hasket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					the amount by	0	1
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		ts (lin	es 54 x	60), or 1% or	f the target		
62. 00	Relief payment (see instructions)	THSTI uctions)					0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions	)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 3	l of the	e cost reporti	na period (See	1 0	64. 00
	instructions)(title XVIII only)	· ·			·			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	per 31	of the d	cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 pl u	s line 6	55)(title XVII	I only). For	0	66. 00
<b>47.00</b>	CAH (see instructions)		- D	01 -				(7.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	ie costs through	ı beceiii	ber 31 C	or the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after [	Decembe	31 of	the cost repo	orting period	0	68. 00
69 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	routine costs (	(line 6	7 + line	48)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N							07.00
70.00	Skilled nursing facility/other nursing facil	•			,			70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line	1 ,	The 70	÷ IIIne	2)			71. 00
73. 00	Medically necessary private room cost applic	able to Program						73. 00
74. 00 75. 00	Total Program general inpatient routine serv	•				Part II column		74. 00 75. 00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine Service	e Costs	(ITOIII V	wrksneet B, i	Part II, Corumn		/5.00
76. 00	Per diem capital-related costs (line 75 ÷ li	. *						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu							77. 00
79. 00	Aggregate charges to beneficiaries for excess		orovi de	record	ls)			79. 00
	Total Program routine service costs for comp		cost li	ni tati or	ı (line 78 min	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)					81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (		* .					83. 00
84. 00	Program inpatient ancillary services (see in		200)					84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum			35)				85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST						
87.00	Total observation bed days (see instructions	•	Lino	2)			1 660 64	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se			<u>-</u> )			1, 660. 64 684, 184	1
_ , . 50	(30)		•				1 331, 104	

Health Financial Systems (	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 05/01/2013 To 04/30/2014	Date/Time Pre 9/30/2014 10:	
		Ti	tle V	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	556, 260	1, 863, 242	0. 29854	4 684, 184	204, 259	90. 00
91.00 Nursing School cost	0	1, 863, 242	0.00000	0 684, 184	0	91.00
92.00 Allied health cost	0	1, 863, 242	0.00000	0 684, 184	0	92. 00
93.00 All other Medical Education	0	1, 863, 242	0. 00000	0 684, 184	0	93. 00

Health Financial Systems	COMMUNI TY	HOSPITAL OF BREMEN		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST AP	PORTI ONMENT	Provi der		Peri od:	Worksheet D-3	
				From 05/01/2013 To 04/30/2014	Date/Time Pre	nared:
				10 04/30/2014	9/30/2014 10:	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description			Ratio of Cost	P	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
INPATIENT ROUTINE SERVICE COS	T CENTEDS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS	OF CENTERS			555, 683		30.00
31. 00   03100   NTENSI VE CARE UNIT				333, 663		31.00
32. 00   03200   CORONARY CARE UNIT						32.00
33. 00 03300 BURN INTENSIVE CARE UNI	Т			0		33.00
34. 00 03400 SURGICAL INTENSIVE CARE				0		34.00
41. 00   04100   SUBPROVI DER -   RF	Sivi i			0		41.00
42. 00 04200 SUBPROVI DER				0		42.00
43. 00   04300   NURSERY						43.00
ANCILLARY SERVICE COST CENTER	₹S		'		!	
50. 00 05000 OPERATI NG ROOM			0. 42218	0 234, 465	98, 986	50.00
52.00 05200 DELIVERY ROOM & LABOR F	MOO:		0. 13765	7 4, 766	656	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 54433	8 26, 068	14, 190	54.00
57. 00  05700 CT SCAN			0. 16558		5, 562	57. 00
58.00   05800   MAGNETIC RESONANCE I MAG			0. 33091		3, 469	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	Į.		0.00000		0	59. 00
60. 00  06000   LABORATORY			0. 30305		47, 578	
60. 01  06001  BL00D LABORATORY			0.00000		0	60. 01
65. 00 06500 RESPIRATORY THERAPY			1. 50950		519	65. 00
66. 00 06600 PHYSI CAL THERAPY			0. 52811			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY			0. 00000		0	67. 00
68. 00 06800 SPEECH PATHOLOGY			0. 18844		269	68. 00
69. 00 06900 ELECTROCARDI OLOGY			0. 13299			
69. 02   06902   SLEEP LAB			0. 57410		0	69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	D TO DATI FATE		0.00000		147 142	70.00

0.702890

0.000000

0. 570288

0.000000

0.000000

0.000000

0. 938723

1.168580

209, 339

216, 201

414

994, 305

994, 305

0

0 88.00

0

0

389

71.00

72.00

73.00

89.00

90.00

91.00

92.00

95.00 488, 183 200. 00

201. 00

202. 00

147, 142

123, 297

71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

72.00

73.00

88.00

89.00

90.00

91.00

92.00

200.00

201.00

202.00

07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

08800 RURAL HEALTH CLINIC

09000 CLI NI C

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

Health Financial Systems	COMMUNITY HOSPITAL (	OF BREMEN			In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 151300		d: 05/01/2013	Worksheet D-3	
		Component	CCN: 15Z300	То	04/30/2014	Date/Time Prep 9/30/2014 10:	
		Ti tl	e XVIII	Swi ng	Beds - SNF	Cost	
Cost Center Description			Ratio of Cos	st Ir	npati ent	Inpati ent	
·			To Charges		Program	Program Costs	
				(	Charges	(col. 1 x col.	
						2)	

Cost Center Description					9/30/2014 10:	58 am
INPATIENT ROUTINE SERVICE COST CENTERS			Title XVIII S	wing Beds - SNF	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS		Cost Center Description	Ratio of Cost	Inpatient	Inpati ent	
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00		'	To Charges			
INPATI ENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00						
NPATIENT ROUTINE SERVICE COST CENTERS   163, 251   30, 00   300				3.1		
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   31.00   31.00   31.00   31.00   31.00   32.00   32.00   33.00   32.00   33			1. 00	2.00		
30.00		INPATIENT ROUTINE SERVICE COST CENTERS			3. 55	
31.00   03100   INTENSIVE CARE UNIT   0   33.00   33				163 251		30.00
22 00   03200   COROMARY CARE UNIT				1		
33.00   03300   BURN   INTENSIVE CARE UNIT				0		
34.00   03400   SUBPROVI DER - IRF   0   41.00   42.				0		
11.00				0		
A2. 00   04200   SUBPROVI DER				0		
A3.00				0		
ANCI LLARY SERVICE COST CENTERS				0		
50.00						43.00
52.00   05200   DELIVERY ROOM & LABDR ROOM   0.137657   0   0.52.00   05400   RADI OLOGY-DI AGNOSTIC   0.544338   10, 174   5, 538   54.00   05700   CT SCAN   0.165583   8, 453   1, 400   57.00   05700   CT SCAN   0.330919   5, 726   1, 895   58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0.330919   5, 726   1, 895   58.00   0.5900   CARDIAC CATHETERIZATION   0.000000   0   0   0.59.00   0.000000   0   0   0.000000   0			0.422100	10/	00	
54.00   05400   RADI OLOGY-DI AGNOSTI C   0.54438   10,174   5,538   54.00   57.00   05700   CT SCAN   0.165583   8.453   1,400   57.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0.330919   5,726   1,895   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0.330919   5,726   1,895   58.00   05900   CARDI AC CATHETERI ZATI ON   0.0000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000						
57. 00   05700   CT SCAN   0.165583   8,453   1,400   57. 00   58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0.330919   5,726   1,895   58. 00   05900   CARDIAC CATHETERI ZATION   0.000000   0   0.5900   0.000000   0   0.000000   0   0.000000   0						
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)   0.330919   5,726   1,895   58. 00   59. 00   05900   CARDI AC CATHETERI ZATION   0.000000   0   0   59. 00   0.000000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000						1
59. 00       05900 CARDIAC CATHETERIZATION       0.000000       0       0       59. 00         60. 00       06000 0 06000 LABORATORY       0.303054       47, 869       14, 507       60. 00         60. 01       0.6001 BLOOD LABORATORY       0.000000       0       0       60. 01         65. 00       0.6500 RESPI RATORY THERAPY       1.509509       0       0       65. 00         66. 00       0.6600 PHYSI CAL THERAPY       0.528113       211, 551       111, 723       66. 00         67. 00       0.6700 DCUPPATIONAL THERAPY       0.000000       0       0       67. 00         68. 00       0.6800 SPEECH PATHOLOGY       0.188448       1, 103       208       68. 00         69. 00       0.6900 ELECTROCARDI OLOGY       0.132994       3, 270       435       69. 00         69. 02       0.6902 SLEEP LAB       0.574103       0       0       69. 02         70. 00       0.7000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.70000       0       0       70. 00         71. 00       0.7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       0       0       72. 00         72. 00       0.7200 IMPL. DEV. CHARGED TO PATI ENTS       0.57288       105, 879       60, 382       73. 00						
60. 00   06000   LABORATORY   0. 303054   47,869   14,507   60. 00   60. 01   06001   BLOOD LABORATORY   0. 000000   0   0   60. 01   65. 00   06500   RESPI RATORY THERAPY   1. 509509   0   0   65. 00   06600   PHYSI CAL THERAPY   0. 528113   211,551   111,723   66. 00   66. 00   06700   0CCUPATI ONAL THERAPY   0. 000000   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 188448   1,103   208   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0. 182994   3,270   435   69. 00   69. 02   06902   SLEEP LAB   0. 574103   0   0   69. 02   70. 00   07000   ELECTROCARDI OLOGY   0. 132994   3,270   435   69. 00   69. 02   70. 00   07000   ELECTROCARDI OLOGY   0. 000000   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 000000   0   0   72. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 000000   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 570288   105, 879   60, 382   73. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0. 000000   0   0   90. 00		, ,				
60. 01   06001   BLOOD LABORATORY   0.000000   0   0   60. 01						
65. 00   06500   RESPIRATORY THERAPY   1.509509   0   0   65. 00   66. 00					14, 507	
66. 00 06600 PHYSICAL THERAPY 0. 528113 211, 551 111, 723 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 0. 000000 0 0 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0. 188448 1, 103 208 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 132994 3, 270 435 69. 00 06900 SLEEP LAB 0. 574103 0 0 0 69. 02 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 0. 000000 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 702890 8, 339 5, 861 71. 00 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 0. 570288 105, 879 60, 382 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 570288 105, 879 60, 382 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 0. 000000 0 0 0 72. 00 07200 INPL. DEV. CHARGED TO PATIENTS 0. 570288 105, 879 60, 382 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 0. 000000 0 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 0. 000000 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 0. 000000 0 0 0 0 0 0 0 0 0 0 0 0 0	60. 01	06001 BLOOD LABORATORY	0. 000000	0	0	60. 01
67. 00	65.00	06500 RESPI RATORY THERAPY	1. 509509	0	0	65.00
67. 00   06700   OCCUPATIONAL THERAPY   0.000000   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0.188448   1,103   208   68. 00   69. 00   06900   ELECTROCARDIOLOGY   0.132994   3,270   435   69. 00   69. 00   06900   SLEEP LAB   0.574103   0   0   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0.000000   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.702890   8,339   5,861   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.570288   105,879   60,382   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.570288   105,879   60,382   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.570288   105,879   60,382   88. 00   08800   RURAL HEALTH CLINIC   0.000000   0   0   88. 00   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0.000000   0   0   90. 00   90. 00   09000   CLINIC   0.000000   0   0   90. 00   91. 00   09100   EMERGENCY   0.938723   1,065   1,000   91. 00   92. 00   09200   DSSERVATION BEDS (NON-DISTINCT PART)   1.168580   0   0   92. 00   07000   TOTHER REIMBURSABLE COST CENTERS   95. 00   07000   NOSOON   TOTAL CLABORATORY SERVICES   95. 00   07000   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   201. 00	66.00	06600 PHYSI CAL THERAPY	0. 528113	211, 551	111, 723	66. 00
69. 00   06900   ELECTROCARDI OLOGY   0. 132994   3, 270   435   69. 00   69. 02   06902   SLEEP LAB   0. 574103   0   0   69. 02   70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 000000   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 702890   8, 339   5, 861   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 000000   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 570288   105, 879   60, 382   73. 00   000000   0   0   0   88. 00   08800   RURAL HEALTH CLINIC   0. 000000   0   89. 00   90. 00   09000   CLINIC   0. 000000   0   0   90. 00   91. 00   09100   EMERGENCY   0. 938723   1, 065   1, 000   91. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0. 168580   0   0   95. 00   09500   AMBULANCE SERVI CES   95. 00   201. 00   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   90. 00   201. 00   000000   0   0   0   90. 00   201. 00   000000   0   0   90. 00   000000   0   0   0   90. 00   000000   0   0   0   90. 00   000000   0   0   0   90. 00   000000   0   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   000000   0   0   90. 00   0000000   0   0   90. 00   0000000   0   0   90. 00   0000000   0   0   90. 00   0000000   0   0   90. 00   0000000   0   0   90. 00   000000000   0   0   90. 00   000000000   0   0   90. 00   00000000000   0   0   90. 00   0000000000000000000000000000000	67. 00	06700 OCCUPATI ONAL THERAPY	0.000000	0		
69. 00   06900   ELECTROCARDI OLOGY   0. 132994   3, 270   435   69. 00   69. 02   06902   SLEEP LAB   0. 574103   0   0   69. 02   70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 000000   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 702890   8, 339   5, 861   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 000000   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 570288   105, 879   60, 382   73. 00   0017PATI ENT SERVI CE COST CENTERS   0. 000000   0   0   88. 00   08800   RURAL HEALTH CLINI C   0. 000000   0   0   89. 00   09900   CLINI C   0. 000000   0   0   90. 00   09000   CLINI C   0. 000000   0   0   91. 00   09100   EMERGENCY   0. 938723   1, 065   1, 000   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0. 168580   0   0   95. 00   09500   AMBULANCE SERVI CES   95. 00   200. 00   Total (sum of lines 50-94 and 96-98)   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0    69. 00   07000000   0. 132994   3, 270   435   69. 00   0. 000000   0   0   0   90. 00   0. 000000   0   0   0   0   90. 00   0. 000000   0   0   0   90. 00   0. 000000   0   0   0   90. 00   0. 000000   0   0   0   90. 00   0. 000000   0   0   0   90. 00   0. 000000   0   0   0   90. 00   0. 000000   0   0   90. 00   0. 000000   0   0   90. 00   0. 000000   0   0   90. 00   0. 000000   0   0   90. 00   0. 000000   0   0   90. 00   0. 000000   0   0   90. 00   0. 000000   0   0   90. 00   0. 000000   0   90. 00	68. 00	06800 SPEECH PATHOLOGY	0. 188448	1, 103	208	68. 00
69. 02   06902   SLEEP LAB   0. 574103   0 0 0 69.02     70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 0000000   0 0 0 70.00     71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 702890   8, 339   5, 861     71. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 000000   0 0 0 72.00     73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 570288   105, 879   60, 382     73. 00   000000   0 0 0 0 0 0 0 0 0 0 0 0	69. 00	06900 ELECTROCARDI OLOGY				69.00
70. 00   07000   ELECTROENCEPHALOGRAPHY   0.000000   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.702890   8, 339   5, 861   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.000000   0   0   72. 00   72. 00   07300   DRUGS CHARGED TO PATIENTS   0.570288   105, 879   60, 382   73. 00   07400			•			
71. 00						
72. 00					5 861	
73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 570288   105, 879   60, 382   73. 00   000000   000000   000000   000000   000000						
Section   Service   Cost   Centers   Service   Cost   Centers					1	
88. 00			0.370200	105,077	00, 302	73.00
89. 00			0.00000	1	1	00 00
90. 00						1
91. 00   09100   EMERGENCY   0. 938723   1, 065   1, 000   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   1. 168580   0   0   92. 00   000						
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)						
OTHER REIMBURSABLE COST CENTERS   95. 00     O9500   AMBULANCE SERVICES   95. 00   200. 00   Total (sum of lines 50-94 and 96-98)   403, 625   203, 032 200. 00   201. 00   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   201. 00						1
95. 00			1. 168580	0	10	92.00
200. 00       Total (sum of lines 50-94 and 96-98)       403,625       203,032       200.00         201. 00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00				1		
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00						
202.00   Net Charges (line 200 minus line 201)   403,625    202.00			ne 61)	_		
	202.00	Net Charges (line 200 minus line 201)		403, 625		202. 00

Health Financial Systems COMM	UNITY HOSPITAL OF BREMEN		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Period: From 05/01/2013	Worksheet D-3	
			To 04/30/2014	Date/Time Prep 9/30/2014 10:	
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cost		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INDATION DOUTING CEDVICE COCT CENTEDS		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			155,000		20.00
30. 00   03000   ADULTS & PEDI ATRI CS			155, 928		30. 00 31. 00
31. 00 03100 INTENSIVE CARE UNIT			0		
32. 00 03200 CORONARY CARE UNIT			0		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT			0		34.00
41. 00   04100   SUBPROVI DER -   I RF			0		41.00
42. 00   04200   SUBPROVI DER			0		42.00
43. 00   04300   NURSERY			66, 756		43. 00
ANCILLARY SERVICE COST CENTERS		0.40040	0 400 044	7/ 400	F0 00
50. 00   05000   0PERATI NG ROOM		0. 42218			50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 13765			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 54433		1, 533	54.00
57. 00   05700   CT   SCAN		0. 16558		906	57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 33091		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 00000		0	59. 00
60. 00   06000   LABORATORY		0. 30305		14, 678	60.00
60. 01   06001   BLOOD LABORATORY		0. 00000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY		1. 50950		2, 130	65. 00
66. 00   06600   PHYSI CAL THERAPY		0. 52811		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 00000		0	67. 00
68. 00   06800   SPEECH PATHOLOGY		0. 18844		0	68. 00
69. 00   06900   ELECTROCARDI OLOGY		0. 13299		1, 203	69. 00
69. 02   06902   SLEEP LAB		0. 57410		0	69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 70289		9, 944	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 00000		0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 57028	8 32, 246	18, 390	73. 00
OUTPATIENT SERVICE COST CENTERS					

0.000000

0. 000000

0. 938723

1. 168580

0

4, 275

404, 886

404, 886

0 88.00

0 89.00

90.00

91.00

95.00

201. 00 202. 00

0

0 92.00

143, 623 200. 00

4, 013

88. 00 08800 RURAL HEALTH CLINIC

OTHER REI MBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVI CES

09000 CLI NI C

09100 EMERGENCY

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

89.00

90.00

91.00

92.00

200.00

201.00

202.00

Health Financial Systems	COMMUNITY HOSPITAL OF BREMEN	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15130	From 05/01/2013	Worksheet E Part B Date/Time Prepared: 9/30/2014 10:58 am
	T: +1 - \0/1/1	11	C+

			10 04/30/2014	9/30/2014 10:	
		Title XVIII	Hospi tal	Cost	
				1. 00	
4 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0.047.700	4 00
1.00	Medical and other services (see instructions)	>		3, 047, 709	
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction PPS payments	ons)		0	
4.00	Outlier payment (see instructions)			0	4.00
5. 00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0. 000	
6. 00	Line 2 times line 5	1 0113)		0.000	6. 00
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Worksheet D, Pa	rt IV, column 13, line	200	0	9. 00
10.00	Organ acqui si ti ons			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			3, 047, 709	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges				10.00
	Ancillary service charges	0 001 4)		0	
13. 00 14. 00	Organ acquisition charges (from Worksheet D-4, Part III, line 6 Total reasonable charges (sum of lines 12 and 13)	9, (01. 4)		0	
14.00	Customary charges			0	14.00
15. 00	Aggregate amount actually collected from patients liable for pa	vment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	9	•	Ö	
	had such payment been made in accordance with 42 CFR 413.13(e)	. 3	J		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19. 00
	instructions)		40) (		
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	IT line ii exceeds ii	ne 18) (see	0	20. 00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		3, 078, 186	21. 00
22. 00	, ,	riisti deti olis)		0,070,100	1
23. 00	Cost of teaching physicians (see instructions, 42 CFR 415.160 a	nd CMS Pub. 15-1. sect	i on 2148)	Ö	1
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)		,	0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			21, 561	
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			934, 282	
27. 00	Subtotal ((lines 21 and 24 - the sum of lines 25 and 26) plus t	he sum of lines 22 and	23} (for CAH,	2, 122, 343	27. 00
20 00	see instructions) Direct graduate medical education payments (from Worksheet E-4,	line EO)		0	28. 00
28. 00 29. 00	ESRD direct medical education costs (from Worksheet E-4, line 3	*		0	1
30. 00	Subtotal (sum of lines 27 through 29)	0)		2, 122, 343	1
31. 00	Primary payer payments			1, 712	ı
32.00	Subtotal (line 30 minus line 31)			2, 120, 631	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	S)			
33. 00	Composite rate ESRD (from Worksheet I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			55, 281	
35. 00	Adjusted reimbursable bad debts (see instructions)			48, 647	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		54, 341	
37. 00	Subtotal (see instructions)			2, 169, 278	
39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	d devices (see instide	11 0113)	o o	39. 99
40. 00	Subtotal (see instructions)			2, 169, 278	1
40. 01	Seguestration adjustment (see instructions)			43, 386	1
41. 00	Interim payments			2, 351, 998	1
42.00	Tentative settlement (for contractors use only)			0	42. 00
43.00	Balance due provider/program (see instructions)			-226, 106	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-II,	section 115.2	325, 239	44. 00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	1
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
	Total (sum of lines 91 and 93)				94.00
, 00	1.22. (22 3. 1.1.03 ). 4 70)				, , 55

 
 DF BREMEN
 In Lieu of Form CMS-2552-10

 Provi der CCN: 151300
 Peri od: From 05/01/2013 To 04/30/2014
 Worksheet E-1 Part I Date/Time Prepared: 9/30/2014 10:58 am
 Health Financial Systems COMMUI ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					9/30/2014 10:	58 am
		Ti	tle XVIII	Hospi tal	Cost	
		Inpati	ent Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1. 00	Total interim payments paid to provider		833, 1	192	2, 351, 998	1.00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		833, 1	192	2, 351, 998	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR					F 00
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	1 0	5. 01
5. 01	TENTATIVE TO PROVIDER			0		5. 01
5. 02				0		5. 02
5.05	Provider to Program			<u> </u>	1 0	3. 03
5. 50	TENTATI VE TO PROGRAM			0	1 0	5. 50
5. 51	TENTITUE TO TROOM WI			o		5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
0. , ,	5. 50-5. 98)					0. ,,
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					2. 20
6. 01	SETTLEMENT TO PROVIDER		148, 7	757	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1	0	226, 106	6. 02
7. 00	Total Medicare program liability (see instructions)		981, 9	-	2, 125, 892	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			0	1. 00	2.00	
8.00	Name of Contractor					8. 00
	•			*	· ·	

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

		·			9/30/2014 10:	58 am
				<u> Swing Beds - SNF</u>		
		Inpatien	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		734, 67	3	0	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
0.00	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 02	7.B3331WENTS TO TROVIDER			o	0	3. 02
3. 03				0	0	3. 03
3. 04				Ö	Ö	3. 04
3. 05				Ö	0	3. 05
	Provider to Program			-		
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				o	0	3. 51
3.52				o	0	3. 52
3.53				o	0	3. 53
3.54				o	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		734, 67	3	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					ļ
г оо	TO BE COMPLETED BY CONTRACTOR				I	F 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			ol	0	5. 01
5. 02	TERMINA VE TO TROVIDER			o	0	5. 02
5. 03				Ö	0	5. 03
	Provider to Program			-1		
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				o	0	5. 51
5.52				o	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			o	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)		_			
6. 01	SETTLEMENT TO PROVIDER		78, 83		0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		813, 50		0	7. 00
				Contractor	NPR Date	
		(	)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor	· ·	)	1.00	2.00	8. 00
0.00	Inalie of collector			1	I	J 0.00

Heal th	Health Financial Systems COMMUNITY HOSPITAL OF BREMEN In Lieu					2552-10
CALCUL	From 05/01/2013 F To 04/30/2014 D					
			Title XVIII	Hospi tal	Cost	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STAN					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECT				0.4.0	
1.00					310	
	2.00 Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12				382	2. 00
3.00	Medicare HMO days from Wkst S-3, Part I, o				120	3. 00
4.00	Total inpatient days from S-3, Part I colu		8-12		710	
5. 00	Total hospital charges from Wkst C, Part I				28, 361, 208	
6. 00	Total hospital charity care charges from W				870, 509	6. 00
7.00	CAH only - The reasonable cost incurred for	or the purchase of cer	tified HIT technology	Worksheet S-2,	976, 350	7. 00
0.00	Part I line 168	( :+			007 400	0 00
8.00	Calculation of the HIT incentive payment (				907, 420 18, 148	
9.00						
10. 00	Calculation of the HIT incentive payment a		ee instructions)		889, 272	10. 00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CA					
	Initial/interim HIT payment adjustment (se	ee instructions)			0	30. 00
	Other Adjustment (specify)				0	31. 00
22 00	100 Delenes due provider (line 0 (er line 10) minus line 20 and line 21) (see instructions)					22 00

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

0 30.00 0 31.00 889,272 32.00

From 05/01/2013     Component CCN: 15Z300   To 04/30/2014   Date/Tim	Form CMS-2552-10
Component CCN: 15Z300   To   04/30/2014   Date/Tim	sheet E-2
	/Time Prepared: /2014 10:58 am

		olliporierit cciv. 152500	10 04/30/2014	9/30/2014 10:	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		632, 327	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A		205, 062	0	3. 00
	Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instr				
4.00	Per diem cost for interns and residents not in approved teaching	program (see		0.00	4. 00
	instructions)				
5.00	Program days		377	0	5. 00
6.00	Interns and residents not in approved teaching program (see instr			0	6. 00
7.00	Utilization review - physician compensation - SNF optional method	onl y	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		837, 389	0	8. 00
9.00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		837, 389	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable)	e to physician	0	0	11. 00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		837, 389	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (e	xcl ude coi nsurance	7, 280	0	13. 00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		830, 109	0	15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
			0		16. 50
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instruct	i ons)	0	0	
	Total (see instructions)		830, 109	0	
19. 01	Sequestration adjustment (see instructions)		16, 602	0	19. 01
20.00	Interim payments		734, 673	0	20. 00
21.00	Tentative settlement (for contractor use only)		0	0	21. 00
22. 00	Balance due provider/program line 19 minus lines 19.01, 20 and 21		78, 834	0	22. 00
23.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	36, 673	0	23. 00
	section 115.2				

Health Financial Systems	COMMUNITY HOSPITAL OF BREMEN	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 1513	From 05/01/2013	Worksheet E-3 Part V Date/Time Prepared: 9/30/2014 10:58 am
	Title XVIII	Hospi tal	Cost

			10 04/30/2014	9/30/2014 10:	
		Title XVIII	Hospi tal	Cost	<u> </u>
		THE XVIII	nospi tui	0031	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PA	ART A SERVICES - COST	REIMBURSEMENT (C		
1.00	Inpatient services			1, 122, 551	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	)		0	2. 00
3.00	Organ acqui si ti on			0	3. 00
4.00	Subtotal (sum of lines 1 thru 3)			1, 122, 551	4. 00
5.00	Primary payer payments			205	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 133, 572	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			, , , ,	
	Reasonabl e charges				
7.00	Routi ne servi ce charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11.00	Aggregate amount actually collected from patients liable for pay	ment for services on	a charge basis	0	11. 00
12.00	Amounts that would have been realized from patients liable for p	payment for services o	n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)				
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15.00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds lin	e 14) (see	0	16. 00
	instructions)			_	
17. 00	Cost of teaching physicians (from Worksheet D-5, Part II, column	n 3, line 20) (see ins	tructions)	0	17. 00
40.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	1. (0)		0	10.00
18. 00	Direct graduate medical education payments (from Worksheet E-4,	line 49)		1 122 572	
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			1, 133, 572	
20. 00	Deductibles (exclude professional component)			133, 792	
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			999, 780	
23. 00	Coinsurance			0	
24. 00	Subtotal (line 22 minus line 23)			999, 780	
25. 00	Allowable bad debts (exclude bad debts for professional services	s) (see instructions)		2, 510	
26. 00	Adjusted reimbursable bad debts (see instructions)	-+:>		2, 209	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		2, 510	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 001, 989	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 99	Recovery of Accelerated Depreciation			0	29. 99
30.00	Subtotal (line 28, plus or minus lines 29)			1, 001, 989	
30. 01	Sequestration adjustment (see instructions)			20, 040	
31. 00	Interim payments			833, 192	
32.00	Tentative settlement (for contractor use only)	22		140.757	
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and		000+i on 11E 0	148, 757	
34.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	Section 115.2	49, 245	34.00

Health Financial Systems	COMMUNITY HOSPITAL OF BREMEN		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 151300	From 05/01/2013 To 04/30/2014	Worksheet E-3 Part VII Date/Time Prepared:

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES  COMPUTATION OF NET COST OF COVERED SERVICES  1.00 Inpatient hospital/SNF/NF services 3.00 Organ acquisition (certified transplant centers only) 4.00 Subtotal (sum of lines 1, 2 and 3) 5.00 Inpatient primary payer payments 6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable Charges 8.00 Routine service charges 9.00 Ancillary service charges 10.00 Organ acquisition charges, net of revenue 11.00 Incentive from target amount computation 12.00 Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES  13.00 Amount actually collected from patients liable for payment for services on a charge		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES  COMPUTATION OF NET COST OF COVERED SERVICES  1.00 Inpatient hospital/SNF/NF services 3.00 Organ acquisition (certified transplant centers only) 4.00 Subtotal (sum of lines 1, 2 and 3) 5.00 Inpatient primary payer payments 6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges  8.00 Routine service charges  9.00 Ancillary service charges  10.00 Organ acquisition charges, net of revenue 11.00 Incentive from target amount computation 12.00 Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES  13.00 Amount actually collected from patients liable for payment for services on a charge	2.00 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES  1.00 Inpatient hospital/SNF/NF services 2.00 Medical and other services 3.00 Organ acquisition (certified transplant centers only) 4.00 Subtotal (sum of lines 1, 2 and 3) 5.00 Inpatient primary payer payments 6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges  8.00 Routine service charges  9.00 Ancillary service charges 10.00 Organ acquisition charges, net of revenue 11.00 Incentive from target amount computation 12.00 Amount actually collected from patients liable for payment for services on a charge	0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
COMPUTATION OF NET COST OF COVERED SERVICES  1.00 Inpatient hospital/SNF/NF services 377, 200 2.00 Medical and other services 377, 200 3.00 Organ acquisition (certified transplant centers only) 0 4.00 Subtotal (sum of lines 1, 2 and 3) 377, 200 5.00 Inpatient primary payer payments 0 6.00 Outpatient primary payer payments 0 7.00 Subtotal (line 4 less sum of lines 5 and 6) 377, 200 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 0 8.00 Routine service charges 0 9.00 Ancillary service charges 404, 886 10.00 Organ acquisition charges, net of revenue 0 11.00 Incentive from target amount computation 0 11.00 Total reasonable charges (sum of lines 8 through 11) 404, 886 CUSTOMARY CHARGES	1, 660, 409	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1.00 Inpatient hospital/SNF/NF services 2.00 Medical and other services 3.00 Organ acquisition (certified transplant centers only) 4.00 Subtotal (sum of lines 1, 2 and 3) 5.00 Inpatient primary payer payments 6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) 6.00 COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable Charges 8.00 Routine service charges 9.00 Ancillary service charges 10.00 Organ acquisition charges, net of revenue 11.00 Incentive from target amount computation 12.00 Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES  13.00 Amount actually collected from patients liable for payment for services on a charge	1, 660, 409	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1.00 Inpatient hospital/SNF/NF services 2.00 Medical and other services 3.00 Organ acquisition (certified transplant centers only) 4.00 Subtotal (sum of lines 1, 2 and 3) 5.00 Inpatient primary payer payments 6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) 6.00 COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable Charges 8.00 Routine service charges 9.00 Ancillary service charges 10.00 Organ acquisition charges, net of revenue 11.00 Incentive from target amount computation 12.00 Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge	1, 660, 409	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
3.00 Organ acquisition (certified transplant centers only) 4.00 Subtotal (sum of lines 1, 2 and 3) 5.00 Inpatient primary payer payments 6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6)  COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable Charges  8.00 Routine service charges 9.00 Ancillary service charges 10.00 Organ acquisition charges, net of revenue 11.00 Incentive from target amount computation 12.00 Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES  13.00 Amount actually collected from patients liable for payment for services on a charge	1, 660, 409	3. 00 4. 00 5. 00 6. 00 7. 00
4.00 Subtotal (sum of lines 1, 2 and 3) 5.00 Inpatient primary payer payments 6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 9.00 Ancillary service charges 10.00 Organ acquisition charges, net of revenue 11.00 Incentive from target amount computation 12.00 Total reasonable charges (sum of lines 8 through 11) 13.00 Amount actually collected from patients liable for payment for services on a charge	1, 660, 409	4. 00 5. 00 6. 00 7. 00 8. 00
1 Inpatient primary payer payments 0 Outpatient primary payer payments 2 Outpatient primary payer payments 3 Subtotal (line 4 less sum of lines 5 and 6) 377, 200  COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable Charges 8.00 Routine service charges 9.00 Ancillary service charges 10.00 Organ acquisition charges, net of revenue 11.00 Incentive from target amount computation 12.00 Total reasonable charges (sum of lines 8 through 11) 10.00 Amount actually collected from patients liable for payment for services on a charge	1, 660, 409	5. 00 6. 00 7. 00 8. 00
6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) 377, 200  COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable Charges  8.00 Routine service charges 9.00 Ancillary service charges 10.00 Organ acquisition charges, net of revenue 11.00 Incentive from target amount computation 12.00 Total reasonable charges (sum of lines 8 through 11) 404, 886  CUSTOMARY CHARGES  13.00 Amount actually collected from patients liable for payment for services on a charge	1, 660, 409	6. 00 7. 00 8. 00
7.00 Subtotal (line 4 less sum of lines 5 and 6)  COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable Charges  8.00 Routine service charges  9.00 Ancillary service charges  10.00 Organ acquisition charges, net of revenue  11.00 Incentive from target amount computation  12.00 Total reasonable charges (sum of lines 8 through 11)  CUSTOMARY CHARGES  13.00 Amount actually collected from patients liable for payment for services on a charge	1, 660, 409	7. 00 8. 00
COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable Charges  8. 00 Routine service charges  9. 00 Ancillary service charges  10. 00 Organ acquisition charges, net of revenue  11. 00 Incentive from target amount computation  12. 00 Total reasonable charges (sum of lines 8 through 11)  CUSTOMARY CHARGES  13. 00 Amount actually collected from patients liable for payment for services on a charge	1, 660, 409	8. 00
Reasonable Charges  8.00 Routine service charges  9.00 Ancillary service charges  10.00 Organ acquisition charges, net of revenue  11.00 Incentive from target amount computation  12.00 Total reasonable charges (sum of lines 8 through 11)  CUSTOMARY CHARGES  13.00 Amount actually collected from patients liable for payment for services on a charge		
8.00 Routine service charges 0 9.00 Ancillary service charges 404,886 10.00 Organ acquisition charges, net of revenue 0 11.00 Incentive from target amount computation 0 12.00 Total reasonable charges (sum of lines 8 through 11) 404,886 CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge 0		
9.00 Ancillary service charges 404,886 10.00 Organ acquisition charges, net of revenue 0 11.00 Incentive from target amount computation 0 12.00 Total reasonable charges (sum of lines 8 through 11) 404,886  CUSTOMARY CHARGES  13.00 Amount actually collected from patients liable for payment for services on a charge 0		
10.00 Organ acquisition charges, net of revenue 0 11.00 Incentive from target amount computation 0 12.00 Total reasonable charges (sum of lines 8 through 11) 404,886  CUSTOMARY CHARGES  13.00 Amount actually collected from patients liable for payment for services on a charge 0		
11.00 Incentive from target amount computation 12.00 Total reasonable charges (sum of lines 8 through 11)  CUSTOMARY CHARGES  13.00 Amount actually collected from patients liable for payment for services on a charge		9. 00
12.00 Total reasonable charges (sum of lines 8 through 11)  CUSTOMARY CHARGES  13.00 Amount actually collected from patients liable for payment for services on a charge 0	<b>I</b>	10. 00
CUSTOMARY CHARGES  13.00 Amount actually collected from patients liable for payment for services on a charge 0		11. 00
13.00 Amount actually collected from patients liable for payment for services on a charge 0	1, 660, 409	12. 00
	_	
	0	13. 00
basis		14 00
14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	14. 00
15.00 Ratio of line 13 to line 14 (not to exceed 1.000000)  0.000000	0. 000000	15. 00
16.00 Total customary charges (see instructions)		16. 00
17. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 27,686		17. 00
line 4) (see instructions)	1,000,407	17.00
18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	o	18. 00
16) (see instructions)	Ĭ	
19.00 Interns and Residents (see instructions)	0	19.00
20.00 Cost of Teaching Physicians (see instructions)	0	20.00
21.00 Cost of covered services (enter the lesser of line 4 or line 16) 377,200	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.		
22.00 Other than outlier payments	0	22. 00
23.00 Outlier payments 0		23. 00
24.00 Program capital payments 0		24. 00
25.00 Capital exception payments (see instructions)	•	25. 00
26.00 Routine and Ancillary service other pass through costs	•	26. 00
27.00 Subtotal (sum of lines 22 through 26)	•	27. 00
28.00 Customary charges (title V or XIX PPS covered services only)	•	28. 00
29.00 Titles V or XIX (sum of lines 21 and 27) 377, 200	0	29. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT	0	20.00
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 377,200		30. 00 31. 00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 377,200 32.00 Deductibles		31.00
33. 00 Coi nsurance		33. 00
34.00   Allowable bad debts (see instructions)		34. 00
35. 00 Utilization review	-	35. 00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  377,200		36. 00
37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		37. 00
38. 00   Subtotal (line 36 ± line 37) 377, 200		38. 00
39.00 Direct graduate medical education payments (from Wkst. E-4)		39. 00
40.00 Total amount payable to the provider (sum of lines 38 and 39)  377, 200		40. 00
41.00 Interim payments	l l	41. 00
42.00 Balance due provider/program (line 40 minus 41)		42. 00
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,		43. 00
section 115. 2	٦	

Health Financial Systems	COMMUNITY HOSPITAL OF BREMEN	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151300	From 05/01/2013	Worksheet E-3 Part VII Date/Time Prepared: 9/30/2014 10:58 am

			10 04/30/2014	Date/lime Pre   9/30/2014 10:	
		Title V	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	1023 1010 11 1223 1 010 7117	COLITYTOLO		
1.00	Inpatient hospital/SNF/NF services		0		1.00
2. 00	Medical and other services			0	1
3.00	Organ acquisition (certified transplant centers only)		0	O	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		0	0	
5. 00	Inpatient primary payer payments		0	O	5. 00
6. 00	Outpatient primary payer payments			0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		<u> </u>		7.00
	Reasonable Charges				1
8. 00	Routine service charges		0		8.00
9. 00	Ancillary service charges		0	0	
10.00	Organ acquisition charges, net of revenue		0	U	10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		0	0	
12.00	CUSTOMARY CHARGES		U	0	12.00
13. 00	Amount actually collected from patients liable for payment for	sorvi cos on a chargo	0	0	13. 00
13.00	basis	services on a charge		U	13.00
14. 00	Amounts that would have been realized from patients liable for	navment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42			O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	ork 110. 10(e)	0. 000000	0. 000000	15. 00
16. 00			0	0	1
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	0	0	
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	o	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16		0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provide	ers.		
22. 00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25.00	Capital exception payments (see instructions)		0		25. 00
26.00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31. 00
32.00	Deducti bl es		0	0	32. 00
33.00	Coi nsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
41.00	Interim payments		0	0	41. 00
42.00	Balance due provider/program (line 40 minus 41)		0	0	42. 00
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43. 00
	section 115.2				

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

Provider CCN: 151300

Peri od: Worksheet G From 05/01/2013 To 04/30/2014 Date/Time Prepared:

			'	0 04/30/2014	9/30/2014 10:	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	Cash on hand in banks	1, 722, 774	l c	0	0	1.00
2.00	Temporary investments	999, 147		0	0	2. 00
3.00	Notes receivable	0	) c	0	0	3. 00
4.00	Accounts receivable	5, 711, 502	2  C	0	0	4. 00
5.00	Other recei vable	0	) c	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-2, 868, 591		0	0	6. 00
7.00	Inventory	150, 980		0	0	7.00
8. 00 9. 00	Prepaid expenses Other current assets	739, 987 45, 481	1	0		8. 00 9. 00
10. 00	Due from other funds	43, 401			0	10.00
11. 00	Total current assets (sum of lines 1-10)	6, 501, 280			l	11.00
	FI XED ASSETS	2,00.,=00				
12.00	Land	440, 039	C	0	0	12. 00
13.00	Land improvements	C	) c	0	0	13. 00
14. 00	Accumulated depreciation	0	) c	0		14. 00
15. 00	Bui I di ngs	17, 740, 106	1	0	0	15.00
16. 00	Accumulated depreciation	-3, 765, 926		0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation			0	0	17. 00 18. 00
19. 00	Fi xed equi pment			_	0	19.00
20. 00	Accumulated depreciation			0	Ö	20.00
21. 00	Automobiles and trucks	Ö		o o	Ō	21. 00
22.00	Accumul ated depreciation	0	) c	0	0	22. 00
23.00	Major movable equipment	6, 878, 214		0	0	23. 00
24.00	Accumulated depreciation	-5, 251, 762	2 c	0	0	24. 00
25. 00	Mi nor equi pment depreci able	0	) c		0	25. 00
26. 00	Accumul ated depreciation	0		_	0	26. 00
27. 00 28. 00	HIT designated Assets			0	0	27. 00 28. 00
29. 00	Accumulated depreciation Minor equipment-nondepreciable	132, 806		0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	16, 173, 477		_	1	30.00
00.00	OTHER ASSETS	10/1/0/1//		<u> </u>		00.00
31.00	Investments	C	) C	0	0	31.00
32.00	Deposits on leases	C	) c	0		32. 00
33.00	Due from owners/officers	0	) c	0	1	33. 00
34. 00	Other assets	0	) C	_	0	34.00
35. 00	Total other assets (sum of lines 31-34)	0 (74 757		_	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	22, 674, 757	' <u> </u> C	J U	0	36. 00
37. 00	Accounts payable	1, 065, 646		0	0	37. 00
38. 00	Salaries, wages, and fees payable	523, 442			ő	38. 00
39. 00	Payroll taxes payable	0		o o	Ō	39. 00
40.00	Notes and Loans payable (short term)	60, 488	3 c	0	0	40. 00
41.00	Deferred income	C	) c	0	0	41. 00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	) (	0	0	43.00
44. 00	Other current liabilities	281, 027 1, 930, 603		_	0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	1, 930, 603	S  C	) U	0	45. 00
46. 00	Mortgage payable	15, 594, 406		0	0	46. 00
47. 00	Notes payable	0		_	l	47. 00
48.00	Unsecured Loans	C		0	l .	48. 00
49.00	Other long term liabilities	6, 001	c c	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	15, 600, 407		0		50. 00
51. 00	Total liabilites (sum of lines 45 and 50)	17, 531, 010	) <u> </u>	0	0	51.00
	CAPI TAL ACCOUNTS					
52. 00	General fund balance	5, 143, 747	1			52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		C	0		53. 00 54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				Ō	58. 00
	replacement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	5, 143, 747	1	0		59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and	22, 674, 757	'l c	0	0	60. 00
	[59]	I	I	1	I	I

19.00

0

0

STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 151300 Peri od: Worksheet G-1 From 05/01/2013 04/30/2014 Date/Time Prepared: 9/30/2014 10:58 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 4, 809, 609 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 334, 138 2.00 3.00 Total (sum of line 1 and line 2) 5, 143, 747 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 5, 143, 747 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 15.00 0 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 5, 143, 747 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

Health Financial Systems CO STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 151300

			Т	o 04/30/2014	Date/Time Pre 9/30/2014 10:	
	Cost Center Description		Inpatient	Outpati ent	Total	oo am
			1, 00	2.00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		2, 055, 430		2, 055, 430	1. 00
2.00	SUBPROVI DER - I PF		, ,		, ,	2. 00
3.00	SUBPROVI DER - I RF		0		0	3. 00
4.00	SUBPROVI DER		0		0	4. 00
5. 00	Swing bed - SNF		207, 858		207, 858	5. 00
6.00	Swing bed - NF		207,000		0	6. 00
7. 00	SKILLED NURSING FACILITY		_		-	7. 00
8.00	NURSING FACILITY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)		2, 263, 288		2, 263, 288	10.00
	Intensive Care Type Inpatient Hospital Services		2,200,200	I	2,200,200	
11. 00	INTENSIVE CARE UNIT		0		0	11. 00
12. 00	CORONARY CARE UNIT		0		0	12. 00
13. 00	BURN INTENSIVE CARE UNIT		0		0	13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT		0		0	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)		O		O	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of li	i nes	0		0	16. 00
10.00	11-15)	11103	0		O	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		2, 263, 288		2, 263, 288	17. 00
18. 00	Ancillary services		3, 522, 324		3, 522, 324	18. 00
19. 00	Outpatient services		0, 322, 324		23, 634, 358	19. 00
20. 00	RURAL HEALTH CLINIC		0		23, 034, 330	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	Ö	0	21. 00
22. 00	HOME HEALTH AGENCY		0		0	22. 00
23. 00	AMBULANCE SERVICES		0		0	23. 00
24. 00	CMHC		0		O	24. 00
24. 10	CORF		0		0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P. )		0		O	25. 00
26. 00	HOSPI CE					26. 00
27. 00	OTHER (SPECIFY)		0		0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	o Wkst	5, 785, 612	23, 634, 358	-	28. 00
20.00	G-3, line 1)	o wkst.	3, 703, 012	23, 034, 330	27, 417, 770	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			16, 226, 707		29. 00
30.00	BAD DEBTS		626, 232			30.00
31. 00	DAD DEDIS		020, 232			31. 00
32. 00			0			32. 00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		0	626, 232		36. 00
37. 00	DEDUCT (SPECIFY)		0	020, 232		37. 00
38. 00	DEDUCT (SPECIFF)		0			38.00
39. 00			0			
40. 00			0			39. 00 40. 00
			0			
41. 00	Total deductions (sum of lines 27 41)		U			41. 00 42. 00
42.00	Total deductions (sum of lines 37-41)	(transfor		16 052 020		
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42) to Wkst. G-3, line 4)	(transier		16, 852, 939		43. 00
	IO MUSI. 0-3, ITTE 4)	I		ı I		

Heal th	Financial Systems COMMUNITY HOSPITA	L OF BREMEN	In Lie	u of Form CMS-2	2552-10
STATE	ENT OF REVENUES AND EXPENSES	Provi der CCN: 151300	Peri od:	Worksheet G-3	
			From 05/01/2013 To 04/30/2014	Date/Time Pre 9/30/2014 10:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	ne 28)		29, 419, 970	1. 00
2.00	Less contractual allowances and discounts on patients' accoun			13, 649, 494	2. 00
3.00	Net patient revenues (line 1 minus line 2)			15, 770, 476	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		16, 852, 939	4. 00
5.00	Net income from service to patients (line 3 minus line 4)	,		-1, 082, 463	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			24, 044	7. 00
8.00	Revenues from telephone and other miscellaneous communication	ı servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			46, 512	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			143, 595	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		25, 282	16.00
17. 00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			3, 487	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
	MI SC/EHR FUNDS			1, 173, 681	24. 00
25. 00	Total other income (sum of lines 6-24)			1, 416, 601	25. 00
26. 00	Total (line 5 plus line 25)			334, 138	26. 00
27. 00				0	
20 00	Total other expenses (sum of Line 27 and subscripts)			0	20 00

334, 138 29. 00

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