Health Financi	al Systems	MARGARET MARY COMMUN	NITY HOSPITAL	In Lie	u of Form CMS-2552-10
		l395g; 42 CFR 413.20(b)). Fai cost reporting period being			FORM APPROVED OMB NO. 0938-0050
HOSPITAL AND F AND SETTLEMENT		EX COST REPORT CERTIFICATION	Provider CCN: 151	329 Period: From 01/01/2014 To 12/31/2014	
PART I - COST	REPORT STATUS				
Provider	1.[X] Electronically fi	led cost report		Date: 5/19/20	15 Time: 11:50 am
use only	2.[] Manually submitte	d cost report			
	 O] If this is an ame F] Medicare Utilizat 	nded report enter the number ion. Enter "F" for full or "L	of times the provid ." for low.	er resubmitted this co	ost report
Contractor use only	5. [1]Cost Report Statu (1) As Submitted (2) Settled without Au (3) Settled with Audit (4) Reopened (5) Amended	7. Contractor No. dit 8. [N] Initial Report fo	or this Provider CCN this Provider CCN	10.NPR Date: 11.Contractor's Vendo 12.[0]If line 5, co number of tim	or Code: 4 lumn 1 is 4: Enter es reopened = 0-9.
PART II - CERT	IFICATION				
ADMINISTRATIVE PROVIDED OR PR	ACTION, FINE AND/OR IMPR	Y INFORMATION CONTAINED IN TO SONMENT UNDER FEDERAL LAW. DIRECTLY OR INDIRECTLY OF A SISONMENT MAY RESULT.	FURTHERMORE, IF SERV	/ICES IDENTIFIED IN TH	IS REPORT WERE
	CERTIFICATION BY OFFICE	R OR ADMINISTRATOR OF PROVIDE	ER(S)		

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARGARET MARY COMMUNITY HOSPITAL (151329) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
ECR: Date: 5/19/2015 Time: 11:50 am
nl95hxjmGspldECCqnx9891: JAGlb0
1p1Vl0sVFsU2M0t7ftnfnzUyr9vDgc
cJ0x0vgehf005yq2
Tr: Date: 5/19/2015 Time: 11:50 am

PI: Date: S/19/2015 Time: 11:50 am pAtdvuiezLFdzOkmr5:u6YA16CYhdO LSZELO4tOGBjSqiJ6OItCSlMvQCtJU DT2gObSFEpOm7Ypg

(Signed)

Officer or Administrator of Provider(s

Title Bran R. Daeger

Date

Title XVIII Title V Part A Part B HIT Title XIX 2.00 1.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1.00 **Hospital** 279,634 -605,261261,791 -151,8281.00 Subprovider - IPF 2.00 2.00 3.00 Subprovider - IRF 0 n 3.00 Swing bed - SNF 0 5.00 5.00 6.00 Swing bed - NF 0 6.00 HOME HEALTH AGENCY I 9.00 9.00 10.00 RURAL HEALTH CLINIC I 14.207 10.00 200.00 Total 279,634 -591,054 261,791 -151,828 200.00

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

Health Financial Systems In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151329 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/19/2015 11:49 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 321 MITCHELL 1.00 PO Box: 1.00 2.00 City: BATESVILLE State: IN Zi p Code: 47006-County: RIPLEY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 MARGARET MARY COMMUNITY 151329 99915 01/07/1966 Ν 0 0 3.00 HOSPI TAI Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA MARGARET MARY COMMUNITY 157143 99915 03/01/1985 N Ρ Ν 12.00 HOSPI TAL 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce MARGARET MARY COMMUNITY 99915 14 00 151551 12/31/2003 14 00 HOSPI TAL 15.00 Hospital-Based Health Clinic - RHC MARGARET MARY COMMUNITY 158511 99915 09/03/2013 N 0 Ν 15.00 HOSPI TAL 16, 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2014 12/31/2014 20.00 Type of Control (see instructions) 21.00 21.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this cost reporting Ν 22.01 Ν period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22. 03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν 22.03 Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" for yes or "N" fo<u>r no</u> In-State In-State Out-of Out-of Medi cai d Other Medi cai d Medi cai d State State HMO days Medi cai d Medi cai d paid days el i gi bl e Medi cai d days unpai d paid days el i gi bl e unpai d days 1.00 2.00 3. 00 4.00 5.00 6.00 24.00 | If this provider is an IPPS hospital, enter the 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

Health Financial Systems MARGARET MA	ARY COMMU	JNITY HOSPITAL	L		In Lie	ı of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der	CCN: 151329	Period: From 01/0		Part I	eet S-2	
				To 12/3	31/2014		me Pre 015 11:	
	In-Stat Medicai		Out-of State	Out-of State	Medica HMO da	id 0	ther di cai d	
	pai d day		Medi cai d	Medi cai d	TIMO Ga	- I	days	
		unpai d days	paid days	el i gi bl e unpai d				
	1.00	2. 00	3. 00	4. 00	5. 00		5. 00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0 0	0	0		0		25. 00
					Rural S			
26.00 Enter your standard geographic classification (not wa	ge) stat	tus at the beg	ginning of t	he 1.	2	2.	JU	26. 00
cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not wa		tus at the one	l of the cos	+	2			27. 00
reporting period. Enter in column 1, "1" for urban or					2			27.00
enter the effective date of the geographic reclassifi 35.00 If this is a sole community hospital (SCH), enter the			`H status in		0			35.00
effect in the cost reporting period.	Tidilibet				, J			33.00
				Begi n		Endi 2.		-
36.00 Enter applicable beginning and ending dates of SCH st		ubscript line	36 for numb					36.00
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter		mber of period	ds MDH statu	S	O			37.00
in effect in the cost reporting period.	C.		20 €					20.00
38.00 Enter applicable beginning and ending dates of MDH st of periods in excess of one and enter subsequent date		abscript iine	38 101 Hullib	er				38. 00
				1.		Y/ 2.		-
39.00 Does this facility qualify for the inpatient hospital				me M	1			39. 00
hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes 40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	uirement or "N" f adjustm er 1. Er	ts in accordar for no. (see i nent? Enter "\ nter "Y" for y	nce with 42 nstructions /" for yes o) r 1	N	١	I	40. 00
no in column 2, for discharges on or after October 1.	(see ir	nstructions)			V	XVIII	XI X	
(DDC) 0 11 1					1. 00		3.00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital paymen	t for di	sproporti onat	te share in	accordance	N	N	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst					N	N	N	46. 00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300 PPS capi	tal? Fr	nter "Y for ve	es or "N" fo	r no	N	N	N	47.00
48.00 Is the facility electing full federal capital payment Teaching Hospitals 56.00 Is this a hospital involved in training residents in	? Enter	"Y" for yes	or "N" for	no.	N N	N N	N	48. 00
or "N" for no.	аррі очес	a dwil programs	s: Liitei i	Tor yes	"			
57.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of thi ", compl	"N" for no ir s cost report ete Worksheet	n column 1. ting period?	If column Enter "Y				57.00
58.00 If line 56 is yes, did this facility elect cost reimb	ursement	t for physicia	ans' service	s as	N			58.00
defined in CMS Pub. 15-1, § 2148? If yes, complete Wk 59.00 Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		N			59.00
60.00 Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"					N			60.00
provider-operated Criteria under 9413.63: Litter i	Y/N	I ME	Direct GM		/E	Di rec	t GME	
	1. 00	2. 00	3. 00	1	00	5.	20	-
61.00 Did your hospital receive FTE slots under ACA	1.00	2.00	3.00	4.	0.00	J.		61.00
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care		0.00	0	. 00				61. 01
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care		0. 00		. 00				61. 02
FTE count (excluding OB/GYN, general surgery FTEs,		0.00]	. 39				31.02

HOSPITAL AND HOSPITAL HEAL	TH CARE COMPLEX IDENTIFICATION DAT	A	Provi der	F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-2 Part I Date/Time Pre 5/19/2015 11:	pared:
		Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4.00	5.00	
and/or general surge	FTE count for primary care ery residents, which is used for acce with the 75% test. (see		0.00	0.0			61.0
1.04 Enter the number of surgery allopathic a	unweighted primary care/or and/or osteopathic FTEs in the ng period.(see instructions).		0.00	0.00			61.0
o1.05 Enter the difference and/or general surge primary care and/or	er between the baseline primary ery FTEs and the current year's general surgery FTE counts (line 03). (see instructions)		0.00	0.00			61. C
1.06 Enter the amount of used for cap relief	ACA §5503 award that is being and/or FTEs that are nonprimary gery. (see instructions)		0. 00	0.0			61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	61.05, specify each new program		1. 00	2. 00	3.00	4.00	61. 1
specialty, if any, a for each new prograr column 1, the prograp program code, enter unweighted count and FTE unweighted count of the FTEs in line program specialty, it residents for each a instructions) Enter enter in column 2, for each a for	and the number of FTE residents an (see instructions) Enter in am name, enter in column 2, the in column 3, the IME FTE d enter in column 4, direct GME t. 61.05, specify each expanded f any, and the number of FTE expanded program. (see in column 1, the program name, the program code, enter in column ghted count and enter in column				0.00		61. 2
						1.00	
	cting the Health Resources and Ser FTE residents that your hospital				od for which	0.00	62. 0
your hospital receives 2.01 Enter the number of during in this cost	/ed HRSA PCRE funding (see instruc FTE residents that rotated from a reporting period of HRSA THC prog	tions) Teachi ram. (s	ng Health Cent see instruction	er (THC) into			62. 0
33.00 Has your facility to	that Claim Residents in Nonprovide rained residents in nonprovider se for no in column 1. If yes, comple	ttings	during this co		period? Enter	N	63. 0
				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the	ACA Base Year FTE Residents in No	nprovi	der Settings	1.00 This base year	is your cost r	3.00 reporting	
period that begins of	on or after July 1, 2009 and befor	e June	30, 2010.				
	fline 63 is yes, or your facility riod, the number of unweighted non-			0.00	0.00	0. 000000	64.0

resident FTEs attributable to rotations occurring in all nonprovider	
settings. Enter in column 2 the number of unweighted non-primary care	
resident FTEs that trained in your hospital. Enter in column 3 the ratio	
of (column 1 divided by (column 1 + column 2)). (see instructions)	
Program Name Program Code Unweighted Unweighted Ratio (co	. 3/
FTEs FTEs in (col. 3 +	col.
Nonprovi der Hospi tal 4))	
Si te	
1.00 2.00 3.00 4.00 5.00	

Heal th	Financial Systems	MARGARET MA	ARY COMMUNIT	Y HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA				eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-2 Part I Date/Time Pre 5/19/2015 11:	pared:
		Program Name	Program	Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
<u> </u>	[1. 00	2. 0	0	3.00	4.00	5.00	/F 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 column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column				0.00	0.00	0. 000000	83.00
	4)). (see instructions)				Unwei ghted	Unweighted	Ratio (col. 1/	
					FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovide	r Setting	1.00 gsEffective fo	2.00 or cost reporti	ng periods	
66. 00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider sett ry care resi 3 the ratio	i ngs. dent of	0.00	0.00	0.000000 Ratio (col. 3/	
		1. 00	2.0		FTEs Nonprovi der Si te 3.00	FTEs in Hospital	(col. 3 + col. 4))	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 + column 4)). (see instructions)				0.00			67. 00
	4)). (see Instructions)					1.00	0 2.00 3.00	
	Inpatient Psychiatric Facility P		55)			1.00	2.00 3.00	70 -
	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, ente reporting period covers the begi or subsequent academic years of instructions) For cost reporting reporting period covers the begi teaching program in existence, e	e facility have an apefore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colunning of the fourth y the new teaching properiods beginning or nning of the sixth or ter 6 in column 3. (oproved GME 004? Enter lity train (D)? Enter umn 3. (see year, enter gram in exis n or after 0	teaching "Y" for y residents "Y" for y instructi 4 in colu tence, en ctober 1, uent acad	program in the ves or "N" for re in a new teach ves or "N" for rons) If this commn 3, or if the ter 5. (see 2012, if this	most io. (see iing io. sst e fifth cost	0	70. 00
	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re subprovider? Enter "Y" for yes	y PPS habilitation Facility			contain an IRF	N		75. 00

CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or 'instructions)	'N" for no in o	column 2. (see					
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sched	dul e? See 42	N				108. 00
	Physi cal	Occupati onal	Speec	h	Respi r	atory	
	1.00	2.00	3.00		4. 0	00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N		109. 00
					1. 0	00	
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)fo	r	N		110. 00
				1. 00	2. 00	3.00	
Miscellaneous Cost Reporting Information							
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, §2208.1.	If column 2 int for long ter	s "E", enter i rm care (includ	n column es	N		0	115. 00
116.00 Is this facility classified as a referral center? Enter "Y"	for yes or "N'	' for no.		N			116. 00
117.00 s this facility legally-required to carry malpractice insurno.	rance? Enter "\	for yes or "	N" for	N			117. 00
118.00 is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 i	f the policy i	S	1			118. 00

Health Financial Systems MARGARET MARY COMM				u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		Period: From 01/01/2014 To 12/31/2014	Date/Time P	repared:
		Premi ums	Losses	5/19/2015 1 Insurance	1: 49 am
		1.00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		1.00	0 0		0118.01
			1.00		
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched			1. 00 N	2.00	118. 02
and amounts contained therein. 119.00D0 NOT USE THIS LINE					119. 00
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 qualified Harmless provision in ACA §3121 and applicable amendments.	column 1, "Y alifies for t	" for yes or he Outpatient	N	N	120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	ntable device	s charged to	Υ		121. 00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" fo	m 1100 cm d 11111	for no 15	N.I.		125 00
yes, enter certification date(s) (mm/dd/yyyy) below.	,		N		125. 00
126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2					126. 00
127.00 f this is a Medicare certified heart transplant center, ent- in column 1 and termination date, if applicable, in column 2		ication date			127. 00
128.00 If this is a Medicare certified liver transplant center, entire in column 1 and termination date, if applicable, in column 2	er the certif	ication date			128. 00
129.00 If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2.			ו		129. 00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col	umn 2.				130. 00
131.00 f this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col	umn 2.				131. 00
132.00 f this is a Medicare certified islet transplant center, ent in column 1 and termination date, if applicable, in column 2					132.00
133.00 If this is a Medicare certified other transplant center, entin column 1 and termination date, if applicable, in column 2 134.00 If this is an organ procurement organization (OPO), enter the					133. 00
and termination date, if applicable, in column 2. All Providers	e of o fidiliber	TH COLUMN 1			134.00
140.00 Are there any related organization or home office costs as d chapter 10? Enter "Y" for yes or "N" for no in column 1. If are claimed, enter in column 2 the home office chain number.	yes, and home (see instruc	office costs	N		140. 00
1.00 2.00 If this facility is part of a chain organization, enter on I		ugh 1/3 the n	3.00	of the	
home office and enter the home office contractor name and co			alle and address	or the	
141. 00 Name: Contractor's Name: 142. 00 Street: PO Box:			or's Number:		141. 00 142. 00
143. 00 Ci ty: State:		Zi p Code:			143. 00
				1.00	
144.00 Are provider based physicians' costs included in Worksheet A				Y	144. 00
145.00 f costs for renal services are claimed on Worksheet A, line only? Enter "Y" for yes or "N" for no.	74, are the	costs for inpa	atient services	N	145. 00
			1. 00	2.00	
146.00 Has the cost allocation methodology changed from the previou Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1 the approval date (mm/dd/yyyy) in column 2.			N		146. 00
147.00 Was there a change in the statistical basis? Enter "Y" for y 148.00 Was there a change in the order of allocation? Enter "Y" for			N N		147. 00 148. 00
149.00 Was there a change to the simplified cost finding method? En no.			N		149. 00
	Part A	Part B	Title V	Title XIX	
Does this facility contain a provider that qualifies for an					
or charges? Enter "Y" for yes or "N" for no for each compone 155.00Hospital	ent for Part A N	and Part B. N	(See 42 CFR §413	3. 13) N	155. 00
156.00 Subprovi der - IPF	N	N	N N	N N	156. 00
157. 00 Subprovi der - IRF	N	N	N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF	N	N	N	N	158. 00 159. 00
160.00 HOME HEALTH AGENCY	N	N	N	N	160. 00
161. 00 CMHC		N	N	N	161. 00

Health Financial Systems	MARGARET MARY	COMMUNIT	Y HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Provi der C	CCN: 15132		01/01/2014	Worksheet S- Part I Date/Time Pr 5/19/2015 11	epared:
							1. 00	_
Multicampus							1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that ha	is one or	more campus	ses in di	fferent	CBSAs?	N	165. 00
	Name	Со	unty	State	Zip Co	de CBSA	FTE/Campus	
	0	1	. 00	2. 00	3.00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							O. C	00 166. 00
Health Information Technology (HI	C) inconting in the Am	mori con Do	acovery and	Doi pyos:	tmont Ac	.+	1.00	
167.00 s this provider a meaningful user	under Section \$1886	n)? Fnte	r "Y" for v	ves or "N	d" for n	. ι Ο	Υ	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the h	05 is "Y") and is a me	ani ngful						33 168. 00
169.00 If this provider is a meaningful utransition factor. (see instruction		and is n	ot a CAH (I	ine 105	is "N")	, enter the	0.0	00169.00
						Begi nni ng	Endi ng	
						1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	eginning date and end	ling date	for the rep	porti ng		01/01/2014	12/31/2014	170. 00
							1.00	
171.00 If line 167 is "Y", does this prov Medicare cost plans reported on Wk (see instructions)							N	171. 00

PI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provi der	CCN: 151329	Peri od: From 01/01/2014	Worksheet S-2 Part II	
					To 12/31/2014	Date/Time Pro 5/19/2015 11:	epare
					Y/N	Date	1
	Constant I action the Constant V for all VCC according	F-+ N 6	I I NO		1.00	2. 00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	onses. Enter N T	or all No re	sponses. Ente	er all dates in t	.ne	
	Provider Organization and Operation						
0	Has the provider changed ownership immediatel reporting period? If yes, enter the date of t				N		1
	reporting perrous in yes, enter the date or t	the change in con	ulli 2. (See	Y/N	Date	V/I	
.0		M. I' D.	0.16	1. 00	2. 00	3. 00	
0	Has the provider terminated participation in yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.	on and in column	gram? IT 3, "V" for	N			2
0	Is the provider involved in business transact 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 f	, chain home off to the provider , or members of	ices, drug or its the board	N			
	relationships? (see instructions)			Y/N	Type	Date	
				1.00	2. 00	3.00	
0	Financial Data and Reports Column 1: Were the financial statements prep	parod by a Contif	Find Dublin	Y	^	02/14/2015	
U	Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for enter date avail	Compiled,	Y	A	03/16/2015	'
0	column 3. (see instructions) If no, see instr Are the cost report total expenses and total	revenues differe		N			
	those on the filed financial statements? If y	es, submit recor	iciliation.		Y/N	Legal Oper.	
					1. 00	2. 00	
o	Approved Educational Activities Column 1: Are costs claimed for nursing scho	ool 2 Column 2: I	f ves is th	e provider is	s N		١.
	the legal operator of the program?			e provider 13	, , , ,		
))	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog	grams approved an		during the	N N		
)	cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program		current cos	t report? If	N		
00	yes, see instructions. Was an Intern-Resident program been initiated	d or renewed in t	he current c	ost reporting	ı N		1
00	period? If yes, see instructions.						
00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		k in an App	rovea	N		1
						Y/N	
	Bad Debts					1.00	
00	Is the provider seeking reimbursement for bac	,				Υ	1
00	If line 12 is yes, did the provider's bad deb period? If yes, submit copy.	ot collection pol	icy change d	uring this co	ost reporting	N	1
00	If line 12 is yes, were patient deductibles a	and/or co-payment	s waived? If	yes, see ins	structi ons.	N	1
	Bed Complement			!		NI .	
00_	Did total beds available change from the price	or cost reporting	period? if	r -	art A	N Part B	1
		Descri pt	ti on	Y/N	Date	Y/N	
	PS&R Data	0		1.00	2. 00	3. 00	
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see			Y	03/05/2015	Y	1
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records			N		N	1
	for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)						
00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file			N		N	1
	this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments			N		N	11
00	made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.						

Health Financial Systems	MARGARET MARY COMMUNI	TY HOSPITAL	I	n Lieu of Form CMS-2552-10
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HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 151329 From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/19/2015 11:49 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the N 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If yes, see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see 25.00 25.00 Ν instructions. 26.00 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 copy Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions Provi der-Based Physi ci ans Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Υ 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 N 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position KYLF SMI TH 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel v. BLUE & CO., LLC 42.00 Enter the employer/company name of the cost report 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317-713-7957 KCSMI TH@BLUEANDCO. COM 43.00 report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 151329 Peri od: Worksheet S-2 From 01/01/2014 To 12/31/2014 Part II Date/Time Prepared: 5/19/2015 11:49 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 03/05/2015 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

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

43.00

43.00

Enter the telephone number and email address of the cost

report preparer in columns 1 and 2, respectively.

Health Financial Systems MARGARET MARGA Provi der CCN: 151329

						То	12/31/2014	Date/Time Pre 5/19/2015 11:	
				1				I/P Days / 0/P	17 (3111
								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		18	6, 57	70	98, 352. 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			18	6, 57	70	98, 352. 00	0	7. 00
	beds) (see instructions)								
8.00	INTENSIVE CARE UNIT	31. 00		7	2, 55	55	7, 080. 00	0	8. 00
9.00	CORONARY CARE UNIT								9. 00
10.00	BURN INTENSIVE CARE UNIT								10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT								11. 00 12. 00
12.00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43. 00						0	12.00
14. 00	Total (see instructions)	43.00		25	9, 12	25	105, 432. 00	0	14. 00
15. 00	CAH visits			20	,, 12	-	100, 102. 00	0	15. 00
16. 00	SUBPROVIDER - IPF								16. 00
17. 00	SUBPROVIDER - IRF								17. 00
18.00	SUBPROVI DER								18. 00
19. 00	SKILLED NURSING FACILITY								19. 00
20.00	NURSING FACILITY								20. 00
21. 00	OTHER LONG TERM CARE								21. 00
22. 00	HOME HEALTH AGENCY	101. 00						0	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	11/ 00		0					23. 00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	116. 00 30. 00		0	'	12			24. 00 24. 10
25. 00	CMHC - CMHC	30.00							25. 00
26. 00	RURAL HEALTH CLINIC	88. 00						0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	00.00						Ŭ	26. 25
27. 00	Total (sum of lines 14-26)			25	5				27. 00
28. 00	Observation Bed Days							0	28. 00
29. 00	Ambul ance Tri ps								29. 00
30.00	Employee discount days (see instruction)								30. 00
31. 00	Employee discount days - IRF								31. 00
32. 00	Labor & delivery days (see instructions)			0		0			32. 00
32. 01	Total ancillary labor & delivery room								32. 01
22 00	outpatient days (see instructions)								22 00
33. 00	LTCH non-covered days		l		1	- 1			33. 00

 Heal th Financial
 Systems
 MARGARET MARY COMMUNITY HOSPITAL

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider Complex Statistical Data

Provi der CCN: 151329

Component Title XVIII Title XIX Total All Total Interns Employees On Patients & Residents Payrol I
1.00 Hospi tal Adul ts & Peds. (col umns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospi ce days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 453 566 2.00 3.00 HMO I PF Subprovi der 0 0 0 4.00 4.00 HMO I RF Subprovi der 0 0 0 4.00 5.00 Hospi tal Adul ts & Peds. Swing Bed SNF 0 0 0 5.00 6.00 Hospi tal Adul ts & Peds. Swing Bed NF 0 0 0 5.00 Total Adul ts and Peds. (exclude observation beds) (see instructions) 1,716 209 4,098 7.00 10.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 453 566 2.00 3.00 HMO IPF Subprovider 0 0 0 0 0 0 0 0 0
1.00 Hospi tal Adul ts & Peds. (col umns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 1,716 209 4,098 1.00 2.00 HMO and other (see instructions) 453 566 2.00 3.00 HMO IPF Subprovi der 0 0 3.00 4.00 HMO IRF Subprovi der 0 0 4.00 5.00 Hospi tal Adul ts & Peds. Swing Bed SNF 0 0 0 5.00 6.00 Hospi tal Adul ts & Peds. Swing Bed NF 0 0 0 6.00 7.00 7.00 Total Adul ts and Peds. (exclude observation beds) (see instructions) 1,716 209 4,098 7.00
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 453 566 2.00 3.00 HM0 IPF Subprovider 0 0 4.00 HM0 IRF Subprovider 0 0 4.00 Hospital Adults & Peds. Swing Bed SNF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
for the portion of LDP room available beds) 2.00 HMO and other (see instructions)
2.00 HMO and other (see instructions) 453 566 3.00 HMO IPF Subprovider 0 0 4.00 HMO IRF Subprovider 0 0 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 6.00 Hospital Adults & Peds. Swing Bed NF 0 0 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 1,716 209 4,098
3.00
4.00 HM0 I RF Subprovi der 0 0 4.00 5.00 Hospi tal Adul ts & Peds. Swing Bed SNF 0 0 0 5.00 6.00 Hospi tal Adul ts & Peds. Swing Bed NF 0 0 0 6.00 7.00 Total Adul ts and Peds. (exclude observation beds) (see instructions) 1,716 209 4,098 7.00
5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 0 0 7.00 4,098 6.00 7.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 1,716 209 4,098 7.00
beds) (see instructions)
8 UU TINTENSIVE LARE UNTT
9. 00 CORONARY CARE UNIT
10. 00 BURN NTENSI VE CARE UNI T 10. 00 11. 00 SURGI CAL NTENSI VE CARE UNI T 11. 00 11. 00 11. 00
11. 00 SURGI CAL INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 11. 00
13. 00 NURSERY 0 988 13. 00
13. 00 Norder 14. 00 Total (see instructions) 1, 894 214 5, 381 0. 00 440. 18 14. 00
15. 00 CAH vi si ts 0 0 0 0 15. 00
16. 00 SUBPROVI DER - I PF
17. 00 SUBPROVI DER - I RF
18. 00 SUBPROVI DER 18. 00
19. 00 SKILLED NURSING FACILITY
20. 00 NURSING FACILITY 20. 00
21. 00 OTHER LONG TERM CARE
22. 00 HOME HEALTH AGENCY 6, 082 935 10, 877 0. 00 18. 45 22. 00
23.00 AMBULATORY SURGICAL CENTER (D. P.)
24. 00 HOSPI CE 0 0 0 0 0.00 11. 29 24. 00
24. 10 HOSPICE (non-distinct part) 0 0 0 24. 10
25. 00 CMHC - CMHC 25. 00
26. 00 RURAL HEALTH CLINIC 1, 235 150 4, 560 0. 00 6. 17 26. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 25
27.00 Total (sum of lines 14-26) 0.00 476.09 27.00
28.00 Observation Bed Days 20 896 28.00
29. 00 Ambul ance Tri ps 0 29. 00
30.00 Employee discount days (see instruction) 0 30.00
31. 00 Employee discount days - IRF 0 31. 00
32.00 Labor & delivery days (see instructions) 0 0 0 32.00
32.01 Total ancillary Labor & delivery room 0 32.01
outpatient days (see instructions)
33. 00 LTCH non-covered days 0 33. 00

Health Financial Systems MARGARET MARGA

Provi der CCN: 151329

Peri od: Worksheet S-3 From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared: 5/19/2015 11: 49 am

							5/19/2015 11:	49 am
		Full Time			Di sch	arges		
	0	Equi val ents	T: +1 - 1/		Title XVIII	T: +1 - VIV	T-+-1 All	
	Component	Nonpai d Workers	Title V		II tie xviii	Title XIX	Total All Patients	
		11.00	12. 00	-	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	0	622	75	15.00	1. 00
1.00	8 exclude Swing Bed, Observation Bed and			۷	022	73	1, 392	1.00
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)			ł	120	244		2. 00
3.00	HMO IPF Subprovider			ł	120	244		3. 00
4. 00	HMO IRF Subprovider			ł				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF			- 1				5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF			- 1				6. 00
7. 00	Total Adults and Peds. (exclude observation			- 1				7. 00
7.00	beds) (see instructions)							7.00
8. 00	INTENSIVE CARE UNIT			ł				8. 00
9. 00	CORONARY CARE UNIT			ł				9. 00
10.00	BURN INTENSIVE CARE UNIT			ł				10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT			ł				11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)			ł				12. 00
13. 00	NURSERY			ł				13. 00
14. 00	Total (see instructions)	0.00		o	622	75	1, 592	14. 00
15. 00	CAH visits	0.00		۷	022	73	1, 392	15. 00
16. 00	SUBPROVIDER - IPF			ł				16. 00
17. 00	SUBPROVIDER - IPF			ł				17. 00
18.00	SUBPROVI DER			ł				18. 00
19. 00								19.00
20. 00	SKILLED NURSING FACILITY NURSING FACILITY							20. 00
								20.00
21. 00	OTHER LONG TERM CARE	0.00						21.00
22. 00 23. 00	HOME HEALTH AGENCY	0.00						23. 00
	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	0. 00						24. 00
24. 00 24. 10	HOSPICE (non-distinct part)	0.00		ł				24. 00
25. 00	CMHC - CMHC			ł				25. 00
26. 00	RURAL HEALTH CLINIC	0. 00		ł				26. 00
26. 25		0.00		ł				26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00						26. 25
28. 00	Total (sum of lines 14-26)	0.00						28. 00
28.00	Observation Bed Days							28.00
	Ambul ance Trips Employee discount days (see instruction)							29. 00 30. 00
30. 00 31. 00								30.00
	Employee discount days - IRF			- 1				
32. 00	Labor & delivery days (see instructions)							32. 00
32. 01	Total ancillary labor & delivery room							32. 01
22 00	outpatient days (see instructions) LTCH non-covered days							33. 00
33.00	LIGHTHON-COVERED DAYS			I		I		33.00

Heal th	Financial Systems MAI	RGARET MARY COM	IMUNITY HOSPITA	L	In Lie	eu of Form CMS-:	2552-10
HOME H	IEALTH AGENCY STATISTICAL DATA			CCN: 151329	Period: From 01/01/2014		
			Componen	t CCN: 157143	To 12/31/2014	5/19/2015 11:	
					Home Health Agency I	PPS	
					1.	00	-
0. 00	County	Title V	Title XVIII	Title XIX	Other	Total	0. 00
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	C		0 0	0	1.00
2. 00	Unduplicated Census Count (see instructions)	0.00	317.00		0.00 ployees (Full Ti		2. 00
					F3 (q,	
		F., 4		C+-66	Ct	Takal	
		Enter the numb your normal		Staff	Contract	Total	
)	1.00	2. 00	3. 00	
2.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						2.00
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		0.00	0.	0.00	0.00	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			0. (l .	1
7.00	Nursi ng Supervi sor			0.	0.00	0.00	7. 00
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			0. (1
10.00	Occupational Therapy Service			0.	0.00	0.00	10. 00
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0. (1
13.00	Speech Pathology Supervisor			0.			1
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0. (1
16.00	Home Heal th Aide			0. (1
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0. (1
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				2		19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			17140			20. 00
	during this cost reporting period (line 20 contains the first code).						
20. 01		Full Ep	oi sodes	99915			20. 01
		Without Outliers	With Outliers	LUPA Epi sode	PEP Only Epi sodes	Total (cols. 1-4)	
	PPS ACTIVITY DATA	1.00	2. 00	3.00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	3, 111			43 73		21. 00
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	476, 787 1, 727	1	1	36 10, 920 28 10	l .	1
24.00	Physical Therapy Visit Charges	330, 473	C	4, 0		336, 533	24. 00
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	478 99, 576		1	4 1 48 216	483 100, 440	1
27. 00	Speech Pathology Visits	48	C		0 0	48	27. 00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	9, 810		1	0 0	9, 810 8	1
30.00	Medical Social Service Visit Charges	2, 240	C		0 0	2, 240	30. 00
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	419 40, 689			4 0 96 0	423 41, 085	
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5, 791	l e	1	79 84		
34. 00	Other Charges	0	(()	1	0 0	000 407	1
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	959, 575					
36. 00	Total Number of Episodes (standard/non outlier)	346		!	50 8	404	36. 00
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	49, 964	582	1, 1	0 36 193	1 51, 925	37. 00 38. 00

	Financial Systems MAR FAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	RGARET MARY COM LED HEALTH CENT		CCN: 151329	Peri od:	eu of Form Cl Worksheet		
TATI S	STICAL DATA		Componen	t CCN: 158511	From 01/01/2014 To 12/31/2014		Prep	
					Rural Health Clinic (RHC) I	Cos		
					1.	. 00		
	Clinic Address and Identification							
00	Street				112 N. BUCKEYE			1.
			С	i ty	State	Zip Code		
			1	. 00	2. 00	3. 00		
00	City, State, Zip Code, County		OSGOOD		11	47037		2.
						1.00		
00	FOHCs ONLY: Designation - Enter "R" for rural	or "U" for ur	ban				0	3.
					Grant Award	Date		
					1. 00	2. 00		
	Source of Federal Funds							
00	Community Health Center (Section 330(d), PHS	Act)			C			4
00	Migrant Health Center (Section 329(d), PHS Ac				C			5.
00	Health Services for the Homeless (Section 340	O(d), PHS Act)			C			6
00	Appalachian Regional Commission				C			7
00	Look-Alikes				C			8
00	OTHER (SPECIFY)				C			9
					1. 00	2.00		
. 00	Does this facility operate as other than an F	DUC or EOUC2 En	tor "V" for v	os or "N" for		2.00	0	10
. 00	no in column 1. If yes, indicate number of ot	ther operations	in column 2.	(Enter in	IN			10
	subscripts of line 11 the type of other opera	Sun			londay	Tuesday		
		from	to		to	from		
		1.00	2. 00	3.00	4. 00	5. 00		
	Facility hours of operations (1)	11.00	2.00	1 0.00	11 00	0.00		
	Clinic			08: 00	16: 30	08: 00		11
					1 00	2 00		
00	Have you received an approval for an exception	on to the produ	ctivity ctand	ord?	1.00	2.00		12
	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column in column in column in column.	d in CMS Pub. 1	00-04, chapte	r 9, section	1. 00 N N	2.00	0	
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. 1 umn 1. If yes,	00-04, chapte enter in colu	r 9, section mn 2 the	N	2.00	0	
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu	d in CMS Pub. 1 umn 1. If yes,	00-04, chapte enter in colu	r 9, section mn 2 the ders and	N	2.00		12 13
3. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.	d in CMS Pub. 1 umn 1. If yes,	00-04, chapte enter in colu	r 9, section mn 2 the ders and	N N			
3. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapte enter in colu of all provi	r 9, section mn 2 the ders and	N N 1 der name 1.00	CCN number	r	13
3. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapte enter in colu of all provi V	r 9, section mn 2 the ders and Provi	N N N ider name 1.00	CCN number 2.00	r	13
1. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. Provider name, CCN number	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapte enter in colu of all provi V 2.00	r 9, section mn 2 the ders and Provi XVIII 3.00	N N N 1 der name 1.00	CCN number 2.00 Total Visi 5.00	r	13
1. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapte enter in colu of all provi V 2.00	r 9, section mn 2 the ders and Provi	N N N ider name 1.00	CCN number 2.00 Total Visi 5.00	r	13
B. 00 H. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapte enter in colu of all provi V 2.00	r 9, section mn 2 the ders and Provi XVIII 3.00	N N N 1 der name 1.00	CCN number 2.00 Total Visi 5.00	r	13
. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapte enter in colu of all provi V 2.00	r 9, section mn 2 the ders and Provi XVIII 3.00	N N N 1 der name 1.00	CCN number 2.00 Total Visi 5.00	r	13
. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapte enter in colu of all provi V 2.00	r 9, section mn 2 the ders and Provi XVIII 3.00	N N N 1 der name 1.00	CCN number 2.00 Total Visi 5.00	r	13
. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapte enter in colu of all provi V 2.00	r 9, section mn 2 the ders and Provi XVIII 3.00	N N N 1 der name 1.00	CCN number 2.00 Total Visi 5.00	r	13
. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapte enter in colu of all provi V 2.00	r 9, section mn 2 the ders and Provi XVIII 3.00	N N N 1 der name 1.00	CCN number 2.00 Total Visi 5.00	r	13
. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapte enter in colu of all provi V 2.00	r 9, section mn 2 the ders and Provi XVIII 3.00	N N N 1 der name 1.00	CCN number 2.00 Total Visi 5.00	r	13
. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapte enter in colu of all provi V 2.00	Provi	N N N 1 der name 1.00	CCN number 2.00 Total Visi 5.00	r	13
. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapte enter in colu of all provi V 2.00	Provi	N N N 1 der name 1.00	CCN number 2.00 Total Visi 5.00	r	13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	d in CMS Pub. 1 umn 1. If yes, List the names	00-04, chapte enter in colu of all provi V 2.00	Provi	N N N 1 der name 1.00	CCN number 2.00 Total Visi 5.00	r	14
4. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	d in CMS Pub. 1 Junn 1. If yes, List the names Y/N 1.00	O0-04, chapte enter in colu of all provi V 2.00	r 9, section mn 2 the ders and Provi XVIII 3.00 unty .00	N N N N N N N N N N N N N N N N N N N	CCN number 2.00 Total Visit 5.00	r	13
4. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	d in CMS Pub. 1 umn 1. If yes, List the names	O0-04, chapte enter in colu of all provi V 2.00	Provi	N N N N N N N N N N N N N N N N N N N	CCN number 2.00 Total Visi 5.00	r	13
4. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	d in CMS Pub. 1 Junn 1. If yes, List the names Y/N 1.00 Tuesday	00-04, chapte enter in colu of all provi V 2.00 Co 4	r 9, section mn 2 the ders and Provi XVIII 3.00 unty .00	N N N 1 der name 1.00 XIX 4.00	CCN number 2, 00 Total Visit 5, 00	r	

Health Financial Systems MA	RGARET MARY	COMMUNI	TY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	FIED HEALTH C	ENTER	Provi der	CCN: 151329	Peri od:	Worksheet S-8	
STATISTICAL DATA			Component	CCN: 158511	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/19/2015 11:	pared: 49 am
					Rural Health	Cost	
					Clinic (RHC) I		
	F	ri day		Sa	turday		
	from		to	from	to		
	11. 00		12.00	13.00	14.00		
Facility hours of operations (1)							
11. 00 Clinic	08: 00	12: 00)				11. 00

HOSPITAL IDENTIFICATION DATA Provider CCN: 151329 Period: Worksheet S-9 From 01/01/2014 Parts I & II	Health Financial Systems	MARGARET MARY COMMUNIT	u of Form CMS-2552-10		
110111 01/01/2011 141 (5 1 4 11	HOSPITAL IDENTIFICATION DATA		Provider CCN: 151329		Worksheet S-9
Component CCN: 151551 To 12/31/2014 Date/Time Prepretation			Component CCN: 151551		
Hospi ce I				Hospi ce I	

						Hospi ce I		
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility			·	
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	6, 816	246	3, 299	0	732	7, 794	2.00
3.00	Inpatient Respite Care	10	0	0	0	0	10	3.00
4.00	General Inpatient Care	2	O	0	0	0	2	4.00
5.00	Total Hospice Days	6, 828	246	3, 299	0	732	7, 806	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	100	11	65	0	22	133	6.00
	Hospi ce Care							
7.00	Total Number of Unduplicated	0. 00		0.00				7.00
	Continuous Care Hours Billable							
	to Medicare							
8.00	Average Length of Stay (line	68. 28	22. 36	50. 75	0. 00	33. 27	58. 69	8.00
	5/line 6)							
9.00	Unduplicated Census Count	123	11	64	0	22	156	9.00

	Financial Systems MARGARET MARY COMMUNITY				u of Form CMS-2	
HOSPI 7	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 151329	Peri od: From 01/01/2014	Worksheet S-10	0
				To 12/31/2014	Date/Time Pre	
				,	5/19/2015 11:	49 am
					1. 00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid Medicaid (see instructions for each line)	ded by lin	ne 202 column	1 8)	0. 390784	1.00
2. 00	Net revenue from Medicaid				3, 628, 529	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.0
4. 00	If line 3 is "yes", does line 2 include all DSH or supplemental p	payments 1	from Medicaio	! ?		4.0
5. 00	If line 4 is "no", then enter DSH or supplemental payments from N	Medi cai d			0	5.0
6. 00	Medi cai d charges				10, 101, 908	6.0
7. 00	Medicaid cost (line 1 times line 6)				3, 947, 664	7.0
8. 00	Difference between net revenue and costs for Medicaid program (Ii	ne 7 minu	us sum of lir	nes 2 and 5; if	319, 135	8.0
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ach line)			
9. 00	Net revenue from stand-alone SCHIP				0	9. 0
10. 00	Stand-alone SCHIP charges				0	
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. 0
	enter zero)					
10 00	Other state or local government indigent care program (see instru				0	100
13.00	Net revenue from state or local indigent care program (Not include the control of				0	
14. 00	Charges for patients covered under state or local indigent care p	orogram (i	Not included	in lines 6 or	0	14.0
15. 00	10) State or local indigent care program cost (line 1 times line 14)				0	15. 0
16. 00		nent care	program (Lir	na 15 minus lina	0	
10.00	13; if < zero then enter zero)	gent care	program (TT	ie is illinus iine	O	10.0
	Uncompensated care (see instructions for each line)					ĺ
17. 00	Private grants, donations, or endowment income restricted to fund	ding chari	ity care		0	17.0
18. 00	Government grants, appropriations or transfers for support of hos				0	18.0
19. 00	Total unreimbursed cost for Medicaid, SCHIP and state and local			ns (sum of lines	319, 135	19.0
	8, 12 and 16)		. 0			
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1.00	2. 00	3. 00	
20. 00	Total initial obligation of patients approved for charity care (a		2, 064, 13	39 0	2, 064, 139	20. 0
21 00	charges excluding non-reimbursable cost centers) for the entire to		00/ //	32 0	00/ /22	21 0
21. 00	Cost of initial obligation of patients approved for charity care times line 20)	(Tine I	806, 63	0	806, 632	21.0
22. 00	1			0 0	0	22. 0
	Cost of charity care (line 21 minus line 22)		806, 63	-	806, 632	
23.00	cost of chartty care (fine 21 minus fine 22)		000, 0	52 0	000, 032	23.0
					1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient of		nd a Length o	of stay limit	N	24.0
25 22	imposed on patients covered by Medicaid or other indigent care pr				_	25.0
25. 00	If line 24 is "yes," charges for patient days beyond an indigent		ogram s rengt	in or stay limit	0	
26. 00					6, 689, 424	
27. 00		,	o lino 27)		407, 161	1
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line		,	20)	6, 282, 263	1
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exper	ise (IIIne	i times iine	: 20)	2, 455, 008	
	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line	30)			3, 261, 640 3, 580, 775	
	TIVIAL UNICIMPULSEU AND UNCOMPENSALEU CALE COST UTILE 19 DIUS ITIE	- 301			J. JOU. //J	1 o 1. ()

Heal th	Financial Systems MAR	RGARET MARY COMMU	JNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	CCN: 151329 P	eri od:	Worksheet A	
					rom 01/01/2014 o 12/31/2014	Date/Time Pre 5/19/2015 11:	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati		
				+ col . 2)	ons (See A-6)		
						(col. 3 +- col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		3, 281, 658			3, 270, 667	1.00
1. 01	OO101 NEW CAP REL COSTS-OFFSITE BLDG OO200 NEW CAP REL COSTS-MVBLE EQUIP		608, 878			619, 869	1. 01
2. 00 2. 01	00200 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		3, 655, 632 0			3, 538, 790 116, 842	2. 00 2. 01
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	163, 561	9, 480, 917			9, 644, 478	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	4, 351, 225	5, 790, 270			10, 345, 205	5. 00
7.00	00700 OPERATION OF PLANT	0	1, 324, 803			1, 324, 803	
7. 01	00701 OPERATION OF PLANT -OFFSITE	0	109, 401		0	109, 401	7. 01
7. 02	00702 OPERATION OF PLANT - HOSPITAL & OFFS	469, 536	13, 081		0	482, 617	7. 02
8.00	00800 LAUNDRY & LI NEN SERVI CE	79, 917	56, 224			136, 141	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	603, 006	251, 672			854, 678	9. 00 10. 00
11. 00	01100 CAFETERI A	800, 588	492, 865 0			217, 961 1, 075, 492	
13. 00	01300 NURSI NG ADMI NI STRATI ON	688, 713	25, 359			714, 072	
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	392, 809			392, 809	14. 00
15.00	01500 PHARMACY	542, 971	1, 928, 810			2, 471, 781	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	873, 998	138, 742	1, 012, 740	0	1, 012, 740	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	1, 305, 247	115, 447			1, 960, 153	
31. 00 43. 00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	322, 518 0	18, 353 7, 000			340, 871 569, 717	31. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	7,000	7,000	562, 717	309, 717	43.00
50.00	05000 OPERATING ROOM	1, 358, 184	2, 591, 819	3, 950, 003	-1, 348, 762	2, 601, 241	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	985, 525	214, 771			98, 120	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 707, 016	4, 554, 287	7, 261, 303	-28, 043	7, 233, 260	54.00
60.00	06000 LABORATORY	1, 207, 305	1, 722, 319			2, 929, 624	
60. 01	06001 BLOOD LABORATORY	0	0	-	_	0	60. 01
65. 00	06500 RESPIRATORY THERAPY	426, 244	69, 926			496, 170	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	936, 715 361, 668	71, 203 34, 947			1, 007, 918 396, 615	
68. 00	06800 SPEECH PATHOLOGY	181, 066	3, 370			148, 969	
69. 00	06900 ELECTROCARDI OLOGY	489, 290	298, 247			787, 537	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0			0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	1, 384, 593	1, 384, 593	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	405 200	58, 665	544, 053	0	544, 053	00.00
88. 00 90. 00	09000 CLINIC	485, 388 1, 427, 282	243, 255			1, 670, 537	88. 00 90. 00
90. 01	09001 WOUND CLINC	210, 846	179, 703			390, 549	90.00
91. 00	09100 EMERGENCY	1, 637, 359	1, 927, 943	1		3, 565, 302	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS			,			
101.00	10100 HOME HEALTH AGENCY	1, 224, 932	203, 262	1, 428, 194	0	1, 428, 194	101. 00
112 00	SPECIAL PURPOSE COST CENTERS					0	112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	583, 164	0 311, 967			895, 131	113.00
118.00	1 1	24, 423, 264	40, 177, 605			64, 776, 900	
110.00	NONREI MBURSABLE COST CENTERS	24, 423, 204	40, 177, 003	04,000,007	170,031	04, 770, 700	1110.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	6, 678, 846	1, 532, 729	8, 211, 575	28, 043	8, 239, 618	192. 00
	19201 PRI VATE DUTY	0	0		0		192. 01
	07950 COMMUNITY RELATIONS	189, 004	466, 448			415, 911	
	07951 COMMUNITY BENEFITS	291, 217	110, 542			401, 759	
	07952 OTHER NONREIMBURSABLE COST CENTERS	15 050	20 202			35, 467	
200.00		15, 059 31, 597, 390	38, 282 42, 325, 606			53, 341 73, 922, 996	
200.00	1.01.12 (00.11 0.11 1.11 1.11 1.11 1.11 1.11 1.	3.,5,7,5,0	.2, 525, 500	, 5, ,22, ,,0	١	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,=55. 55

Period: Worksheet A From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/19/2015 11: 49 am

				5/19/2015 11:	49 am
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-1, 008, 812	2, 261, 855	5	1. 00
1. 01	00101 NEW CAP REL COSTS-OFFSITE BLDG	0	619, 869		1. 01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-322, 188	3, 216, 602		2. 00
2. 01	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	116, 842	2	2. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-2, 124, 196			5. 00
7.00	00700 OPERATION OF PLANT	-6, 102		1	7. 00
7. 01	00701 OPERATION OF PLANT -OFFSITE	0	109, 401	l .	7. 01
7. 02	00702 OPERATION OF PLANT - HOSPITAL & OFFS	0		1	7. 02
8. 00	00800 LAUNDRY & LINEN SERVICE	-721	135, 420		8. 00
9. 00	00900 HOUSEKEEPING	, , ,	854, 678		9. 00
10. 00	01000 DI ETARY	-26, 352			10.00
	01100 CAFETERI A	-271, 679			11. 00
	01300 NURSING ADMINISTRATION	-2/1,0/9		1	13. 00
	01400 CENTRAL SERVICES & SUPPLY			1	14. 00
	01500 PHARMACY			1	15. 00
	l l				1
16.00	01600 MEDI CAL RECORDS & LI BRARY	-3, 304	1, 009, 436		16. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1 0/0 450	J	
30.00	03000 ADULTS & PEDI ATRI CS	0		l control of the cont	30.00
	03100 NTENSI VE CARE UNI T	0		1	31.00
43.00	04300 NURSERY	0	569, 717		43. 00
	ANCILLARY SERVICE COST CENTERS	_			
50.00	05000 OPERATING ROOM	0		1	50. 00
	05200 DELIVERY ROOM & LABOR ROOM	0			52. 00
	05400 RADI OLOGY-DI AGNOSTI C	-814, 374			54. 00
	06000 LABORATORY	0	_,,	1	60.00
	06001 BLOOD LABORATORY	0	0		60. 01
65. 00	06500 RESPI RATORY THERAPY	0	496, 170		65. 00
66. 00	06600 PHYSI CAL THERAPY	-17, 345	990, 573	3	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	396, 615	5	67. 00
68.00	06800 SPEECH PATHOLOGY	0	148, 969		68. 00
69.00	06900 ELECTROCARDI OLOGY	-149, 079	638, 458	3	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 384, 593	3	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0			73. 00
	OUTPATIENT SERVICE COST CENTERS	•	•		
88. 00	08800 RURAL HEALTH CLINIC	0	544, 053	3	88. 00
90. 00	09000 CLI NI C	-456, 879		1	90.00
	09001 WOUND CLINC	0	390, 549	l .	90. 01
	09100 EMERGENCY	-1, 516, 523		1	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,010,020	2,010,777		92. 00
72.00	OTHER REIMBURSABLE COST CENTERS				72.00
101 00	10100 HOME HEALTH AGENCY	0	1, 428, 194		101. 00
101.00	SPECIAL PURPOSE COST CENTERS		1, 420, 174	T .	1101.00
112 00	11300 I NTEREST EXPENSE	T 0	0		113. 00
	11600 HOSPI CE	0			116. 00
118.00		1			
118.00	,	-6, 717, 554	58, 059, 346		118. 00
100.00	NONREI MBURSABLE COST CENTERS		0.000 (10		100.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0		1	192. 00
	19201 PRI VATE DUTY	0		1	192. 01
	07950 COMMUNITY RELATIONS	0			194. 00
	07951 COMMUNITY BENEFITS	0			194. 01
	07952 OTHER NONREIMBURSABLE COST CENTERS	0		1	194. 02
	07953 EMS	0	,	1	194. 03
200.00	TOTAL (SUM OF LINES 118-199)	-6, 717, 554	67, 205, 442	2	200. 00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15132	9 Period: Worksheet A-6 From 01/01/2014

					To 12/31/2014	Date/Time Prepa 5/19/2015 11:49	red:
		Increases				37 197 2013 11. 49	alli
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3.00	4.00	5. 00			
	A - CAFETERIA						
1.00	CAFETERI A	11. 00	665, 680	409, 812			1.00
	0		665, 680	409, 812			
	B - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	442, 933	96, 526			1.00
2.00	NURSERY	43.00	462, 029	100, 688			2.00
	0		904, 962	197, 214			
	C - COMMUNITY RELATIONS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	66, 151	173, 390			1.00
	0 — — — — —		66, 151	173, 390			
	D - OFFSITE BUILDING DEPR REC	CLASS					
1.00	NEW CAP REL COSTS-OFFSITE	1. 01	0	10, 991			1.00
	BLDG						
2.00	NEW CAP REL COSTS-MVBLE	2. 01	0	116, 842			2.00
	EQUIP OFFSIT						
	0		0	127, 833			
	E - IMPLANTABLE SUPPLIES RECL						
1.00	IMPL. DEV. CHARGED TO	72. 00	0	1, 384, 593			1.00
	PATI ENT						
	0		0	1, 384, 593			
	F - SPEECH RECLASS						
1.00	OTHER NONREIMBURSABLE COST	194. 02	34, 819	648			1.00
	CENTERS	+					
	0		34, 819	648			
	G - ANESTHESIA MED DIRECTOR F						
1.00	OPERATI NG ROOM	5000	•	3 <u>5, 8</u> 31			1.00
	0		0	35, 831			
	H - RADIOLOGY AND ULTRASOUND						
1.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	<u> 25, 8</u> 27	<u>2, 2</u> 16			1. 00
	0		25, 827	2, 216			
500.00	Grand Total: Increases		1, 697, 439	2, 331, 537		50	00.00

| Peri od: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

						10 12/31/2014	5/19/2015 11: 49 am
		Decreases		·			
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - CAFETERIA						
1.00	DI ETARY	10. 00	66 <u>5, 6</u> 80	40 <u>9, 8</u> 12			1. 00
	0		665, 680	409, 812			
	B - OB RECLASS						
1. 00	DELIVERY ROOM & LABOR ROOM	52.00	904, 962	197, 214	(1. 00
2.00		0.00	0_	0	(<u>]</u>	2. 00
	0		904, 962	197, 214			
	C - COMMUNITY RELATIONS				T		
1.00	COMMUNITY RELATIONS	1 <u>94.</u> 00	6 <u>6, 1</u> 51	17 <u>3, 3</u> 90		<u> </u>	1. 00
	0		66, 151	173, 390			
	D - OFFSITE BUILDING DEPR REC				ı		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	10, 991	Ġ	9	1. 00
	FI XT						
2.00	NEW CAP REL COSTS-MVBLE	2. 00	0	116, 842	9	9	2. 00
	EQUI P	+			<u> </u>	4	
	U E LANDI ANTARI E CURRILLEG DECI	166	<u> </u>	127, 833			
1 00	E - IMPLANTABLE SUPPLIES RECL			4 204 502	1	N .	1.00
1.00	OPERATI NG_ROOM	5000		<u>1, 384, 593</u>		4	1.00
	U CDEFOULDEGLACO		U	1, 384, 593			
1 00	F - SPEECH RECLASS	(0.00	24 010	(40		\	1.00
1.00	SPEECH PATHOLOGY		34, 819			4	1. 00
	G - ANESTHESIA MED DIRECTOR F	DECLACE	34, 819	648			
1 00		5. 00	ما	25 021	1	\	1.00
1.00	ADMI NI STRATI VE & GENERAL			3 <u>5, 8</u> 31		4	1.00
	U DADLOLOGY AND HITTOACOUND	DECLACE	UU	35, 831			
1 00	H - RADI OLOGY AND ULTRASOUND		25 027	2.21/		\	1.00
1. 00	RADI OLOGY-DI AGNOSTI C	54.00	2 <u>5, 827</u>			4	1.00
F00 00	U Constant		25, 827	2, 216		4	F00 00
500.00	Grand Total: Decreases		1, 697, 439	2, 331, 537			500.00

MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 Health Financial Systems RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 151329 Worksheet A-7 Peri od: From 01/01/2014 To 12/31/2014 Part I Date/Time Prepared: 5/19/2015 11:49 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Retirements 5.00 Bal ances 2.00 3.00 4. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2, 371, 158 0 1.00 2.00 Land Improvements 374, 770 23, 540 23, 540 2.00 0 0 0 0 3.00 Buildings and Fixtures Building Improvements 68, 450, 191 518, 625 518, 625 0 3.00 4.00 0 4.00 5.00 Fi xed Equipment 6, 341, 285 5.00 6. 00 7. 00 Movable Equipment 32, 063, 983 6, 182, 347 0 0 0 6, 182, 347 0 6.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 109, 601, 387 6, 724, 512 6, 724, 512 0 8.00 9.00 Reconciling Items 0 9.00 10.00 Total (line 8 minus line 9) 6, 724, 512 10.00 109, 601, 387 0 0 6, 724, 512 Fully Endi ng Bal ance

			Deprecrated	
			Assets	
		6. 00	7. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		
1.00	Land	2, 371, 158	0	1. 00
2.00	Land Improvements	398, 310	0	2. 00
3.00	Buildings and Fixtures	68, 968, 816	0	3. 00
4.00	Building Improvements	0	0	4. 00
5.00	Fixed Equipment	6, 341, 285	0	5. 00
6.00	Movable Equipment	38, 246, 330	0	6. 00
7.00	HIT designated Assets	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	116, 325, 899	0	8. 00
9.00	Reconciling Items	0	0	9. 00
10.00	Total (line 8 minus line 9)	116, 325, 899	0	10.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15132	9 Peri od:	Worksheet A-7

				rom 01/01/2014 o 12/31/2014		
		SU	IMMARY OF CAPIT	AL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9. 00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	2, 059, 324	0	1, 222, 334	0	0	1. 00
1. 01 NEW CAP REL COSTS-OFFSITE BLDG	608, 878	0	0	0	0	1. 01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	3, 655, 632	0	0	0	0	2. 00
2.01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	0	2. 01
3.00 Total (sum of lines 1-2)	6, 323, 834	0	1, 222, 334	0	0	3. 00
	SUMMARY O					
Cost Center Description		Total (1) (sum				
	Capi tal -Relate					
	d Costs (see	through 14)				
	instructions)	45.00				
DADT II. DECONCILIATION OF AMOUNTS FROM WORK	14.00	15. 00	2			
PART II - RECONCILIATION OF AMOUNTS FROM WORK 1.00 NEW CAP REL COSTS-BLDG & FIXT	SHEET A, CULUM	N 2, LINES 1 at 3, 281, 658				1. 00
1.01 NEW CAP REL COSTS-BLDG & FIXT	0	608, 878				1. 00
2.00 NEW CAP REL COSTS-MYBLE EQUIP		3, 655, 632				2. 00
2.01 NEW CAP REL COSTS-MVBLE EQUIP 2.01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		3, 000, 032 0				2. 00
3.00 Total (sum of lines 1-2)		7, 546, 168				3. 00
5.00 10tal (Suil of 111les 1-2)	ı	7, 340, 100	I			J. 00

Haal th	Financial Systems MAF	RGARET MARY COM	IMIINI TV HOSDI TA	ı	In lie	u of Form CMS-2	2552_10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151329 F	Period: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part III Date/Time Pre 5/19/2015 11:	pared:
		COME	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col.	Ratio (see instructions)	Insurance	
		1.00	2.00	2) 3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		2.00	3.00	4.00	3.00	
1.00	NEW CAP REL COSTS-BLDG & FLXT	58, 839, 136	О	58, 839, 136	0. 505813	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	12, 899, 148	O	12, 899, 148	0. 110888	0	1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	44, 587, 615	0	44, 587, 615	0. 383299	0	2. 00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	(0	2. 01
3.00	Total (sum of lines 1-2)	116, 325, 899		116, 325, 899			3. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
	Cost Center Description	Taxes	Other Capi tal-Relate		Depreciation	Lease	
		/ 00	d Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	6.00	7. 00	8. 00	9. 00	10. 00	
1. 00	NEW CAP REL COSTS-BLDG & FIXT	INTERS 0	0		2, 048, 333	0	1.00
1. 00	NEW CAP REL COSTS-DEDG & TTXT	0			619, 869	_	1. 00
2.00	NEW CAP REL COSTS-011311E BEDG	0			3, 216, 602	0	2.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0			116, 842	0	2. 00
3. 00	Total (sum of lines 1-2)	0			6, 001, 646	_	3. 00
3.00	Total (Suil Of Titles 1-2)	U	SI	JMMARY OF CAPI		0	3.00
			30	DIVINIART OF CAPT	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
					Capi tal -Rel ate		
			,	,	d Costs (see	through 14)	
					instructions)	,	
		11. 00	12.00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	213, 522	0	(0	2, 261, 855	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	· C	0	619, 869	1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	(0	3, 216, 602	2. 00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	(0	116, 842	2. 01
3.00	Total (sum of lines 1-2)	213, 522	0	(0	6, 215, 168	3.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES

				T	o 12/31/2014	Date/Time Pre	
				Expense Classification on	Worksheet A	5/19/2015 11:	49 am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - NEW CAP	1.00	2.00	3.00 NEW CAP REL COSTS-BLDG &	4. 00	5. 00 0	1. 00
	REL COSTS-BLDG & FIXT (chapter			FLXT			
1. 01	2) Investment income - NEW CAP		0	NEW CAP REL COSTS-OFFSITE	1. 01	0	1. 01
	REL COSTS-OFFSITE BLDG (chapter 2)			BLDG			
2.00	Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2.00	0	2. 00
	REL COSTS-MVBLE EQUIP (chapter 2)			EQUI P			
2. 01	Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2. 01	0	2. 01
	REL COSTS-MVBLE EQUIP OFFSIT (chapter 2)			EQUIP OFFSIT			
3. 00	Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)		O				
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Tel ephone servi ces (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-2, 936, 505			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00	Cafeteria-employees and guests		0		0.00	0	
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0.00	0	19. 00
	books, etc.)		-				
20. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
27.00	(chapter 21)		_	NEW CAR DEL COCTO PLEO A	4.65		2/ 22
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
26. 01	Depreciation - NEW CAP REL COSTS-OFFSITE BLDG			NEW CAP REL COSTS-OFFSITE BLDG	1. 01	0	26. 01
27. 00	Depreciation - NEW CAP REL			NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
27. 01	COSTS-MVBLE EQUIP Depreciation - NEW CAP REL		0	EQUIP NEW CAP REL COSTS-MVBLE	2. 01	0	27. 01
	COSTS-MVBLE EQUIP OFFSIT			EQUIP OFFSIT			
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00		28. 00 29. 00
		· I		•			

ADJUSTMENTS TO EXPENSES Provi der CCN: 151329 Peri od: From 01/01/2014 12/31/2014 Date/Time Prepared:

5/19/2015 11:49 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code (2) Cost Center Description Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 30.00 Adjustment for occupational OOCCUPATIONAL THERAPY 30. 00 A-8-3 67.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Α -322, 188 NEW CAP REL COSTS-MVBLE 2.00 32.00 Depreciation and Interest EQUI P OTHEROPERATING GIRLS ON THE -25, 544 ADMI NI STRATI VE & GENERAL 33.00 В 5.00 33.00 RUN REVE OTHEROPERATING OTHOP -23 ADMINI STRATI VE & GENERAL 34.00 В 5.00 34.00 INTERNAL SALE MMCH OTHER OPERATING -22, 356 ADMI NI STRATI VE & GENERAL 35.00 В 5.00 35.00 COMMBENEFITS SC OTHEROPERATING DIABETES 36.00 В -29, 336 ADMINI STRATI VE & GENERAL 5.00 36.00 **PROGRAM** OTHEROPERATING OTHOP-COMMUNITY -12, 921 ADMI NI STRATI VE & GENERAL 37.00 37.00 5.00 В CLASS OTHEROPERATING OTHOP-PURCHASE 38.00 В -873 ADMINISTRATIVE & GENERAL 5.00 38.00 DI SCOU 39.00 OTHEROPERATING OTHOP-MISC -2, 037 ADMI NI STRATI VE & GENERAL 39.00 5.00 REVENUE NON-OPERATING R OTHOP-MISC -3,510 OPERATION OF PLANT 40.00 7.00 40.00 В REVENUE OTHEROPERATING OTHOP-LAUNDRY -721 LAUNDRY & LINEN SERVICE 41.00 R 8.00 41.00 SERVI CE 43.00 OTHEROPERATING OTHOP-VENDING -2, 646 DI ETARY 10.00 43.00 В SALES 44.00 OTHEROPERATING OTHOP-DIET В -23, 706 DI ETARY 10.00 44.00 SLIPP / I NS CAFETERIA OFFSET -271, 539 CAFETERI A 45.00 В 11.00 45.00 NON-OPERATING OTHOP-CAFE SALES -140 CAFETERI A 11.00 45.01 45.01 В 45.02 OTHEROPERATING OTHOP-MEDRED -3,304 MEDICAL RECORDS & LIBRARY 16.00 45.02 В TRANSC OTHEROPERATING OTHOP-PHYSICAL -17, 345 PHYSI CAL THERAPY 45.03 66.00 45.03 B THERAP 45.04 OTHEROPERATING OTHOP-EMS В -350 EMERGENCY 91.00 45.04 EDUCATI ON 45.05 INTEREST OFFSET -1,008,812 NEW CAP REL COSTS-BLDG & 11 45.05 1.00 Α IFT XT -2,592 OPERATION OF PLANT 45.06 TV OFFSET 7.00 45.06 Α 0 LOBBYING EXPENSE -4, 582 ADMINISTRATIVE & GENERAL 45.07 Α 5.00 45.07 MEDICAL STAFF RETENTION COST -239, 815 ADMI NI STRATI VE & GENERAL 45.08 45.08 Α 5.00 MEDICAL STAFF PLACEMENT FEE 45.09 -79,815 ADMINISTRATIVE & GENERAL 5.00 45.09 Α 45.10 -1, 706, 940 ADMINI STRATI VE & GENERAL 45.10 HAF Δ 5.00 45.11 0.00 45.11 TOTAL (sum of lines 1 thru 49) -6, 717, 554 50.00 50.00 (Transfer to Worksheet A, column 6, line 200.)

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT MARGARET MARY COMMUNITY HOSPITAL
Provider CCN: 151329 | Peri od: | Worksheet A-8-2 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

Style="block of light right	
Identifier Remuneration Component Component Ider Component Ide	V
1.00	
1.00	
2. 00	
3. 00	0 1.00
4. 00	0 2.00
S. 00	0 3.00
6. 00 60. 00 LABORATORY 62, 240 0 62, 240 0 0 62, 240 0 0 7. 00 69. 00 ELECTROCARDI OLOGY 27, 996 0 27, 996 0 0 27, 996 0 0 27, 996 0 0 27, 996 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 4.00
7. 00 69. 00 ELECTROCARDI OLOGY 8. 00 69. 00 ELECTROCARDI OLOGY 9. 96 0 0 9. 00 69. 00 ELECTROCARDI OLOGY 9. 996 0 9. 996 0 0 9. 996 0 0 9. 996 0 0 9. 996 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 5.00
8. 00 69. 00 ELECTROCARDI OLOGY 149, 079 149, 079 0 0 0 0 0 0 0 0 0	0 6.00
9. 00 69. 00 ELECTROCARDI OLOGY 9, 996 0 9, 996 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 7.00
10.00	0 8.00
11. 00	9.00
12.00	0 10.00
200.00 Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Unadjusted RCE Limit Cost of Unadjusted RCE Limit Share of col. Insurance Reducation 12	0 00
Wkst. A Line # Cost Center/Physician I dentifier Unadjusted RCE S Percent of Unadjusted RCE Limit Continuing Education Share of col. Insurance I	0 12.00 0 200.00
Identifier	
Li mi t Continuing Education 12 Insurance 12	
Too	
1. 00 43. 00 NURSERY 0 0 0 2. 00 54. 00 RADI OLOGY - DI AGNOSTI C 0 0 0 3. 00 54. 00 RADI OLOGY - DI AGNOSTI C 0 0 0 4. 00 54. 00 RADI OLOGY - DI AGNOSTI C 0 0 0 5. 00 54. 00 RADI OLOGY - DI AGNOSTI C 0 0 0 6. 00 60. 00 LABORATORY 0 0 0 7. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 8. 00 69. 00 ELECTROCARDI OLOGY 0 0 0	
2. 00	
3. 00 54. 00 RADI OLOGY - DI AGNOSTI C 0 0 0 0 0 0 0 0 0	0 1.00
4. 00 54. 00 RADI OLOGY - DI AGNOSTI C 0 0 0 5. 00 54. 00 RADI OLOGY - DI AGNOSTI C 0 0 0 6. 00 60. 00 LABORATORY 0 0 0 7. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 8. 00 69. 00 ELECTROCARDI OLOGY 0 0 0	0 2.00
5. 00 54. 00 RADI OLOGY - DI AGNOSTI C 0 0 0 6. 00 60. 00 LABORATORY 0 0 0 7. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 8. 00 69. 00 ELECTROCARDI OLOGY 0 0 0	0 3.00
6. 00 60. 00 LABORATORY 0 0 0 0 0 0 7. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 4.00
7. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 0 0 8. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 0	0 5.00
8. 00 69. 00 ELECTROCARDI OLOGY 0 0 0	0 6.00
	0 7.00
	0 8. 00 0 9. 00
10. 00 90. 00 CLINIC 0 0 0	0 10.00
11. 00 91. 00 EMERGENCY 0 0 0	0 11.00
12. 00 91. 00 EMERGENCY 0 0 0	0 12.00
200.00	0 200.00
Wkst. A Line # Cost Center/Physician Provider Adjusted RCE RCE Adjustment	
Identifier Component Limit Disallowance	
Share of col.	
14	
1.00 2.00 15.00 16.00 17.00 18.00	
1. 00 43. 00 NURSERY 0 0 0 0 0 0 0 0 0	1.00
2. 00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 216, 125 3. 00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 10, 000	2. 00 3. 00
4. 00 54. 00 RADI OLOGY - DI AGNOSTI C 0 0 10, 000 10, 0	4. 00
5. 00 54. 00 RADI OLOGY - DI AGNOSTI C 0 0 531, 253	5. 00
6.00 60.00 LABORATORY 0 0 0 0 0	6. 00
7. 00 69. 00 ELECTROCARDI OLOGY 0 0 0	7. 00
8. 00 69. 00 ELECTROCARDI OLOGY 0 0 149, 079	8.00
9.00 69.00ELECTROCARDI OLOGY 0 0 0	9. 00
10. 00 90. 00(CLI NI C	10. 00
11. 00 91. OOLEMERGENCY 0 0 99, 478	11. 00
12. 00 91. 00 EMERGENCY 0 0 1, 416, 695	12. 00
200. 00 0 0 2, 936, 505	200. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 151329

Peri od: Worksheet B From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared: 5/19/2015 11:49 am

					12/31/2014	5/19/2015 11:	
				CAPITAL REL	ATED COSTS		
	Cost Center Description	Net Expenses	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE	
		for Cost	FLXT	BLDG	EQUI P	EQUIP OFFSIT	
		Allocation (from Wkst A					
		col. 7)					
		0	1. 00	1.01	2. 00	2. 01	
	GENERAL SERVICE COST CENTERS	2 2/1 055	2 2/1 055				1 00
	DO100 NEW CAP REL COSTS-BLDG & FIXT DO101 NEW CAP REL COSTS-OFFSITE BLDG	2, 261, 855 619, 869	2, 261, 855 0	619, 869			1. 00 1. 01
	DO200 NEW CAP REL COSTS-MVBLE EQUIP	3, 216, 602	U	017,007	3, 216, 602		2. 00
	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	116, 842			0	116, 842	2. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	9, 644, 478	11, 623	0	16, 530	0	4. 00
	DO500 ADMINISTRATIVE & GENERAL	8, 221, 009	276, 264		392, 877	0	5. 00
	00700 OPERATION OF PLANT	1, 318, 701	513, 128		729, 722	0	7.00
	DO701 OPERATION OF PLANT -OFFSITE DO702 OPERATION OF PLANT - HOSPITAL & OFFS	109, 401 482, 617	0	0	0	0	7. 01 7. 02
	DO800 LAUNDRY & LINEN SERVICE	135, 420	28, 458	-	40, 470	0	8.00
	00900 HOUSEKEEPI NG	854, 678	30, 484		43, 351	0	9. 00
	D1000 DI ETARY	191, 609	14, 526		20, 658	0	10.00
	D1100 CAFETERI A	803, 813	71, 703	0	101, 969	0	11.00
	D1300 NURSI NG ADMI NI STRATI ON	714, 072	6, 443		9, 163	0	13. 00 14. 00
	D1400 CENTRAL SERVICES & SUPPLY D1500 PHARMACY	392, 809 2, 471, 781	10, 788 8, 657		15, 341 12, 312	0	15. 00
	01600 MEDICAL RECORDS & LIBRARY	1, 009, 436	37, 940		53, 955	0	
Ī	NPATIENT ROUTINE SERVICE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5.75	-1	20, 122		
	D3000 ADULTS & PEDIATRICS	1, 960, 153	195, 454		277, 957	0	
	03100 INTENSIVE CARE UNIT	340, 871	18, 829		26, 777	0	31.00
-	D4300 NURSERY ANCILLARY SERVICE COST CENTERS	569, 717	9, 597	0	13, 648	0	43. 00
	D5000 OPERATING ROOM	2, 601, 241	47, 903	0	68, 123	0	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	98, 120	15, 508		22, 054	0	
	D5400 RADI OLOGY-DI AGNOSTI C	6, 418, 886	210, 315	0	299, 091	0	54. 00
	D6000 LABORATORY	2, 929, 624	52, 456		74, 598	0	60.00
	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
	D6500 RESPI RATORY THERAPY D6600 PHYSI CAL THERAPY	496, 170 990, 573	43, 026 51, 067	0	61, 187 72, 623	0	65. 00 66. 00
	06700 OCCUPATI ONAL THERAPY	396, 615	13, 597	0	19, 336	0	67.00
	D6800 SPEECH PATHOLOGY	148, 969	7, 383	Ō	10, 500	0	68. 00
	D6900 ELECTROCARDI OLOGY	638, 458	29, 408	0	41, 821	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	1, 384, 593	53, 563	0	76, 172	0	72. 00 73. 00
73. 00	D7300 DRUGS CHARGED TO PATIENTS DUTPATIENT SERVICE COST CENTERS	l d	0	l o	0	0	/3.00
88. 00	D8800 RURAL HEALTH CLINIC	544, 053	0	47, 709	0	8, 993	88. 00
	09000 CLI NI C	1, 213, 658	108, 003	0	153, 592	0	90. 00
	09001 WOUND CLINC	390, 549	6, 454		9, 178	0	90. 01
	D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 048, 779	130, 017	0	184, 899	0	91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS						92.00
H H	10100 HOME HEALTH AGENCY	1, 428, 194	35, 663	0	50, 717	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE	005 404					113.00
116.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	895, 131 58, 059, 346	0 2, 038, 257	47, 709	2, 898, 621		116. 00 118. 00
-	NONREI MBURSABLE COST CENTERS	30, 037, 340	2, 030, 237	47,709	2, 090, 021	0, 773	110.00
	19200 PHYSI CLANS' PRI VATE OFFICES	8, 239, 618	200, 498	572, 160	285, 130	107, 849	192. 00
	19201 PRI VATE DUTY	0	0	0	0		192. 01
	07950 COMMUNITY RELATIONS	415, 911	2, 642		3, 757		194. 00
	07951 COMMUNITY BENEFITS	401, 759	20, 458	0	29, 094		194. 01 194. 02
	D7952 OTHER NONREIMBURSABLE COST CENTERS	35, 467 53, 341	0		O O		194. 02
200.00	Cross Foot Adjustments	55,541	O		Ĭ	O	200. 00
201.00	Negative Cost Centers		0	0	o		201. 00
202. 00	TOTAL (sum lines 118-201)	67, 205, 442	2, 261, 855	619, 869	3, 216, 602	116, 842	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 151329

EMBRAL SERVICE COST CENTERS Subtotal ALMINISTRATIVE GENERAL OF					''	0 12/31/2014	5/19/2015 11:	
SENDRUL SERVICE COST CRUTERS		Cost Center Description	EMPLOYEE	Subtotal	ADMI NI STRATI VE	OPERATION OF		
GENERAL SERVICE COST CENTERS		·	BENEFITS		& GENERAL	PLANT	PLANT -OFFSITE	
CONTRACT SERVICE COST CENTERS			DEPARTMENT					
1.00			4. 00	4A	5. 00	7. 00	7. 01	
1.01 0.010 NEW CAP REL COSTS-OFFSI TE BLDQ 2.01 0.0200 NEW CAP REL COSTS-OWBIE EQUIP OFFSI T 4.00 0.0400 DIVER CAP REL COSTS-OWBIE EQUIP OFFSI T 5.00 0.0200 NEW CAP REL COSTS-OWBIE EQUIP OFFSI T 5.00 0.0300 DISTORTATIVE & GENERAL 1.359, 286 2.561, 551 460, 961 3.022, 512 7.01 0.0710 OWBI OPERATIVE OF PLANT - OFFSI TE 7.02 0.0702 OPERATION 0.0 PLANT - OFFSI TE 7.02 0.0702 OPERATION 0.0 PLANT - OFFSI TE 7.03 0.0702 OPERATION 0.0 PLANT - OFFSI TE 7.04 0.0702 OPERATION 0.0 PLANT - OFFSI TE 7.05 0.0702 OPERATION 0.0 PLANT - OFFSI TE 7.06 0.0702 OPERATION 0.0 PLANT - OFFSI TE 7.07 0.0702 OPERATION 0.0 PLANT - OFFSI TE 7.08 0.0702 OPERATION 0.0 PLANT - OFFSI TE 7.09 0.00 0.0000 OUSEKEEPING 7.00 0.0000 OPERATIVE OFFSI TE 7.00 0.0000 OPERAT		GENERAL SERVICE COST CENTERS						
2.00	1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.01 002001 NEW CAP REL COSTS-INVEILE EQUIP OFFSIT	1.01	00101 NEW CAP REL COSTS-OFFSITE BLDG						1. 01
4.00 00400 EMPLOYEE RENEFIT IS DEPARTMENT 9,672,631 10,249,438 10,249,438 10,249,438 5,00 5,00 00500 DAMIN ISTRATION OF PLANT 1,399,288 10,249,438 10,249,438 10,249,438 7,00	2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
5.00 00500 AMM INSTRATIVE & CERERAL 1, 359, 288 10, 249, 438 10, 249, 438 10, 249, 438 7.00 30, 000 00700 0PERATION OF PLANT 10, 001	2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2. 01
7. 00 00700 00FRATION OF PLANT - OFFSITE 0 2, 561, 551 460, 961 3, 022, 512 7, 00 129, 088 7, 01 7, 00 00702 00FRATION OF PLANT - OFFSITE 1 0 109, 401 19, 687 0 129, 088 7, 01 7, 00 00702 00FRATION OF PLANT - HOSPITAL & OFFS 144, 483 627, 100 112, 849 0 0 7, 02 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 000000	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	9, 672, 631					4. 00
7. 01 00701 OPERATION OF PLANT - HOSPITAL & OFFS 144, 483 627, 100 112, 849 0 7. 02 0070 00800 LAUNDRY & LINEN SERVICE 24, 592 228, 940 41, 199 58, 879 0.8, 00 00900 LOUSEKEEPIN 41, 513 268, 306 48, 283 30, 056 0.10, 00 1000 01000 DIETARY 41, 513 268, 306 48, 283 30, 056 0.10, 00 1000 01000 DIETARY 41, 513 268, 306 48, 283 30, 056 0.10, 00 1000 01000 DIETARY 41, 513 268, 306 48, 283 30, 056 0.10, 00 1000 DIETARY 41, 513 268, 306 48, 283 30, 056 0.10, 00 1000 DIETARY 41, 513 268, 306 48, 283 30, 056 0.10, 00 1000 DIETARY 41, 513 268, 306 48, 283 30, 056 0.10, 00 1000 DIETARY 41, 513 268, 306 48, 283 30, 056 0.10, 00 1000 DIETARY 41, 513 268, 306 48, 283 30, 056 0.10, 00 1000 DIETARY 580 27, 274 48, 283 73, 300 22, 320 0.14, 00 13, 00 DIETARY 580 27, 274 48, 283 73, 300 22, 320 0.14, 00 13, 00 DIETARY 580 28, 284 1, 370, 272 246, 588 74, 499 0.15, 00 DIETARY 580 28, 284 1, 370, 272 246, 588 74, 499 0.15, 00 DIETARY 580 28, 284 1, 370, 272 246, 588 74, 499 0.16, 00 DIETARY 580 28, 284 1, 370, 272 246, 588 74, 499 0.16, 00 DIETARY 580 28, 284 1, 370, 272 246, 588 74, 499 0.16, 00 DIETARY 580 28, 284 2	5.00	00500 ADMINISTRATIVE & GENERAL	1, 359, 288	10, 249, 438	10, 249, 438			5. 00
2.00 00000 DEPARTION OF PLANT - HOSPITAL & OFFS 144, 483 627, 100 112, 849 0 0 7, 02 0.00	7.00	00700 OPERATION OF PLANT	O	2, 561, 551	460, 961	3, 022, 512	<u>:</u>	7. 00
8. 00	7.01	00701 OPERATION OF PLANT -OFFSITE	o	109, 401	19, 687	0	129, 088	7. 01
8. 00	7.02	00702 OPERATION OF PLANT - HOSPITAL & OFFS	144, 483	627, 100	112, 849	0	0	7. 02
10.00 01000 011000 011000 011000 011000 01000 01000 01000 011000	8.00		24, 592	228, 940	41, 199	58, 879	0	8. 00
11.00 01100 O1100 O110	9.00	00900 HOUSEKEEPI NG	185, 553	1, 114, 066	200, 481	63, 071	0	9. 00
13.00 01300 OUSBNING ADMINISTRATION 211, 927 941, 605 169, 446 13, 332 0 14.00 14.00 01400 OENTRAL SERVICES & SUPPLY 0 418, 938 75, 390 22, 320 0 14.00 16.00 01500 MEDI CAL RECORDS & LI BRARY 268, 941 1, 370, 272 246, 586 78, 499 0 15.00 16.00 1600 MEDI CAL RECORDS & LI BRARY 268, 941 1, 370, 272 246, 586 78, 499 0 15.00 16.00 1600 MEDI CAL RECORDS & LI BRARY 268, 941 1, 370, 272 246, 586 78, 499 0 30.00 31.00 0300 ONDO ADULTS & SEPLIATRIC S 537, 939 2, 971, 503 534, 734 404, 399 0 30.00 31.00 03100 INTERSI VE CABE UNIT 99, 243 485, 720 87, 407 38, 958 0 31.00 31.00 03100 INTERSI VE CABE UNIT 99, 243 485, 720 87, 407 38, 958 0 31.00 32.00 0300 OENGERI RESORDO 142, 732 735, 135 132, 290 19, 857 0 42.00 30.00 0300 OPERATI IN BOWN 417, 932 3, 135, 199 564, 192 99, 112 0 50.00 52.00 05200 OEL VERY ROON & LABOR ROOM 24, 790 160, 472 28, 878 32, 087 0 52.00 63.00 0500 ORLO RESORATORY 371, 505 3, 428, 183 616, 915 108, 533 0 60.00 64.00 05400 BLOOD LABORATORY 0 0 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 131, 161 731, 544 131, 644 89, 021 0 65.00 66.00 06500 DESPIRATORY THERAPY 111, 290 546, 038 97, 326 23, 132 0 67, 00 67.00 06700 OCCUPATI ONAL THERAPY 111, 290 546, 038 97, 326 23, 132 0 67, 00 68.00 06800 SPEECH PATHOLOCY 45, 002 211, 854 38, 124 15, 776 0 68, 00 69.00 06800 SPEECH PATHOLOCY 45, 002 211, 854 38, 124 15, 776 0 68, 00 69.00 06800 DELECTROCARDI DIORY THERAPY 149, 501 349,	10.00	01000 DI ETARY	41, 513	268, 306	48, 283	30, 056	0	10.00
14. 00 O1400 (CENTRAL SERVICES & SUPPLY 0 418, 928 75, 390 22, 320 0 14. 00 16. 00 O1600 PHARMACY 167, 080 2, 659, 830 478, 647 17, 912 0 15. 00 10. 00 O1600 MEDICAL RECORDS & LI BRARY 288, 941 1, 370, 272 246, 586 78, 499 0 16. 00 10. 00 O3000 ADULTS & PEDI ATRIC S 537, 939 2, 971, 503 534, 734 404, 399 0 30. 00 30. 00 O3000 ADULTS & PEDI ATRIC S 537, 939 2, 971, 503 534, 734 404, 399 0 30. 00 30. 00 O3000 INTENSI YE CARE UNI T 99, 243 485, 720 878, 740 38, 958 0 31. 00 30. 00 O3000 NURSERY CE CARE UNI T 99, 243 485, 720 878, 740 38, 958 0 31. 00 30. 00 O3000 NURSERY CE CARE UNI T 99, 243 485, 720 878, 740 783, 958 0 31. 00 30. 00 O3000 NURSERY CE COST CENTERS	11. 00	01100 CAFETERI A	204, 839	1, 182, 324	212, 764	148, 354	. 0	11. 00
15.00 01500 PHARMACY 16.7 0.00 2, 659, 830 478, 647 17.912 0 15. 0.0 16. 00 1600 MEDI CAL RECORDS & LIBRARY 28, 8941 1, 370, 272 246, 586 78, 499 0 16. 00 16. 00 140	13.00	01300 NURSI NG ADMI NI STRATI ON	211, 927	941, 605	169, 446	13, 332	<u>.</u>	13. 00
16.00 01600 MEDICAL RECORDS & LIBRARY 268, 941 1, 370, 272 246, 586 78, 499 0 16.00	14.00	01400 CENTRAL SERVICES & SUPPLY	O	418, 938	75, 390	22, 320	0	14. 00
INPATI ENT ROUTI NE. SERVI CE COST CENTERS	15.00	01500 PHARMACY	167, 080	2, 659, 830	478, 647	17, 912	0	15. 00
30.00 03000 ADULTS & PEDIATRICS 537, 939 2, 971, 503 534, 734 404, 399 0 30.00 43.00 043.00	16.00	01600 MEDICAL RECORDS & LIBRARY	268, 941	1, 370, 272	246, 586	78, 499	0	16. 00
33.00 03100 INTENSIVE CARE UNIT 99, 243 485, 720 87, 407 38, 958 0 31.00		INPATIENT ROUTINE SERVICE COST CENTERS						
43.00 04300 NURSERY 142, 173 735, 135 132, 290 19, 857 0 33. 00	30.00	03000 ADULTS & PEDIATRICS	537, 939	2, 971, 503	534, 734	404, 399	0	30. 00
ANCILLARY SERVICE COST CENTERS	31.00	03100 INTENSIVE CARE UNIT	99, 243	485, 720	87, 407	38, 958	0	31. 00
50.00	43.00	04300 NURSERY	142, 173	735, 135	132, 290	19, 857	0	43.00
52.00 05.200 05		ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADIOLOGY-DIAGNOSTIC 825,039 7,753,331 1,395,243 435,145 0 54,00 60. 01 06000 LABORATORY 371,505 3,428,183 616,915 108,533 0 60.00 60. 01 06001 BLOOD LABORATORY 131,161 731,544 131,644 89,021 0 65.00 65. 00 06500 RESPIRATORY THERAPY 131,161 731,544 131,644 89,021 0 65.00 66. 00 06600 PHYSICAL THERAPY 288,240 1,402,503 252,386 105,659 0 66.00 66. 00 06600 PHYSICAL THERAPY 111,290 540,838 97,326 28,132 0 67.00 67. 00 06700 OCCUPATIONAL THERAPY 115,002 211,884 38,124 15,276 0 68.00 69. 00 06900 ELECTROCARDIOLOGY 45,002 211,884 38,124 15,276 0 68.00 69. 00 06900 ELECTROCARDIOLOGY 150,561 860,248 154,805 60,846 0 69.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 76. 00 09000 LINIC 439,195 1,914,448 344,513 223,461 0 90.00 79. 00 09000 LINIC 439,195 1,914,448 344,513 223,461 0 90.00 79. 00 09000 LINIC 439,195 1,914,448 344,513 223,461 0 90.00 79. 00 09000 LINIC 439,195 1,914,448 344,513 223,461 0 90.00 79. 00 09000 LINIC 439,195 1,914,448 344,513 223,461 0 90.00 79. 00 09000 LINIC 439,195 1,914,448 344,513 223,461 0 90.00 79. 00 09000 LINIC 439,195 1,914,448 344,513 223,461 0 90.00 79. 00 09000 LINIC 439,195 1,914,448 344,513 223,461 0 90.00 79. 00 09000 LINIC 439,195 1,914,448 344,513 223,461 0 90.00 79. 00 09000 LINIC 439,195 1,914,448 344,513 223,461 0 90.00 79. 00 09000 LINIC 439,195 1,914,448 344,513 223,461 0 90.00 79. 00 09000 09000	50.00	05000 OPERATI NG ROOM	417, 932	3, 135, 199	564, 192	99, 112	. 0	50. 00
60. 00 06000 LABORATORY 371, 505 3, 428, 183 616, 915 108, 533 0 60. 00 60. 01 60. 00 06000 BLOOD LABORATORY 131, 161 731, 544 131, 644 89, 021 0 65. 00 65. 00 06600 RESPIRATORY THERAPY 131, 161 731, 544 131, 644 89, 021 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 288, 240 1, 402, 503 252, 386 105, 659 0 66. 00 66. 00 67. 00 6700 00cUpaTri IONAL THERAPY 111, 290 540, 838 97, 326 28, 132 0 67. 00 68, 00 06800 SPEECH PATHOLOGY 45, 002 211, 854 38, 124 15, 276 0 68. 00 69. 00 6900 LECTROCARDI OLOGY 150, 561 860, 248 154, 805 60, 846 0 69. 00 6900 LECTROCARDI OLOGY 150, 561 860, 248 154, 805 60, 846 0 69. 00 0 0 0 0 0 0 0 0 0	52.00	05200 DELIVERY ROOM & LABOR ROOM	24, 790	160, 472	28, 878	32, 087	0	52. 00
60.01 06.001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0	54.00	05400 RADI OLOGY-DI AGNOSTI C	825, 039	7, 753, 331	1, 395, 243	435, 145	0	54.00
65.00 06500 RESPIRATORY THERAPY 131, 161 731,544 131, 644 89,021 0 65.00 66.00 06600 PHYSI CAL THERAPY 288,240 1,402,503 252,386 105,659 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 111,290 540,838 97,326 28,132 0 67.00 68.00 06800 SPECH PATHOLOGY 45,002 211,854 38,124 15,276 0 68.00 69.00 06900 ELECTROCARDI OLOGY 150,561 860,248 154,805 60,846 0 69,00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74.00 07300 DRUGS CHARGED TO PATI ENT 0 1,514,328 272,509 110,823 0 72.00 75.00 07300 DRUGS CHARGED TO PATI ENT 0 1,514,328 272,509 110,823 0 72.00 76.00 08000 RURAL HEALTH CLINIC 149,361 750,116 134,986 0 9,935 88.00 77.00 09000 CLI NI C 439,195 1,914,448 344,513 223,461 0 90.00 78.00 09000 CLI NI C 439,195 1,914,448 344,513 223,461 0 90.00 79.00 09000 DRUGS CHARGED TO PATI ENT 503,838 2,867,533 516,024 269,009 0 91.00 79.00 09000 DRUGS CHARGED TO PATI ENT 503,838 2,867,533 516,024 269,009 0 91.00 79.00 09000 DRUGS CHARGED TO PATI ENT 503,838 2,867,533 516,024 269,009 0 91.00 79.00 09000 DRUGS CHARGED TO PATI ENT 74,466,742 54,631,869 7,986,797 2,559,882 9,935 118.00 79.00 09000 DRUGS CHARGED TO PATI ENT 74,466,742 54,631,869 7,986,797 2,559,882 9,935 118.00 79.00 09000 DRUGS CHARGED TO PATI ENT 74,466,742 54,631,869 7,986,797 2,559,882 9,935 118.00 79.00 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 79.00 09000 09000 09000 09000 09000 09000 09000 09000 09000 79.00 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 79.00 09000 09000 09000 09000 09000 09000 09000	60.00	06000 LABORATORY	371, 505	3, 428, 183	616, 915	108, 533	0	60.00
66. 00 06600 PHYSI CAL THERAPY 288, 240 1, 402, 503 252, 386 105, 659 0 66. 00 67. 00 06700 0ctoparti on Nat Therapy 111, 290 540, 838 97, 326 28, 132 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 45, 502 211, 854 38, 124 15, 276 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 150, 561 860, 248 154, 805 60, 846 0 69. 00 0 0 0 0 0 0 0 0 0	60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
67. 00 06700 OCCUPATI ONAL THERAPY 111, 290 540, 838 97, 326 28, 132 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 45, 002 211, 854 38, 124 15, 276 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 150, 561 860, 248 154, 805 60, 846 0 69. 00 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 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 80. 00 08000 RURAL HEALTH CLINIC 149, 361 750, 116 134, 986 0 9, 935 88. 00 80. 00 09000 CLINIC 439, 195 1, 914, 448 344, 513 223, 461 0 90. 00 80. 01 09001 WOUND CLINC 64, 880 471, 061 84, 769 13, 353 0 90. 01 80. 00 09200 085ERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 80. 00 09200 085ERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 80. 00 09200 085ERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 80. 00 09200 085ERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 80. 00 09200 085ERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 80. 00 09200 085ERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 80. 00 09200 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 80. 00 09200 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 80. 00 00 0 0 0 0 0 0 0	65.00	06500 RESPI RATORY THERAPY	131, 161	731, 544	131, 644	89, 021	0	65. 00
68.00 06800 SPEECH PATHOLOGY 45,002 211,854 38,124 15,276 0 68.00 69.00 06900 ELECTROCARDIOLOGY 150,561 860,248 154,805 60,846 0 67.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 1,514,328 272,509 110,823 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLINI C 149,361 750,116 134,986 0 9,935 88.00 90.01 09001 WOUND CLINC 64,880 471,061 84,769 13,353 0 90.01 91.00 09100 EMERGENCY 503,838 2,867,533 516,024 269,009 0 91.00 92.00 09200 DSEEXWATI ON BEDS (NON-DISTINCT PART) 92.00 0718.00 09100 FMERGENCY 376,929 1,891,503 340,384 73,788 0 116.00 11600 HOME HEALTH AGENCY 376,929 1,891,503 340,384 73,788 0 116.00 11600 HOSPI CE 179,448 1,074,579 193,375 0 0 116.00 116.00 11600 HOSPI CE 179,448 1,074,579 193,375 0 0 116.00 1192.00 PHYSI CI ANS' PRI VATE OFFI CES 2,063,125 11,468,380 2,063,758 414,835 119,153 192.00 194.00 07950 COMMUNI TY BENEFI TS 89,612 540,923 97,341 42,328 0 194.00 194.01 07951 COMMUNI TY BENEFI TS 89,612 540,923 97,341 42,328 0 194.00 194.02 07952 OTHER NONREI MBURSABLE COST CENTERS 10,714 46,181 8,310 0 0 194.00 194.01 07951 COMMUNI TY BENEFI TS 89,612 540,923 97,341 42,328 0 194.00 194.02 07952 OTHER NONREI MBURSABLE COST CENTERS 10,714 46,181 8,310 0 0 194.00 194.03 07953 EMS 0 0 0 0 0 0 0 0 0 1000 Nongeti ve Cost Centers 0 0 0 0 0 0 0 0 1000 Nongeti ve Cost Centers 0 0 0 0 0 0 0 0 1000 000 000 000 0 0 0 0	66.00	06600 PHYSI CAL THERAPY	288, 240	1, 402, 503	252, 386	105, 659	0	66. 00
69. 00 06900 ELECTROCARDIOLOGY 150, 561 860, 248 154, 805 60, 846 0 69. 00 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 72. 00 73. 00 7	67.00	06700 OCCUPATI ONAL THERAPY	111, 290	540, 838	97, 326	28, 132	. 0	67. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 00 00 0 0 0 0 0 0	68.00	06800 SPEECH PATHOLOGY	45, 002	211, 854	38, 124	15, 276	0	68. 00
72. 00 07200 IMPL DEV. CHARGED TO PATIENT 0 1,514,328 272,509 110,823 0 72. 00 73. 00 0 0 0 0 0 0 0 0 0	69. 00	06900 ELECTROCARDI OLOGY	150, 561	860, 248	154, 805	60, 846	0	69. 00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
Second S			0	1, 514, 328	272, 509	110, 823	. 0	72. 00
88. 00 08800 RURAL HEALTH CLINIC 149, 361 750, 116 134, 986 0 9, 935 88. 00 90. 00 90000 CLINIC 439, 195 1, 914, 448 344, 513 223, 461 0 90. 00 90.	73. 00		0	0	0	0	0	73. 00
90. 00			,					
90. 01			1		1			1
91. 00		1 1	1		1		1	1
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 10100 HORE REI MBURSABLE COST CENTERS 101. 00 10100 HORE HEALTH AGENCY 376, 929 1, 891, 503 340, 384 73, 788 0 101. 00 10100 HORE HEALTH AGENCY 113. 00 11300 INTEREST EXPENSE 113. 00 11600 HOSPI CE 179, 448 1, 074, 579 193, 375 0 0 116. 00 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 7, 466, 742 54, 631, 869 7, 986, 797 2, 559, 882 9, 935 118. 00 NONREI MBURSABLE COST CENTERS 2, 063, 125 11, 468, 380 2, 063, 758 414, 835 119, 153 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 2, 063, 125 11, 468, 380 2, 063, 758 414, 835 119, 153 192. 00 192. 01 19201 PRI VATE DUTY 0 0 0 0 0 0 192. 01 194. 00 07950 COMMUNI TY RELATI ONS 37, 804 460, 114 82, 799 5, 467 0 194. 00 194. 01 194. 02 07951 COMMUNI TY BENEFI TS 89, 612 540, 923 97, 341 42, 328 0 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 10, 714 46, 181 8, 310 0 0 194. 02 194. 03 07953 EMS Cross Foot Adjustments 0 0 0 0 0 0 0 0 0			1		1		1	1
OTHER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 376, 929 1, 891, 503 340, 384 73, 788 0 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 179, 448 1, 074, 579 193, 375 0 0 116. 00 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 7, 466, 742 54, 631, 869 7, 986, 797 2, 559, 882 9, 935 118. 00 NONREI MBURSABLE COST CENTERS 113. 00 110000 110000 110000 110000 110000 110000 110000 110000 110000 110000 110000 110000 1100000 1100000 110000000 1100000000			503, 838		1	269, 009	0	1
101. 00 10100 HOME HEALTH AGENCY 376, 929 1, 891, 503 340, 384 73, 788 0 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 179, 448 1, 074, 579 193, 375 0 0 116. 00 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 7, 466, 742 54, 631, 869 7, 986, 797 2, 559, 882 9, 935 118. 00 NONRE! MBURSABLE COST CENTERS 113, 468, 380 2, 063, 758 414, 835 119, 153 192. 00 192. 01 1920 PRI VATE DUTY 0 0 0 0 192. 01 194. 00 194. 01 07951 COMMUNI TY RELATIONS 37, 804 460, 114 82, 799 5, 467 0 194. 00 194. 01 194. 02 07952 COMMUNI TY BENEFI TS 89, 612 540, 923 97, 341 42, 328 0 194. 01 194. 02 07953 EMS 200. 00 Cross Foot Adj ustments 4, 634 57, 975 10, 433 0 0 194. 02 200. 00 Cross Foot Adj ustments 0 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 0 0 0	92. 00			0				92.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 179,448 1,074,579 193,375 0 0 116.00 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 7,466,742 54,631,869 7,986,797 2,559,882 9,935 118.00 119.00 11					1		_	
113. 00 11300 11300 1NTEREST EXPENSE 179,448 1,074,579 193,375 0 0 0 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 7,466,742 54,631,869 7,986,797 2,559,882 9,935 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 2,063,125 11,468,380 2,063,758 414,835 119,153 192. 00 192. 01 19201 PRI VATE DUTY 0 0 0 0 0 0 192. 01 194. 00 07950 COMMUNI TY RELATI ONS 37,804 460,114 82,799 5,467 0 194. 00 194. 01 07951 COMMUNI TY BENEFI TS 89,612 540,923 97,341 42,328 0 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 10,714 46,181 8,310 0 0 194. 02 194. 03 07952 EMS Cross Foot Adjustments 4,634 57,975 10,433 0 0 194. 02 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	101.00		376, 929	1, 891, 503	340, 384	73, 788	0	101. 00
116. 00 1160 HOSPI CE 179, 448 1, 074, 579 193, 375 0 0 116. 00 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 2, 063, 125 11, 468, 380 2, 063, 758 414, 835 119, 153 192. 00 192. 01 19201 PRI VATE DUTY 0 0 0 0 0 0 192. 01 194. 00 194. 01 194. 01 195 194. 02 195 1					1			
118. 00 SUBTOTALS (SUM OF LINES 1-117) 7, 466, 742 54, 631, 869 7, 986, 797 2, 559, 882 9, 935 118. 00		1 1				_	_	
NONREI MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 2,063,125 11,468,380 2,063,758 414,835 119,153 192.00 192.01 19201 PRI VATE DUTY 0 0 0 0 0 0 0 0 192.01 194.00 194.00 195.01 194.01 194.01 195.01 194.01 195.01 19					l			
192. 00	118.00		7, 466, 742	54, 631, 869	7, 986, 797	2, 559, 882	9, 935	1118.00
192. 01 1920	400.00		0.040.405	44 440 000			110.150	
194. 00 07950 COMMUNITY RELATIONS 37, 804 460, 114 82, 799 5, 467 0 194. 00 194. 01 194. 02 07951 COMMUNITY BENEFITS 89, 612 540, 923 97, 341 42, 328 0 194. 01 194. 02 194. 03 07953 EMS 4, 634 57, 975 10, 433 0 0 194. 03 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 201. 00 0 0 201. 00 0 0 0 0 0 0 0 0 0				11, 468, 380	2, 063, 758	414, 835		
194. 01 07951 COMMUNITY BENEFITS 89, 612 540, 923 97, 341 42, 328 0 194. 01 194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS 10, 714 46, 181 8, 310 0 194. 02 194. 03 07953 EMS 4, 634 57, 975 10, 433 0 0 194. 03 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	1 0	0		
194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS 10, 714 46, 181 8, 310 0 0 194. 02 194. 03 07953 EMS 4, 634 57, 975 10, 433 0 0 194. 03 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 201. 00			1					
194. 03 07953 EMS		l l	1					1
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			1				1	
201.00 Negative Cost Centers 0 0 0 0 201.00			4, 634		1	0	1 0	
			_	-		_	_	
202.00 TOTAL (SUM LINES 118-201) 9,672,637 67,205,442 10,249,438 3,022,572 129,088 202.00			1 -1	ŭ	· ·	0 000 510		
	202.00	η	9,6/2,631	67, 205, 442	10, 249, 438	3, 022, 512	.] 129, 088	J2U2. UU

Provider CCN: 151329 | Period: From 01/01/2014 | Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

			To	12/31/2014	Date/Time Pre 5/19/2015 11:	pared:
Cost Center Description	OPERATION OF PLANT - HOSPITAL &	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	49 аш
	0FFS 7. 02	8. 00	9. 00	10.00	11. 00	
GENERAL SERVICE COST CENTERS	7.02	0.00	7.00	10.00	11.00	
1. 00						1. 00 1. 01 2. 00 2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT - OFFSITE						4. 00 5. 00 7. 00 7. 01
7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS	739, 949					7. 02
8.00 00800 LAUNDRY & LINEN SERVICE	11, 300					8. 00
9. 00 00900 HOUSEKEEPI NG	12, 105		1, 404, 587			9. 00
10. 00 01000 DI ETARY	5, 768		10, 964	363, 892	4 (07 005	10.00
11. 00 01100 CAFETERI A	28, 473		54, 120	O O	1, 627, 995	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	2, 559 4, 284		4, 863 8, 142	0	67, 281 0	13. 00 14. 00
15. 00 01500 PHARMACY	3, 438		6, 534	0	47, 037	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	15, 066		28, 636	0	121, 150	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10,000	<u> </u>	20,000	<u> </u>	12.7.100	
30. 00 03000 ADULTS & PEDI ATRI CS	77, 613	83, 743	147, 525	345, 708	256, 110	30.00
31.00 03100 INTENSIVE CARE UNIT	7, 477	4, 343	14, 212	18, 184	38, 923	31. 00
43. 00 04300 NURSERY	3, 811	16, 999	7, 244	0	57, 098	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	19, 022		36, 156	0	166, 611	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	6, 158		11, 705	0	9, 956	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	83, 515		158, 742	0	157, 695	54.00
60. 00 06000 LABORATORY	20, 830	1	39, 593	0	188, 943	60.00
60. 01 06001 BLOOD LABORATORY	17.005	1	0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	17, 085		32, 475	O O	62, 245 0	65. 00 66. 00
67. 00 06700 OCCUPATIONAL THERAPY	20, 278 5, 399		38, 544 10, 263	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	2, 932		5, 573	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	11, 678		22, 197	0	53, 564	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		22, 177	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	21, 269	18, 351	40, 428	o	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	15, 551		29, 559	0	0	88. 00
90. 00 09000 CLI NI C	42, 887		81, 519	0	0	90. 00
90. 01 09001 WOUND CLI NC	2, 563		4, 871	0	0	90. 01
91. 00 09100 EMERGENCY	51, 629	44, 090	98, 135	0	205, 792	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	14, 162	0	26, 918	o		101. 00
SPECIAL PURPOSE COST CENTERS	14, 102	0	20, 710	O _I	0	1101.00
113. 00 11300 NTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	0	o	0	o	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	506, 852	334, 670	918, 918	363, 892	1, 432, 405	118. 00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS' PRIVATE OFFICES	223, 924	5, 648	468, 234	0	143, 709	
192. 01 19201 PRI VATE DUTY	0	-	0	0		192. 01
194. 00 07950 COMMUNITY RELATIONS	1, 049	1	1, 994	0		194. 00
194. 01 07951 COMMUNITY BENEFITS	8, 124	1	15, 441	0		194. 01
194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS	0		0	0		194. 02
194. 03 07953 EMS	0	⁰	0	이	2, 397	194. 03
200.00 Cross Foot Adjustments	_				0	200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	739, 949	340, 318	1, 404, 587	363, 892	1, 627, 995	201.00
202.00 TOTAL (30111 TITIES TTO-201)	137, 747	1 340, 310	1, 404, 307	303, 072	1,027,773	1202.00

Heal th Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151329 Period:
From 01/01/2014 To 12/31/2014 Date/Time Prepared:
5/19/2015 11: 49 am

Cost Center Description

NURSING ADMINISTRATION SERVICES & SUPPLY LIBRARY

13.00 14.00 15.00 16.00 24.00

GENERAL SERVICE COST CENTERS

1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01

1.01 00101 NEW CAP REL COSTS-OFFSITE BLDG

	Cost Center Description	NURSI NG ADMI NI STRATI ON	SERVICES &	PHARMACY	MEDICAL RECORDS &	Subtotal	
		13.00	SUPPLY 14. 00	15. 00	16. 00	24. 00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	13.00	10.00	24.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 NEW CAP REL COSTS-OFFSITE BLDG						1. 01
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT -OFFSITE						7. 01
7. 02	00702 OPERATION OF PLANT - HOSPITAL & OFFS						7. 02
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	· · · · · · · · · · · · · · · · · · ·						10.00
11. 00	+ I						11. 00
13. 00		1, 199, 086					13. 00
14.00	0 01400 CENTRAL SERVICES & SUPPLY	53, 085	587, 770				14. 00
15. 00		0	110, 406	3, 323, 804			15. 00
16.00	0 01600 MEDICAL RECORDS & LIBRARY	o	101	0	1, 860, 310		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>. </u>	,				
30.00	03000 ADULTS & PEDIATRICS	289, 035	4, 738	0	1, 257, 559	6, 372, 667	30.00
31. 00	03100 INTENSIVE CARE UNIT	43, 927	494	0	0	739, 645	31. 00
43.00		64, 438	0	0	0	1, 036, 872	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	I I	0	145, 179	0	93, 152	4, 294, 511	50.00
52.00	I I	11, 236	5, 797	0	0	267, 760	52. 00
54.00		177, 952	195, 554	0	336, 993	10, 733, 394	54. 00
60.00		213, 235	63, 277	0	0	4, 679, 509	1
60. 0°	I I	0	0	0	0	0	60. 01
65. 00		70, 248	3, 799	0	0	1, 145, 303	65. 00
66. 00	I I	0	893	0	0	1, 850, 516	66. 00
67. 00		0	1, 614	0	0	683, 572	67. 00
68. 00	I I	0	61	0	0	273, 820	68. 00
69. 00	I I	40, 975	2, 229	0	35, 617	1, 242, 867	69. 00
71.00	1 1	0	0	0	0	0	71.00
72.00		0	0	0	0	1, 977, 708	72.00
73. 00		0	0	3, 323, 804	UU	3, 323, 804	73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS O 08800 RURAL HEALTH CLINIC	O	1, 179	0	٥	941, 326	88. 00
90.00	1 1		9, 641	0	106, 851	2, 752, 728	90.00
90.0	1 1		10, 854	0	100, 651	587, 471	90.00
91. 0		232, 250	5, 695	0	16, 439	4, 306, 596	91. 00
92. 00	1 1	232, 230	3, 073	O	10, 437	4, 300, 370	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101. (10100 HOME HEALTH AGENCY	0	1, 288	0	0	2, 348, 043	101.00
	SPECIAL PURPOSE COST CENTERS	-1	., ====[-1			
113. (00 11300 NTEREST EXPENSE						113. 00
116. (00 11600 H0SPI CE	0	6, 303	0	0	1, 274, 257	116. 00
118. (SUBTOTALS (SUM OF LINES 1-117)	1, 196, 381	569, 102	3, 323, 804	1, 846, 611	50, 832, 369	118. 00
	NONREI MBURSABLE COST CENTERS						
	00 19200 PHYSICIANS' PRIVATE OFFICES	0	18, 352	0	13, 699	14, 939, 692	1
	01 19201 PRI VATE DUTY	0	0	0	0		192. 01
	00 07950 COMMUNITY RELATIONS	0	18	0	0	566, 271	
	01 07951 COMMUNITY BENEFITS	0	298	0	0	739, 109	1
	02 07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	54, 491	
	03 07953 EMS	2, 705	0	0	0	73, 510	
200. (200. 00
201. (0	0	0	0		201. 00
202. (00 TOTAL (sum lines 118-201)	1, 199, 086	587, 770	3, 323, 804	1, 860, 310	67, 205, 442	202. 00

Provider CCN: 151329 | Period: | Worksheet B | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				To	12/31/2014	Date/Time Pre	
	Cost Center Description	Intern &	Total			5/19/2015 11:	49 alli
	p	Residents Cost					
		& Post					
		Stepdown					
		Adjustments 25.00	26. 00				
	GENERAL SERVICE COST CENTERS	20.00	20.00				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
1. 01	00101 NEW CAP REL COSTS-OFFSITE BLDG						1. 01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 4. 00	OO201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 01 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT -OFFSITE						7. 01
7. 02	00702 OPERATION OF PLANT - HOSPITAL & OFFS						7. 02
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY						15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY						16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	O	6, 372, 667				30.00
31. 00	03100 NTENSI VE CARE UNI T	0	739, 645				31.00
43.00	04300 NURSERY	0	1, 036, 872				43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	4, 294, 511				50.00
52. 00 54. 00	O5200 DELIVERY ROOM & LABOR ROOM O5400 RADIOLOGY-DIAGNOSTIC	0	267, 760 10, 733, 394				52. 00 54. 00
60. 00	06000 LABORATORY	0	4, 679, 509				60.00
60. 01	06001 BLOOD LABORATORY	0	0				60. 01
65. 00	06500 RESPI RATORY THERAPY	0	1, 145, 303				65. 00
66.00	06600 PHYSI CAL THERAPY	0	1, 850, 516				66.00
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	0	683, 572 273, 820				67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	1, 242, 867				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATI ENT	0	1, 977, 708				72. 00
73. 00	O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	3, 323, 804				73. 00
88. 00	08800 RURAL HEALTH CLINIC	0	941, 326				88. 00
90. 00	09000 CLINIC	Ö	2, 752, 728				90.00
90. 01	09001 WOUND CLINC	0	587, 471				90. 01
91. 00	09100 EMERGENCY	0	4, 306, 596				91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92. 00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	2, 348, 043				101. 00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	2,010,010				101.00
	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	0	1, 274, 257				116. 00
118. 00		0	50, 832, 369				118. 00
192. 00	NONREIMBURSABLE COST CENTERS 19200 PHYSICIANS' PRIVATE OFFICES	l ol	14, 939, 692				192. 00
	19201 PRI VATE DUTY		0				192. 01
	07950 COMMUNITY RELATIONS	0	566, 271				194. 00
	07951 COMMUNITY BENEFITS	0	739, 109				194. 01
	07952 OTHER NONREIMBURSABLE COST CENTERS	0	54, 491				194. 02
200.00	1 1		73, 510 0				194. 03 200. 00
201.00			o				201. 00
202.00		0	67, 205, 442				202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| Period: | Worksheet B | From 01/01/2014 | Part II | Date/Time Prepared: | 5/19/2015 | 11: 49 am

					5/19/2015 11:	49 am
			CAPITAL REL	ATED COSTS		
Cost Center Description	Di rectly	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE	
	Assi gned New	FLXT	BLDG	EQUI P	EQUIP OFFSIT	
	Capi tal					
	Related Costs	1 00	1 01	2 00	2 01	
GENERAL SERVICE COST CENTERS	0	1. 00	1. 01	2. 00	2. 01	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MYBLE EQUIP						2.00
2.01 00200 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	11, 623	0	16, 530	0	4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	0	276, 264	0	392, 877	0	5. 00
7. 00 00700 OPERATION OF PLANT	0	513, 128		729, 722	0	7. 00
7. 01 00701 OPERATION OF PLANT -OFFSITE	0	313, 120	0	121, 122	0	7. 00
7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	0	7. 01
8.00 00800 LAUNDRY & LINEN SERVICE	0	28, 458	1 1	40, 470	0	8. 00
9. 00 00900 HOUSEKEEPI NG	0	30, 484	0	43, 351	0	9. 00
10. 00 01000 DI ETARY	0	14, 526	l "I	20, 658	0	10.00
11. 00 01100 CAFETERI A	0	71, 703		101, 969	0	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	o o	6, 443		9, 163	0	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	o o	10, 788		15, 341	0	14. 00
15. 00 01500 PHARMACY	0	8, 657	0	12, 312	0	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	37, 940	0	53, 955	0	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	37, 740	<u> </u>	33, 733	0	10.00
30. 00 03000 ADULTS & PEDIATRICS	0	195, 454	0	277, 957	0	30.00
31. 00 03100 NTENSI VE CARE UNI T	0	18, 829		26, 777	0	31.00
43. 00 04300 NURSERY	0	9, 597	0	13, 648	0	43. 00
ANCI LLARY SERVI CE COST CENTERS		7, 071	<u> </u>	10, 010	<u> </u>	10.00
50. 00 05000 OPERATING ROOM	0	47, 903	0	68, 123	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	O	15, 508		22, 054	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	210, 315		299, 091	0	54.00
60. 00 06000 LABORATORY	o	52, 456		74, 598	0	60.00
60. 01 06001 BLOOD LABORATORY	o	0	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	o	43, 026	0	61, 187	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	51, 067	0	72, 623	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	13, 597	0	19, 336	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	7, 383	0	10, 500	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	29, 408	0	41, 821	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	53, 563	0	76, 172	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	0	0	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	47, 709	0	8, 993	88. 00
90. 00 09000 CLI NI C	0	108, 003	0	153, 592	0	90.00
90. 01 09001 WOUND CLINC	0	6, 454	0	9, 178	0	90. 01
91. 00 09100 EMERGENCY	0	130, 017	0	184, 899	0	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	35, 663	0	50, 717	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	2, 038, 257	47, 709	2, 898, 621	8, 993	118. 00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	200, 498	572, 160	285, 130	107, 849	
192. 01 19201 PRI VATE DUTY	0	0	0	0		192. 01
194.00 07950 COMMUNITY RELATIONS	0	2, 642		3, 757		194. 00
194. 01 07951 COMMUNITY BENEFITS	0	20, 458	0	29, 094		194. 01
194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194. 02
194. 03 07953 EMS	0	0	0	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0		201.00
202.00 TOTAL (sum lines 118-201)	0	2, 261, 855	619, 869	3, 216, 602	116, 842	J202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: | 11/40 | From 14/40 | From Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MARGARET MARY COMMUNITY HOSPITAL
Provider CCN: 151329

				10	0 12/31/2014	5/19/2015 11:	
	Cost Center Description	Subtotal	EMPLOYEE	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	
			BENEFITS	& GENERAL	PLANT	PLANT -OFFSITE	
			DEPARTMENT		7.00	7.04	
	CENEDAL CEDVICE COST CENTEDS	2A	4. 00	5. 00	7. 00	7. 01	
	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
	00101 NEW CAP REL COSTS-DEDG & TTXT						1. 00
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2. 01
	00400 EMPLOYEE BENEFITS DEPARTMENT	28, 153	28, 153				4. 00
	00500 ADMINISTRATIVE & GENERAL	669, 141	3, 958				5. 00
	00700 OPERATION OF PLANT	1, 242, 850	0	1	1, 273, 122		7. 00
	00701 OPERATION OF PLANT -OFFSITE	o	0		0	1, 293	7. 01
7.02	00702 OPERATION OF PLANT - HOSPITAL & OFFS	o	421	7, 411	0	0	7. 02
8.00	00800 LAUNDRY & LINEN SERVICE	68, 928	72	2, 706	24, 801	0	8. 00
	00900 HOUSEKEEPI NG	73, 835	540	13, 166	26, 566	0	9. 00
	01000 DI ETARY	35, 184	121	3, 171	12, 660	0	10.00
	01100 CAFETERI A	173, 672	596		62, 489	0	11. 00
	01300 NURSING ADMINISTRATION	15, 606	617		5, 615	0	13. 00
	01400 CENTRAL SERVI CES & SUPPLY	26, 129	0		9, 402	0	14. 00
	01500 PHARMACY	20, 969	487	· ·	7, 545	i e	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	91, 895	783	16, 194	33, 065	0	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	473, 411	1, 566	35, 117	170, 338	0	30. 00
	03100 NTENSI VE CARE UNIT	45, 606	289		16, 409	l e	31. 00
	04300 NURSERY	23, 245	414		8, 364	Ö	43. 00
101.00	ANCILLARY SERVICE COST CENTERS	20,2.10		0,000	0,001		.0.00
50.00	05000 OPERATING ROOM	116, 026	1, 217	37, 052	41, 747	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	37, 562	72	1, 896	13, 515	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	509, 406	2, 402		183, 288	0	54.00
60.00	06000 LABORATORY	127, 054	1, 082	40, 514	45, 715	0	60.00
	06001 BLOOD LABORATORY	0	0		0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	104, 213	382		37, 497	0	65. 00
66.00	06600 PHYSI CAL THERAPY	123, 690	839		44, 505	0	66. 00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	32, 933 17, 883	324 131	·	11, 850 6, 435	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	71, 229	438		25, 629		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	71,229	430	· · · · · · · · · · · · · · · · · · ·	25, 029		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	129, 735	Ö	1	46, 680	ĺ	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	· ·	0	Ö	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	56, 702	435	8, 865	0	100	88. 00
	09000 CLI NI C	261, 595	1, 279		94, 125	l e	90.00
	09001 WOUND CLINC	15, 632	189		5, 625	0	90. 01
	09100 EMERGENCY	314, 916	1, 467	33, 889	113, 310	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92. 00
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	86, 380	1, 098	22, 354	31, 081	0	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	00, 300	1,070	22, 334	31,001		101.00
113.00	11300 I NTEREST EXPENSE						113. 00
116. 00	11600 HOSPI CE	o	523	12, 699	0	0	116. 00
118.00		4, 993, 580	21, 742	524, 512	1, 078, 256	100	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	1, 165, 637	5, 996		174, 734		192. 00
	19201 PRI VATE DUTY	(200	0	1	2 202		192. 01
	07950 COMMUNITY RELATIONS 07951 COMMUNITY BENEFITS	6, 399 49, 552	110 261				194. 00 194. 01
	07952 OTHER NONREIMBURSABLE COST CENTERS	49, 352	31				194. 01 194. 02
	07953 EMS		13				194. 02 194. 03
200.00	Cross Foot Adjustments		13	000	0		200. 00
201.00		ا	0	o	0		201. 00
202.00		6, 215, 168	28, 153		1, 273, 122		202. 00
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Health Financial Systems In Lieu of Form CMS-2552-10 MARGARET MARY COMMUNITY HOSPITAL ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151329 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/19/2015 11:49 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A PLANT -LINEN SERVICE HOSPITAL & 0FFS 11.00 8.00 9.00 10.00 7.02 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.01 00101 NEW CAP REL COSTS-OFFSITE BLDG 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.01 00701 OPERATION OF PLANT -OFFSITE 7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS 7,832 00800 LAUNDRY & LINEN SERVICE 8.00 120 96, 627 9.00 00900 HOUSEKEEPI NG 128 4, 220 118, 455 10.00 01000 DI ETARY 61 146 925 52, 268 01100 CAFETERI A 301 556 256, 151 11.00 4.564 0 01300 NURSING ADMINISTRATION 13.00 27 410 0 10, 586 14.00 01400 CENTRAL SERVICES & SUPPLY 45 1,593 687 0 0 01500 PHARMACY 15.00 36 551 0 7, 401 19<u>, 062</u> 01600 MEDICAL RECORDS & LIBRARY 16 00 159 2 415 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 822 23, 777 12, 441 49, 656 40, 296 03100 INTENSIVE CARE UNIT 31.00 79 1, 233 1, 199 2, 612 6, 124 40 611

Health Financial Systems In Lieu of Form CMS-2552-10 MARGARET MARY COMMUNITY HOSPITAL ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 151329 Peri od: Worksheet B From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/19/2015 11:49 am Cost Center Description NURSI NG CENTRAL **PHARMACY** MEDI CAL Subtotal ADMI NI STRATI ON SERVICES & RECORDS & **SUPPLY** LI BRARY 13.00 15.00 24.00 14.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP REL COSTS-OFFSITE BLDG 1.01 1.01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7 00 7.01 00701 OPERATION OF PLANT -OFFSITE 7.01 7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS 7 02 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPING 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 43.989 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 1,947 44, 754 14.00 15.00 01500 PHARMACY 15.00 8, 406 76,829 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 163, 581 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 10,605 361 0 110, 580 928, 970 30.00 03100 INTENSIVE CARE UNIT 0 80, 940 31.00 31.00 1,611 38 57, 537 04300 NURSERY 2, 364 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 11, 054 0 8, 191 254, 942 50.00 05200 DELIVERY ROOM & LABOR ROOM 412 52.00 441 0 56, 935 52.00 0 54 00 05400 RADI OLOGY-DI AGNOSTI C 6.528 14, 890 29, 632 887, 995 54 00 06000 LABORATORY 0 60.00 7,823 4,818 260, 294 60.00

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06001 BLOOD LABORATORY

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

09000 CLI NI C

09001 WOUND CLINC

101.00 10100 HOME HEALTH AGENCY

113. 00 11300 | INTEREST EXPENSE

192. 01 19201 PRI VATE DUTY

194, 00 07950 COMMUNITY RELATIONS

194. 01 07951 COMMUNITY BENEFITS

116. 00 11600 HOSPI CE

194. 03 07953 EMS

09100 EMERGENCY

06900 ELECTROCARDI OLOGY

06500 RESPIRATORY THERAPY

06700 OCCUPATIONAL THERAPY

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

07200 IMPL. DEV. CHARGED TO PATIENT

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS
08800 RURAL HEALTH CLINIC

OTHER REIMBURSABLE COST CENTERS

SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS

194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

SPECIAL PURPOSE COST CENTERS

192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES

| Peri od: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151329

				То	12/31/2014	Date/Time Pro 5/19/2015 11:	
	Cost Center Description	Intern &	Total			37 177 2013 11.	. 47 am
	·	Residents Cost					
		& Post					
		Stepdown Adjustments					
		25. 00	26. 00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
1. 01	00101 NEW CAP REL COSTS-OFFSITE BLDG						1. 01
2. 00 2. 01	00200 NEW CAP REL COSTS MVBLE EQUIP						2. 00 2. 01
4. 00	OO201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT OO400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7.01	00701 OPERATION OF PLANT -OFFSITE						7. 01
7. 02	00702 OPERATION OF PLANT - HOSPITAL & OFFS						7. 02
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	928, 970				30.00
31. 00 43. 00	03100 NTENSI VE CARE UNI T 04300 NURSERY	0	80, 940 57, 537				31. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	J O	57, 557				43.00
50.00	05000 OPERATI NG ROOM	0	254, 942				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	56, 935				52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	887, 995				54. 00
60.00	06000 LABORATORY	0	260, 294				60.00
60. 01	06001 BLOOD LABORATORY	0	140 272				60. 01
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		168, 373 197, 733				65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		52, 545				67. 00
68. 00	06800 SPEECH PATHOLOGY	o	27, 459				68. 00
69.00	06900 ELECTROCARDI OLOGY	0	122, 892				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	203, 156				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	U	76, 829				73. 00
88. 00	08800 RURAL HEALTH CLINIC	0	68, 850				88. 00
90.00	09000 CLINIC		405, 433				90.00
90. 01	09001 WOUND CLINC	0	28, 277				90. 01
91.00	09100 EMERGENCY	0	527, 701				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92. 00
101 00	OTHER REIMBURSABLE COST CENTERS		142 421				101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	143, 431				101. 00
113 00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	13, 702				116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	4, 563, 994				118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	1, 551, 762				192. 00
	19201 PRIVATE DUTY 07950 COMMUNITY RELATIONS	0	16 762				192. 01 194. 00
	07951 COMMUNITY RELATIONS 07951 COMMUNITY BENEFITS		16, 763 80, 898				194. 00
	07952 OTHER NONREIMBURSABLE COST CENTERS		577				194. 01
	07953 EMS		1, 174				194. 03
200.00		0	0				200. 00
201.00	1 1 0	0	0				201. 00
202.00	TOTAL (sum lines 118-201)		6, 215, 168				202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 151329 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/19/2015 11:49 am CAPITAL RELATED COSTS NEW MVBLE **EMPLOYEE** Cost Center Description NEW BLDG & NEW OFFSITE NEW MVBLE EQUIP OFFSIT FIXT BLDG **FOULP BENEFITS** (SQUARE (SOLIARE (SQUARE (SQUARE DEPARTMENT FEET) FEET) FEET) FEET) (GROSS SALARI ES) 1.00 1. 01 2.00 2. 01 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 216, 587 1 00 1.01 00101 NEW CAP REL COSTS-OFFSITE BLDG 48, 723 1.01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 216, 587 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2 01 48 723 2 01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 1, 113 C 1, 113 31, 433, 829 4.00 26, 454 5.00 00500 ADMINISTRATIVE & GENERAL 26, 454 4, 417, 376 5.00 7.00 00700 OPERATION OF PLANT 49, 135 0 49, 135 0 7.00 00701 OPERATION OF PLANT -OFFSITE 7 01 0 7 01 0 C 0 7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS 0 469, 536 7. 02 00800 LAUNDRY & LINEN SERVICE 2,725 2, 725 0 79, 917 8.00 8.00 0 00900 HOUSEKEEPI NG 2,919 2, 919 9.00 603.006 9.00 1, 391 1, 391 134, 908 10.00 01000 DI ETARY Ω 10.00 11.00 01100 CAFETERI A 6,866 0 6,866 0 665, 680 11.00 01300 NURSING ADMINISTRATION 0 13.00 617 617 688, 713 13.00 0 01400 CENTRAL SERVICES & SUPPLY 1,033 0 14.00 14.00 1,033 0 15 00 01500 PHARMACY 829 C 829 0 542, 971 15 00 873, 998 01600 MEDICAL RECORDS & LIBRARY 16.00 3,633 3, 633 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDLATRICS 18.716 18.716 1, 748, 180 30.00 31.00 03100 INTENSIVE CARE UNIT 1,803 C 1,803 0 322, 518 31.00 04300 NURSERY 919 0 919 43.00 0 462, 029 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 4. 587 50.00 4.587 0 1. 358. 184 05200 DELIVERY ROOM & LABOR ROOM 52.00 1, 485 C 1, 485 0 80, 563 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 20, 139 20, 139 0 0 2, 681, 189 54.00 1, 207, 305 60.00 06000 LABORATORY 5.023 0 5.023 60.00 60.01 06001 BLOOD LABORATORY C 60.01 06500 RESPIRATORY THERAPY 4, 120 4, 120 0 426, 244 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 4,890 0 4, 890 0 936, 715 66.00 06700 OCCUPATIONAL THERAPY 361, 668 67.00 1, 302 C 1, 302 67.00 68.00 06800 SPEECH PATHOLOGY 707 0 707 146, 247 68.00 0 06900 ELECTROCARDI OLOGY 69.00 2,816 0 2,816 489, 290 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 0 C 72.00 5, 129 5, 129 Λ 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 3. 750 0 3 750 Ω 485, 388 88 00 90.00 09000 CLI NI C 10, 342 10, 342 1, 427, 282 90.00 90.01 09001 WOUND CLINC 618 618 0 210, 846 90.01 91.00 09100 EMERGENCY 12, 450 C 12, 450 0 1, 637, 359 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 92 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 3, 415 0 3, 415 0 1, 224, 932 101. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE n 583, 164 116. 00 SUBTOTALS (SUM OF LINES 1-117) 3, 750 24, 265, 208 118. 00 195, 176 3,750 195, 176 NONREI MBURSABLE COST CENTERS

192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 44. 973 44. 973 6, 704, 673 192. 00 19, 199 19, 199 192. 01 19201 PRI VATE DUTY 0 192. 01 194.00 07950 COMMUNITY RELATIONS 0 253 Ω 253 122, 853 194. 00 194. 01 07951 COMMUNITY BENEFITS 1, 959 0 291, 217 194. 01 Ω 1, 959 194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS 0 34, 819 194. 02 C 194. 03 07953 EMS 15, 059 194. 03 0 0 200.00 Cross Foot Adjustments 200.00 201 00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 261, 855 619, 869 3, 216, 602 116, 842 9, 672, 631 202. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 10.443171 12. 722308 14.851316 2.398087 0. 307714 203. 00 28, 153 204. 00 204 00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000896 205.00

	<u> </u>	ARGARET MARY COMM	MUNITY HOSPITA	L	In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
					o 12/31/2014		
	Cook Cook on Door on the cook	D	ADMINI CTDATI VE	ODEDATION OF	ODEDATION OF	5/19/2015 11:	49 am
	Cost Center Description	Reconciliation/	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	OPERATION OF PLANT -	
			(ACCUM.	(SQUARE	. 2,	HOSPI TAL &	
			COST)	FEET)	(SQUARE	0FFS	
					FEET)	(SQUARE FEET)	
		5A	5. 00	7. 00	7. 01	7. 02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	OO101 NEW CAP REL COSTS-OFFSITE BLDG OO200 NEW CAP REL COSTS-MVBLE EQUIP						1. 01 2. 00
2. 00 2. 01	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			•			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-10, 249, 438	56, 956, 004	l .			5. 00
7.00	00700 OPERATION OF PLANT	0	2, 561, 551				7.00
7. 01 7. 02	OO701 OPERATION OF PLANT -OFFSITE OO702 OPERATION OF PLANT - HOSPITAL & OFFS	0	109, 401 627, 100	1) 48, 723) 0	178, 434	7. 01 7. 02
8.00	00800 LAUNDRY & LINEN SERVICE	0	228, 940			2, 725	1
9.00	00900 HOUSEKEEPI NG	0	1, 114, 066			2, 919	1
10.00	01000 DI ETARY	0	268, 306			1, 391	
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0	1, 182, 324 941, 605			6, 866 617	1
	01400 CENTRAL SERVICES & SUPPLY	0	418, 938			1, 033	1
15. 00	01500 PHARMACY	o	2, 659, 830	1		829	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	1, 370, 272	3, 633	0	3, 633	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		2 071 502	10 71/		10.71/	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	2, 971, 503 485, 720	1			1
43. 00	04300 NURSERY		735, 135				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	3, 135, 199			4, 587	1
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	160, 472			1, 485	1
60.00	06000 LABORATORY	0	7, 753, 331 3, 428, 183			20, 139 5, 023	
60. 01	06001 BLOOD LABORATORY	0	0, 120, 100	1		0	1
65. 00	06500 RESPI RATORY THERAPY	0	731, 544			4, 120	1
66. 00 67. 00	06600 PHYSI CAL THERAPY	0	1, 402, 503			4, 890	1
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	540, 838 211, 854			1, 302 707	
69. 00	06900 ELECTROCARDI OLOGY	Ö	860, 248	l .		2, 816	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(1	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	1, 514, 328			5, 129	
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0		0	0	73. 00
88. 00	08800 RURAL HEALTH CLINIC	0	750, 116		3, 750	3, 750	88. 00
90.00	09000 CLI NI C	0	1, 914, 448			10, 342	90.00
	09001 WOUND CLINC	0	471, 061				90. 01
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 867, 533	12, 450	0	12, 450	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	0	1, 891, 503	3, 415	0	3, 415	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE 11600 HOSPICE		1 074 570			0	113.00
118.00		0 -10, 249, 438	1, 074, 579 44, 382, 431		3, 750		116.00
110.00	NONREI MBURSABLE COST CENTERS	10, 217, 100	11, 002, 101	110, 17	0, 700	122, 221	1110.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	11, 468, 380	19, 199	44, 973		192. 00
	19201 PRI VATE DUTY	0	0	(-		192. 01
	07950 COMMUNITY RELATIONS 07951 COMMUNITY BENEFITS	0	460, 114 540, 923				194. 00 194. 01
	07952 OTHER NONREIMBURSABLE COST CENTERS		46, 181				194. 02
	07953 EMS	0	57, 975		0	0	194. 03
200.00	, ,						200.00
201. 00 202. 00	9		10, 249, 438	3, 022, 512	129, 088	739, 949	201. 00
202.00	Part I)		10, 249, 438	3,022,512	127, 088	137, 949	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		0. 179954	21. 607120	2. 649426	4. 146906	203. 00
204.00			673, 099	1, 273, 122	1, 293	7, 832	204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part		0. 011818	9. 101205	0. 026538	0. 043893	205 00
200.00			0. 011010	7. 101200	0.020030	0.043093	200.00
		•					

	FINANCIAI SYSTEMS MAI LLOCATION - STATISTICAL BASIS	RGARET MARY COM		CCN: 151329 Pe	eriod: com 01/01/2014	Worksheet B-1 Date/Time Pre 5/19/2015 11:	pared:
	Cost Center Description	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSI NG ADMI NI STRATI ON (HOURS OF SERVI CE)	
		8. 00	9. 00	10.00	11. 00	13.00	
1. 00 1. 01 2. 00 2. 01 4. 00 5. 00 7. 00 7. 01 7. 02 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MYBLE EQUIP 00201 NEW CAP REL COSTS-MYBLE EQUIP OFFSIT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - OFFSITE 00702 OPERATION OF PLANT - HOSPITAL & OFFS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 MEDICAL RECORDS & LIBRARY	276, 277 12, 067 418 1, 591 0 4, 555 0	178, 195 1, 391 6, 866 617 1, 033 829 3, 633	17, 070 0 0 0 0	422, 527 17, 462 0 12, 208 31, 443	275, 756 12, 208 0 0	14. 00 15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	67, 984	18, 716	16, 217	66, 470	66, 470	30.00
31.00	03100 INTENSIVE CARE UNIT	3, 526	1, 803	853		10, 102	•
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	13, 800	919	0	14, 819	14, 819	43. 00
50. 00 52. 00 54. 00 60. 00 60. 01 65. 00 66. 00 67. 00 68. 00 71. 00	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	29, 135 1, 194 31, 843 0 0 5, 879 24, 560 0 0 575	4, 587 1, 485 20, 139 5, 023 0 4, 120 4, 890 1, 302 707 2, 816	0 0 0 0 0 0 0	43, 242 2, 584 40, 928 49, 038 0 16, 155 0 0 0 13, 902	0 2, 584 40, 924 49, 038 0 16, 155 0 0 0 9, 423	52. 00 54. 00 60. 00 60. 01 65. 00 66. 00 67. 00 68. 00 69. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	14, 898	5, 129	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73. 00
88. 00 90. 00 90. 01 91. 00 92. 00	008800 RURAL HEALTH CLINIC 09000 CLINIC 09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0 23, 874 0 35, 793	3, 750 10, 342 618 12, 450	0 0 0 0	0 0 0 53, 411	0 0 0 53, 411	90. 00 90. 01
101.00	10100 HOME HEALTH AGENCY	0	3, 415	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0 271, 692	0 116, 580	0 17, 070	0 371, 764	0 275, 134	113. 00 116. 00 118. 00
192. 01 194. 00 194. 01 194. 02	19200 PHYSICIANS' PRIVATE OFFICES 19201 PRIVATE DUTY 07950 COMMUNITY RELATIONS 07951 COMMUNITY BENEFITS 07952 OTHER NONREIMBURSABLE COST CENTERS 07953 EMS Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	4, 585 0 0 0 0 0 0	59, 403 0 253 1, 959 0 0	0 0 0 0 0 0	0 3, 849 8, 994 0 622	0 0 0 0	192. 00 192. 01 194. 00 194. 01 194. 02 194. 03 200. 00 201. 00 202. 00
203. 00 204. 00	Cost to be allocated (per Wkst. B,	1. 231800 96, 627	7. 882303 118, 455	21. 317633 52, 268	3. 852996 256, 151	4. 348359 43, 989	203. 00 204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part 	0. 349747	0. 664749	3. 061980	0. 606236	0. 159521	205. 00

Provider CCN: 151329 | Period: | Worksheet B-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Cost Center Description					Ţ	0 12/31/2014	Date/Time Prep 5/19/2015 11:4	
SUPPLY COSTED PHÁRBACCY CTIME		Cost Center Description					37 1 77 2013 11. 4	7 alli
CIDSTED SPINITS SPIN								
				THANWACT)				
GRINBAL STRVICE COST CENTERS 1 00 00100 100 CAP PEL COSTS-BEDG & FIXT 1 01 00 0110 New CAP REL COSTS-BEDG & FIXT 1 01 00 110 New CAP REL COSTS-BEDG & FIXT 1 01 0110 New CAP REL COSTS-BEDG & FIXT 2 01 00 0010 New CAP REL COSTS-MELE EQUIP OFFS!T 2 01 00 0010 New CAP REL COSTS-MELE EQUIP OFFS!T 4 00 00400 New CAP REL COSTS-MELE EQUIP OFFS!T 4 00 00400 New CAP REL COSTS-MELE EQUIP OFFS!T 4 00 00 0000 New CAP REL COSTS-MELE EQUIP OFFS!T 7 00 00 0000 New CAP REL COSTS-MELE EQUIP OFFS!T 7 00 00 0000 New CAP REL COSTS-MELE EQUIP OFFS!T 7 00 00 0000 New CAP REL COSTS-MELE EQUIP OFFS!T 7 00 00 0000 New CAP REL COSTS-MELE EQUIP OFFS!T 7 00 00 0000 New CAP REL COSTS-MELE EQUIP OFFS!T 7 00 00 0000 New CAP REL COSTS-MELE EQUIP OFFS!T 7 00 00 0000 New CAP REL COSTS-MELE EQUIP OFFS:T 7 00 00 0000 New CAP REL COSTS-MELE EQUIP OFFS:T 7 00 00 0000 NEXT 1				15.00				
1.01 0.101 NEW CAP REL COSTS-OFFSITE BLDG 2.00 2		GENERAL SERVICE COST CENTERS	14.00	15.00	10.00			
2.00		1 1						
2.01 0.0010 INST CAR PELL COSTS-MUSE FOULD OFFSIT		1 1						
0.0000 OBODO ADMINISTRATIVE & GENERAL		1						
0.0700 OPERATION OF PLANT OFFSITE								
7.02 0.0702 DERATIN OF PLANT - HOSPITAL & OFFS 8.00 0.000 0.0000 DETARY 10.00 11.00 0.0000 DETARY 10.00 11.00 0.1000 DETARY 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 DETAR RECORDS & LIBRARY 1.641 0.00 679 10.00 10.		l l						
8.00		i i						
0.000 0.0000 DUSERKER ING 0.000 0.000 DETARY 10.000 0.000 DETARY 10.000 0.000 DETARY 10.000 0.000 DETARY 11.000 0.11.000 0.11.000 0.11.000 0.000 DETARY 0.000 0.11.0000 0.11.0000 0.11.0000 0.11.0000 0.11.0000 0.11.0000 0.11.0000 0.11.000		1 1						
11.00 01100 CAFFERIA		1 1						
13.0 0 1300 NURSING ADMINISTRATION 13.0 0 15.0 0 0 0 0 0 0 31.0 0 0 0 0 0 0 0 0 0								
14. 00 01400 CNITRAL SERVICES & SUPPLY 9, 507, 596 1, 785, 898 100 15. 00 1500 16. 0		1						
16. 00		01400 CENTRAL SERVICES & SUPPLY						
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 31.		1						
31.00 03100 INTERSIVE CARE UNIT 7.983 0 0 43.00	10.00		1,041	O O	077			10.00
43. 00 04300 NURSERY 0 0 0 0 43. 00		1 1						
ANCILLARY SERVICE COST CENTERS 50.00		1 1						
S2.00 05200 DELLUYERY ROOM & LABOR ROOM		ANCILLARY SERVICE COST CENTERS			-			
54.00		i i						
60.01 0.001 0.000 0.00 0.0				-	_			
65. 00 06500 ROSPI RATORY THERAPY 61, 453 0 0 0 66. 00 67. 00 66. 00 67. 00 66. 00 67. 00 66. 00 67. 00 66. 00 67.		1 1	1, 023, 548	_				
66.00 06600 PMSI CAL THERAPY		1 1	61, 453	Ĭ				
68. 00 06800 SPEECH PATHOLOGY 989 0 0 68. 00 699. 00 06900 ELECTROCARDI OLOGY 36, 060 0 13 69, 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 100 0 0 73. 00 000 000 000 000 000 000 000 000 88. 00 08800 RURAL HEALTH CLINIC 195, 951 0 39 99. 00 90. 00 09000 CLINIC 175, 571 0 0 99. 01 91. 00 09100 EMERGENCY 92. 121 0 6 99. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 121 0 6 99. 00 001 FREE REIMBURSABLE COST CENTERS 101.000 101.000 1000 HOME HEALTH AGENCY 20, 833 0 0 116. 00 11600 HOSPICE 101.000 116. 00 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 9, 205, 621 100 674 118. 00 NONREI MBURSABLE COST CENTERS 101.953 0 0 118. 00 192. 01 192. 01 192. 01 192. 01 194. 01 07951 COMMUNITY RELATIONS 290 0 0 194. 01 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 296, 865 0 5 192. 00 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 4, 820 0 0 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0		1 1		Ö	_			
69. 00 06900 ELECTROCARDI DLOGY 36,060 0 13 69. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72. 00 72. 00 1MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72. 00 73. 00 07300 RURUS CHARGED TO PATIENTS 0 100 0 0 0 73. 00 07300 RURUS CHARGED TO PATIENTS 0 100 0 0 0 0 0 0 0		1 1		0				
72. 00 07200 IMPL DEV. CHARGED TO PATIENT 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 100 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 100 0 0 0 0 0 0 0				0				
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 100 0 0 0 0 0 0 0			0	-			1	
OUTPATT ENT SERVICE COST CENTERS		1 1	0				1	
90. 00 09000 CLINIC 155,951 0 39 90. 00 90. 01 09001 WOUND CLINC 175,571 0 0 0 91. 00 09100 EMERGENCY 92. 121 0 6 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 121 0 6 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 101 00 OTHER REI MBURSABLE COST CENTERS 101. 00 O SPECIAL PURPOSE COST CENTERS 113. 00 1300 INTEREST EXPENSE 113. 00 1300 INTEREST EXPENSE 113. 00 1300 SUBTOTALS (SUM OF LINES 1-117) 9, 205, 621 100 674 118. 00 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 192. 01 192.00 PHYSICIANS' PRIVATE OFFICES 296, 865 0 5 192. 00 194. 01 07951 COMMUNI TY RELATIONS 290 0 0 194. 01 194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 01 194. 03 07953 EMS 0 0 0 0 194. 02 194. 03 07953 EMS 0 0 0 0 194. 02 194. 03 07953 EMS 0 0 0 0 194. 02 194. 03 07953 EMS 0 0 0 0 194. 02 194. 04 00 00 0 0 194. 02 194. 05 00 00 00 194. 02 194. 06 00 00 00 194. 02 194. 07 00 00 00 194. 02 194. 08 07953 EMS 0 0 0 0 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 201. 00 202. 00 Cost to be allocated (per Wkst. B, 587, 770 3, 323, 804 1, 860, 310 203. 00 Unit cost multiplier (Wkst. B, Part I) 0.061821 33, 238.040000 2, 739.779087 203. 00 204. 00 Cost to be allocated (per Wkst. B, 44, 754 76, 829 163, 581 205. 00 Unit cost multiplier (Wkst. B, Part I) 0.004707 768.290000 240.914580 205. 00		OUTPATIENT SERVICE COST CENTERS						
90. 01 09001 WOUND CLI NC 175,571 0 0 0 99. 01 91. 00 09200 DEBERGENCY 92, 121 0 6 91. 00 92. 00 09200 DESERVATI ON BEDS (NON-DISTINCT PART) 92, 121 0 6 92. 00 09200 DESERVATI ON BEDS (NON-DISTINCT PART) 92. 00 00 00 00 00 00 00 00 00 00 00 010 NONER REI MBURSABLE COST CENTERS 113. 00 116.00 1								
92. 00 OP200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REI MBURSABLE COST CENTERS		l l						
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 20,833 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 113.00 115.00 113.00 116		1	92, 121	0	6			
101. 00 10100 HOME HEALTH AGENCY 20, 833 0 0 0 101. 00	92.00							92.00
113.00	101.00	10100 HOME HEALTH AGENCY	20, 833	0	0		1	101. 00
116. 00	113 00						-	113 00
NONREI MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 296, 865 0 5 192.00 192.01 19201 19201 PRI VATE DUTY 0 0 0 0 192.01 194.00 195.01 194.00 194.00 194.00 194.01 194.01 194.01 194.01 194.02 194.01 194.02 194.01 194.02 194.01 194.02 194.03 194.02 194.03 194.0	116.00	11600 H0SPI CE					1	116. 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192. 01 194. 01 194.	118.00	,	9, 205, 621	100	674		1	118. 00
194. 00	192.00		296, 865	0	5		1	192. 00
194. 01 07951 COMMUNITY BENEFITS 4,820 0 0 194. 01 194. 02 194. 03 07952 COMMUNITY BENEFITS 0 0 0 0 194. 02 194. 03 07953 EMS 0 0 0 0 0 194. 03 19			0					
194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 02 194. 03 07953 EMS 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 0.061821 33, 238. 040000 2, 739. 779087 203. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 0.004707 768. 290000 240. 914580 205. 00				-	_			
200. 00 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) 203. 00 Unit cost multiplier (Wkst. B, Part II) 204. 00 Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part III) 205. 00 Unit cost multiplier (Wkst. B, Part III) 205. 00 Unit cost multiplier (Wkst. B, Part III) 206. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 209. 00 209.			0	Ĭ				
201.00 202.00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 206.00 Negative Cost Centers Ser, 770 Ser, 77		i i	0	0	0			
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part III) 205.00 Part II) 0.061821 33, 238.040000 2, 739.779087 203.00 204.00 204.00 205.00		1 1						
203.00 Unit cost multiplier (Wkst. B, Part I) 0.061821 33, 238.040000 2, 739.779087 204.00 Cost to be allocated (per Wkst. B, Part II) 44, 754 76, 829 163, 581 204.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 205.00 205.00 240.914580 205.00		Cost to be allocated (per Wkst. B,	587, 770	3, 323, 804	1, 860, 310			
204.00 Cost to be allocated (per Wkst. B, Part 163,581 204.00 205.00 Unit cost multiplier (Wkst. B, Part 0.004707 768.290000 240.914580 205.00 205.00	203. 00		0. 061821	33, 238. 040000	2, 739, 779087		:	203. 00
205.00 Unit cost multiplier (Wkst. B, Part 0.004707 768.290000 240.914580 205.00		Cost to be allocated (per Wkst. B,	1					
	205 00		0 004707	768 290000	240 914590			205 00
	_55.00		0.301737	33. 270000	_ 10. 71 1000			, , , , ,

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der C	CN: 151329	Peri od: From 01/01/2014	Worksheet C Part I

12/31/2014 Date/Time Prepared: To 5/19/2015 11:49 am Title XVIII Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 3.00 4. 00 5. 00 1.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 6, 372, 667 30 00 03000 ADULTS & PEDIATRICS 6, 372, 667 0 Ω 31.00 03100 INTENSIVE CARE UNIT 739, 645 739, 645 0 0 31.00 04300 NURSERY o 43.00 43.00 1,036,872 1, 036, 872 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 4, 294, 511 4, 294, 511 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 267, 760 267, 760 0 0 0 0 0 0 0 0 0 0 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 10, 733, 394 10, 733, 394 54.00 4, 679, 509 60. nn 06000 LABORATORY 4, 679, 509 60.00 Λ 60.01 06001 BLOOD LABORATORY 0 60.01 65.00 06500 RESPIRATORY THERAPY 1, 145, 303 1, 145, 303 65.00 06600 PHYSI CAL THERAPY 1, 850, 516 1, 850, 516 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 683, 572 683, 572 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 273,820 273, 820 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 1, 242, 867 1, 242, 867 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1, 977, 708 1, 977, 708 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 323, 804 3, 323, 804 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88. 00 88. 00 08800 RURAL HEALTH CLINIC 941, 326 0 941, 326 0 0 90.00 09000 CLI NI C 2, 752, 728 2, 752, 728 0 90.00 09001 WOUND CLINC 0 90. 01 90.01 587, 471 587, 471 0 ol 91 00 09100 EMERGENCY 4, 306, 596 4, 306, 596 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1, 143, 350 1, 143, 350 0 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 101. 00 2, 348, 043 2, 348, 043 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 274, 257 1, 274, 257 0 116.00 Subtotal (see instructions) 200.00 51, 975, 719 0 51, 975, 719 0 0 200. 00 201.00 Less Observation Beds 0 201. 00 1, 143, 350 1, 143, 350 202.00 Total (see instructions) 50, 832, 369 0 50, 832, 369 0 202. 00 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 151329 Peri od: Worksheet C From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/19/2015 11:49 am Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 6, 054, 428 6, 054, 428 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 590, 330 590, 330 31.00 04300 NURSERY 2, 224, 138 2, 224, 138 43.00 43.00 ANCILLARY SERVICE COST CENTERS 0.000000 0. 261618 50.00 3, 258, 002 13, 157, 203 16, 415, 205 50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 991, 369 82, 281 1,073,650 0. 249392 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 084, 098 40, 916, 110 42, 000, 208 0. 255556 0.000000 54.00 06000 LABORATORY 2, 368, 785 0. 225914 60.00 0.000000 60.00 18, 344, 851 20, 713, 636 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 60 01 65.00 06500 RESPIRATORY THERAPY 1, 836, 418 618, 074 2, 454, 492 0.466615 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 222, 511 2, 895, 361 3, 117, 872 0. 593519 0.000000 66.00 06700 OCCUPATIONAL THERAPY 945, 027 0.000000 67.00 69.446 1,014,473 0.673820 67.00 68.00 06800 SPEECH PATHOLOGY 67,071 200, 780 267, 851 1.022285 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 404, 317 3, 180, 635 3, 584, 952 0.346690 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0.000000 71.00 C 07200 I MPL. DEV. CHARGED TO PATIENT 1,046,267 899, 758 1, 946, 025 0.000000 72 00 72.00 1.016281 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 753, 029 6, 897, 413 9, 650, 442 0.344420 0.00000073.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 656, 224 656, 224 5, 273, 471 5, 382, 767 90.00 09000 CLI NI C 109, 296 0.511396 0.000000 90.00 90.01 09001 WOUND CLINC 7,097 1, 175, 632 1, 182, 729 0.496708 0.000000 90.01 0.647728 91.00 09100 EMERGENCY 243, 305 6, 405, 471 6, 648, 776 0.000000 91.00 1, 780, 232 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 19, 511 1, 760, 721 0.642248 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 25 1, 856, 533 1, 856, 558 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 463, 001 1, 463, 001 116. 00 200.00 Subtotal (see instructions) 23, 349, 443 106, 728, 546 130, 077, 989 200.00

23, 349, 443

106, 728, 546

130, 077, 989

201 00

202.00

201 00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems	MARGARET MARY COMMUNIT	Y HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 151329	From 01/01/2014	Worksheet C Part I Date/Time Prepared: 5/19/2015 11:49 am

				5/19/2015 11:	49 am
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00
31.00 03100 INTENSIVE CARE UNIT					31. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
60. 01 06001 BLOOD LABORATORY	0. 000000				60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88. 00
90. 00 09000 CLI NI C	0. 000000				90.00
90. 01 09001 WOUND CLI NC	0. 000000				90. 01
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113. 00
116. 00 11600 HOSPI CE					116. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151329	Period: Worksheet C

To 12/31/2014 Date/Time Prepared: 5/19/2015 11:49 am Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj . Di sal I owance Part I, col. 26) 2.00 4. 00 5. 00 1.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 6, 372, 667 6. 372. 667 6, 372, 667 31.00 03100 INTENSIVE CARE UNIT 739, 645 739, 645 0 739, 645 31.00 04300 NURSERY o 43.00 1,036,872 1, 036, 872 1, 036, 872 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 294, 511 4, 294, 511 4, 294, 511 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 267, 760 267, 760 0 267, 760 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 10, 733, 394 10, 733, 394 0 10, 733, 394 54.00 4, 679, 509 4, 679, 509 60.00 06000 LABORATORY 4, 679, 509 60.00 60.01 06001 BLOOD LABORATORY Ω 60.01 65.00 06500 RESPIRATORY THERAPY 1, 145, 303 1, 145, 303 0 0 0 1, 145, 303 65.00 06600 PHYSI CAL THERAPY 1, 850, 516 0 1, 850, 516 1, 850, 516 66.00 66.00 06700 OCCUPATIONAL THERAPY 683, 572 683, 572 683, 572 67.00 C 67.00 68.00 06800 SPEECH PATHOLOGY 273,820 273, 820 273, 820 68.00 06900 ELECTROCARDI OLOGY 69.00 1, 242, 867 1, 242, 867 0 1, 242, 867 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1, 977, 708 1, 977, 708 1, 977, 708 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 323, 804 3, 323, 804 3, 323, 804 73.00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 941, 326 0 941, 326 88 00 941, 326 90.00 09000 CLI NI C 2, 752, 728 2, 752, 728 0 2, 752, 728 90.00 09001 WOUND CLINC 0 90. 01 587, 471 587, 471 587, 471 90.01 ol 91 00 09100 EMERGENCY 4, 306, 596 4, 306, 596 4, 306, 596 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1, 143, 350 1, 143, 350 1, 143, 350 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 2, 348, 043 2, 348, 043 2, 348, 043 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 274, 257 1, 274, 257 1, 274, 257 116. 00 200.00 Subtotal (see instructions) 51, 975, 719 0 51, 975, 719 0 51, 975, 719 200. 00 201.00 Less Observation Beds 1, 143, 350 201. 00 1, 143, 350 1, 143, 350 202.00 Total (see instructions) 50, 832, 369 0 50, 832, 369 0 50, 832, 369 202. 00

	ATTION OF RATIO OF COSTS TO CHARGES	COMET WART COM	Provi der	CCN: 151329	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/19/2015 11:	pared:
				le XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpatient 7.00	Total (col. + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o 10.00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
30 00	03000 ADULTS & PEDIATRICS	6, 054, 428		6, 054, 42	Q		30.00
31. 00	03100 I NTENSI VE CARE UNI T	590, 330		590, 33			31. 00
	04300 NURSERY	2, 224, 138		2, 224, 13			43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	2,224,130		2,224,10			1 43.00
50.00	05000 OPERATING ROOM	3, 258, 002	13, 157, 203	16, 415, 20	0. 261618	0. 000000	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	991, 369	82, 281			0. 000000	•
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 084, 098	40, 916, 110			0. 000000	
60.00	06000 LABORATORY	2, 368, 785	18, 344, 851			0.000000	
60. 01	06001 BLOOD LABORATORY	0	0		0. 000000	0.000000	60. 01
65.00	06500 RESPI RATORY THERAPY	1, 836, 418	618, 074	2, 454, 49	2 0. 466615	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	222, 511	2, 895, 361	3, 117, 87	2 0. 593519	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	69, 446	945, 027	1, 014, 47	3 0. 673820	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	67, 071	200, 780	267, 85	1. 022285	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	404, 317	3, 180, 635	3, 584, 95	2 0. 346690	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0. 000000	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 046, 267	899, 758	1, 946, 02	1. 016281	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 753, 029	6, 897, 413	9, 650, 44	2 0. 344420	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	656, 224			0. 000000	
90.00	09000 CLI NI C	109, 296	5, 273, 471			0. 000000	
90. 01	09001 WOUND CLINC	7, 097	1, 175, 632			0. 000000	
	09100 EMERGENCY	243, 305	6, 405, 471			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	19, 511	1, 760, 721	1, 780, 23	0. 642248	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	25	1, 856, 533	1, 856, 55	8		101. 00
	SPECIAL PURPOSE COST CENTERS						4
	11300 I NTEREST EXPENSE		4 4/0 001	4 4/6 66			113.00
	11600 HOSPI CE	0	1, 463, 001				116. 00
200.00	,	23, 349, 443	106, 728, 546	130, 077, 98	19		200. 00
201.00		22 240 440	10/ 700 54/	120 077 00			201. 00
202.00	Total (see instructions)	23, 349, 443	106, 728, 546	130, 077, 98	Y		202. 00

Health Financial Systems	MARGARET MARY COMMUNIT	TY HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 151329	From 01/01/2014	Worksheet C Part I Date/Time Prepared: 5/19/2015 11:49 am
				4 .

				5/19/2015 11:	49 am_
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00
31.00 03100 INTENSIVE CARE UNIT					31. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
60. 01 06001 BL00D LABORATORY	0. 000000				60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS	·				
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				88. 00
90. 00 09000 CLI NI C	0. 000000				90.00
90. 01 09001 WOUND CLINC	0. 000000				90. 01
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS	·				
101.00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE					113. 00
116. 00 11600 HOSPI CE					116. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

	Health Financial Systems MAR	inancial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form				u of Form CMS-2	2552-10	
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provi der	CCN: 151329	Peri od:	Worksheet D	
						From 01/01/2014 To 12/31/2014	Date/Time Pre	oared:
							5/19/2015 11:	49 am_
				Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total	Charges	Ratio of Co	st Inpatient	Capital Costs	
		Related Cost	(from	Wkst C	to Charges	s Program	(column 3 x	

						To 12/3	31/2014	Date/Time 5/19/2015		
				Ti tl	e XVIII	Hospi	tal	Cos		
	Cost Center Description	Capi tal	Total (Charges	Ratio of Cos	Inpat	ient	Capital Cos	ts	
		Related Cost	(from W	/kst. C,	to Charges	Prog	ıram	(column 3	x	
		(from Wkst. B,	Part I	, col.	(col. 1 ÷ col	. Char	ges	column 4)		
		Part II, col.	8	3)	2)					
		26)								
		1.00	2.	00	3. 00	4. (00	5. 00		
	LLARY SERVICE COST CENTERS		T							
	OO OPERATING ROOM	254, 942		415, 205			923, 803			
	OO DELIVERY ROOM & LABOR ROOM	56, 935		073, 650			749	l .	40	52.00
	OO RADI OLOGY-DI AGNOSTI C	887, 995		000, 208			575, 733			54.00
	OO LABORATORY	260, 294	20,	713, 636			149, 936	14, 4	150	60. 00
	1 BLOOD LABORATORY	0		0	0.00000		0		0	60. 01
	O RESPI RATORY THERAPY	168, 373		454, 492			119, 670			65.00
	O PHYSI CAL THERAPY	197, 733		117, 872			136, 885			66.00
	OO OCCUPATI ONAL THERAPY	52, 545	1,	014, 473			41, 668		158	67.00
	O SPEECH PATHOLOGY	27, 459		267, 851			60, 265		178	68.00
69. 00 0690	O ELECTROCARDI OLOGY	122, 892	3,	584, 952	0. 03428	0 :	268, 198	9, 1	194	69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0. 00000		0		0	71.00
	OO IMPL. DEV. CHARGED TO PATIENT	203, 156	1,	946, 025	0. 10439	5 !	566, 562	59, 1	146	72.00
	OD DRUGS CHARGED TO PATIENTS	76, 829	9,	650, 442	0. 00796	1 1, 3	335, 492	10, 6	532	73.00
	ATIENT SERVICE COST CENTERS									
	OO RURAL HEALTH CLINIC	68, 850		656, 224	0. 10491	8	0		0	88.00
90.00 0900	OO CLI NI C	405, 433	5,	382, 767	0. 07532	1	67, 212	5, (062	90.00
	01 WOUND CLINC	28, 277	1,	182, 729	0. 02390	8	3, 024		72	90. 01
	OO EMERGENCY	527, 701	6,	648, 776	0. 07936	8	9, 827	-	780	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)	166, 671	1,	780, 232	0. 09362	3	0		0	92.00
200.00	Total (lines 50-199)	3, 506, 085	117,	889, 534		6, 3	259, 024	219,	721	200. 00

	ARGARET MARY COM				u of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PAS	S Provi der	CCN: 151329	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre	nared:
				10 12/31/2014	5/19/2015 11:	49 am
			e XVIII	Hospi tal	Cost	
Cost Center Description		Nursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	9	
					4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		-				
50. 00 05000 OPERATI NG ROOM	0	C)	0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C)	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)	0	0	0 00
60. 00 06000 LABORATORY	0	C)	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	C)	0	0	00.0.
65. 00 06500 RESPI RATORY THERAPY	0	C)	0	0	00.00
66. 00 06600 PHYSI CAL THERAPY	0	C)	0 0	0	00.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C)	0 0	0	07.00
68. 00 06800 SPEECH PATHOLOGY	0	C)	0 0	0	00.00
69. 00 06900 ELECTROCARDI OLOGY	0	C)	0 0	0	07.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C)	0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0	0	, 2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	C)	0 0	0	73. 00
OUTPATIENT SERVICE COST CENTERS		1				
88. 00 08800 RURAL HEALTH CLINIC	0	C		0 0	0	
90. 00 09000 CLI NI C	0	C		0	0	
90. 01 09001 WOUND CLINC	0	C		0	0	70.0.
91. 00 09100 EMERGENCY	0	C)	0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C)	0	0	1
200.00 Total (lines 50-199)	0	[C)	0 0	0	200.00

Heal th	Financial Systems M.	ARGARET MARY CON	MUNI T	Y HOSPITA	L	In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE SH COSTS				CCN: 151329	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/19/2015 11:	pared:
					e XVIII	Hospi tal	Cost	
	Cost Center Description	Total			Ratio of Cos		Inpati ent	
				n Wkst. C,		Ratio of Cost	Program	
		Cost (sum of			(col. 5 ÷ col		Charges	
		col . 2, 3 and		8)	7)	(col. 6 ÷ col.		
		4)				7)		
		6. 00		7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	0		6, 415, 205			923, 803	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		1, 073, 650	1		749	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1	2, 000, 208	1		575, 733	1
60.00	06000 LABORATORY	0) 2	20, 713, 636	1		1, 149, 936	
60. 01	06001 BLOOD LABORATORY	0)	0	0.00000		0	60. 01
65. 00	06500 RESPI RATORY THERAPY	0)	2, 454, 492	1		1, 119, 670	
66. 00	06600 PHYSI CAL THERAPY	0		3, 117, 872	1		136, 885	
67.00	06700 OCCUPATI ONAL THERAPY	0		1, 014, 473	0.00000	0. 000000	41, 668	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		267, 851	0.00000	0. 000000	60, 265	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		3, 584, 952	0.00000	0. 000000	268, 198	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0. 00000	0. 000000	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0		1, 946, 025	0.00000	0. 000000	566, 562	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		9, 650, 442	0.00000	0. 000000	1, 335, 492	73. 00
	OUTPATIENT SERVICE COST CENTERS							
88. 00	08800 RURAL HEALTH CLINIC	0		656, 224	0.00000	0. 000000	0	88. 00
90.00	09000 CLI NI C	0		5, 382, 767	0.00000	0. 000000	67, 212	90.00
90. 01	09001 WOUND CLINC	0		1, 182, 729	0.00000	0. 000000	3, 024	90. 01
01 00	00100 EMEDCENCY		d .	4 4 4 0 7 7 4	0 0000	0 000000	0 027	01 00

6, 648, 776 1, 780, 232

117, 889, 534

0.000000

0.000000

0.000000

0.000000

6, 259, 024 200. 00

9, 827 91. 00 0 92. 00

90. 01 | 09001 | WOUND CLINC 91. 00 | 09100 | EMERGENCY

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

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILL THROUGH COSTS	ARY SERVICE OTHER PASS Provider CCN: 151329	Period: From 01/01/2014 To 12/31/2014 Worksheet D Part IV Date/Time Prepared: 5/19/2015 11:49 am

					10	12/31/2014	5/19/2015 11	
			Ti tl	e XVIII		Hospi tal	Cost	
Cost Center Description	I npati ent	Out	pati ent	Outpati ent				
	Program	Pr	ogram	Program				
	Pass-Through		narges	Pass-Through	1			
	Costs (col. 8			Costs (col. (9			
	x col. 10)			x col. 12)				
	11. 00	1	2. 00	13. 00				
ANCI LLARY SERVI CE COST CENTERS		1						
50. 00 05000 OPERATI NG ROOM	0		0		0			50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0		0			52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0		0		0			54. 00
60. 00 06000 LABORATORY	0		0		0			60.00
60. 01 06001 BLOOD LABORATORY	0		0		0			60. 01
65. 00 06500 RESPI RATORY THERAPY	0		0		0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0		0		0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		0		0			67. 00
68. 00 06800 SPEECH PATHOLOGY	0		0		0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		0		0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0		0		0			72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0		0		0			73. 00
OUTPATIENT SERVICE COST CENTERS								
88. 00 08800 RURAL HEALTH CLINIC	0	1	0		0			88. 00
90. 00 09000 CLI NI C	0		0		0			90. 00
90. 01 09001 WOUND CLINC	0		0		0			90. 01
91. 00 09100 EMERGENCY	0		0		0			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0			92. 00
200.00 Total (lines 50-199)	0		0		0			200. 00

Health Financial Systems		MARGARET MARY COMMUNIT	Y HOSPI TAL		In Lie	u of Form CMS-2552-10
ADDODEL ONMENT OF MEDICAL	OTHER HEALTH CERVICES	AND MACCINE COCT	D: -I CCN 11	E1220 David		Wasalaalaa A D

Heal th	Financial Systems	IARGARET MARY CON	MMUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 5/19/2015 11:	
			Ti tl	e XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
			Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
	TANGLEL ARY OF BUILDS OF STATE OF	1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		1		-1 -		
50.00	05000 OPERATING ROOM	0. 261618		3, 115, 02		0	
	05200 DELIVERY ROOM & LABOR ROOM	0. 249392		12		0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	0. 255556		15, 610, 91	· ·	0	
60.00	06000 LABORATORY	0. 225914		5, 011, 11	0	0	
60. 01	06001 BLOOD LABORATORY	0. 000000	l .		0	0	
65. 00	06500 RESPI RATORY THERAPY	0. 466615		230, 05		0	
66. 00	06600 PHYSI CAL THERAPY	0. 593519		777, 04		0	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 673820		195, 23		0	
68. 00	06800 SPEECH PATHOLOGY	1. 022285		31, 60		0	
69. 00	06900 ELECTROCARDI OLOGY	0. 346690	l .	1, 260, 65	9 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	l .		0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	1. 016281	l .	297, 38		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 344420	0	2, 831, 85	0 503	0	73. 00
	OUTPATIENT SERVICE COST CENTERS		T	1			
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				0	
90. 00	09000 CLI NI C	0. 511396		1, 986, 92		0	
90. 01	09001 WOUND CLINC	0. 496708		460, 91		0	
91. 00	09100 EMERGENCY	0. 647728		1, 705, 57		0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 642248	0	791, 87			1 /2.00
200.00			0	34, 306, 31	2 3, 581		200. 00
201.00					0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0	34, 306, 31	2 3, 581	0	202. 00

Provider CCN: 151329 | Period: | Worksheet D | From 01/01/2014 | Part V | To | 19/21/2014 | Part V | P

				To 12/31/2014	Date/Time Pre 5/19/2015 11:	
		Ti tl	e XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLLI ADV. CEDVI OF COCT. CENTEDO	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	014.047		1			
50. 00 05000 OPERATING ROOM	814, 947	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	30	0 591				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 989, 464	591				54.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	1, 132, 081	0				60. 00 60. 01
	107.047	0				
65. 00 06500 RESPIRATORY THERAPY	107, 347	0				65.00
66. 00 06600 PHYSI CAL THERAPY	461, 193	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	131, 556	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	32, 304	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	437, 058	0				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	202 224	0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	302, 224					72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	975, 346	173				73. 00
88. 00 08800 RURAL HEALTH CLINIC	1 0	0				88. 00
90. 00 09000 CLI NI C	1, 016, 108	_				90.00
90. 01 09001 WOUND CLI NC	228, 940					90.00
91. 00 09100 EMERGENCY	1, 104, 751	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	508, 579	482				92.00
200.00 Subtotal (see instructions)	11, 241, 928		1			200.00
201.00 Less PBP Clinic Lab. Services-Program	11, 241, 920	1, 234				200.00
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)	11, 241, 928	1, 254				202. 00

Health Financial Systems	MARGARET MARY COMMUNIT	Y HOSPITAL	In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151329	Period: From 01/01/2014	Worksheet D-1		
			To 12/31/2014	Date/Time Pre 5/19/2015 11:	pared: 49 am	
		Title XVIII	Hospi tal	Cost		
Cost Center Description						
				1. 00		
PART I - ALL PROVIDER COMPONENTS						
I NPATI ENT DAYS						
1.00 Inpatient days (including private room	Inpatient days (including private room days and swing-bed days, excluding newborn) 4,994 1.0					
2.00 Inpatient days (including private room	days, excluding swing-bed	d and newborn days)		4, 994	2. 00	

	Cost Center Description		
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 994	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4, 994	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)	4, 098	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 716	9. 00
7. 00	newborn days)	1, 710	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11 00	through December 31 of the cost reporting period (see instructions)		11 00
11. 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)	0	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
17.00	reporting period		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
04 00	reporting period		04 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line)	6, 372, 667 0	21. 00 22. 00
22.00	5 x line 17)	J	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
26. 00	X line 20)	0	26. 00
27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6, 372, 667	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	0,0,2,00,	27.00
28. 00		0	28. 00
29. 00		0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33. 00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0 6, 372, 667	36. 00 37. 00
37.00	27 minus line 36)	3, 3, 2, 307	000
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 27/ 0/	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	1, 276. 06 2, 189, 719	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	2, 107, 717	40. 00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 189, 719	41. 00

16. 00	Nursery days (title V or XIX only)	0	16. 00
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
17.00	reporting period		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
40.00	reporting period	0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
	Total general inpatient routine service cost (see instructions)	6, 372, 667	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6)	o	23. 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)	0	24. 00
25. 00	X line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
	Total swing-bed cost (see instructions)	•	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6, 372, 667	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Private room charges (excluding swing-bed charges)	0	29. 00
	Semi -pri vate room charges (excluding swing-bed charges)	ő	
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
	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
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	6, 372, 667	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 07/ 0/	
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 276. 06	
	Program general inpatient routine service cost (line 9 x line 38)	2, 189, 719	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 189, 719	41.00

	Financial Systems MAF ATION OF INPATIENT OPERATING COST	RGARET MARY COMM		ΓAL r CCN: 151329	In Lie	eu of Form CMS-2 Worksheet D-1	
3 S.III & I					From 01/01/2014 To 12/31/2014		pared:
			Ti	tle XVIII	Hospi tal	Cost	47 (1111
	Cost Center Description	Total Inpatient Costl	Total npatient Da	Average Pe ysDiem (col. 1 col. 2)	r Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0		0 0.	00 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	739, 645	21	95 2,507.	27 178	446, 294	43. 00
44. 00	CORONARY CARE UNIT	739, 645	2	2, 507.	2/ 1/8	440, 294	44.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk:	st. D-3. col. 3.	line 200)			2, 513, 150	48. 00
	Total Program inpatient costs (sum of lines			i ons)		5, 149, 163	1
	PASS THROUGH COST ADJUSTMENTS	-					
50.00	Pass through costs applicable to Program inpa	atient routine s	services (fr	om Wkst. D, su	m of Parts I and	0	50. 00
51. 00		ationt ancillary	u sarvicas (from Wkst D	sum of Darts II	0	51.00
31.00	and IV)	atrent unerriary	y services (ITOM WKSt. D,	Juli Of Tul 13 II	Ĭ	31.00
52. 00	Total Program excludable cost (sum of lines!					0	
53.00	Total Program inpatient operating cost exclude	9 1	ated, non-p	hysician anest	hetist, and	0	53. 00
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54. 00						0	54.00
55.00	Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0	
57. 00	Difference between adjusted inpatient operati	ng cost and tar	rget amount	(line 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period (anding 1006	undated and o	omnounded by the	0.00	
37.00	market basket	on tring period e	ending 1770,	upuateu anu c	ompounded by the	0.00	37.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the	market basket		0.00	60.00
61.00	If line 53/54 is less than the lower of lines					0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see it		s (lines 54	x 60), or 1% c	f the target		
62. 00	1	0	62.00				
	Allowable Inpatient cost plus incentive payme	0	63. 00				
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decem	mber 31 of t	he cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the	cost reportir	a period (See	0	65. 00
	instructions)(title XVIII only)				9		
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	64 plus line	65)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	costs through	Docombor 21	of the cost r	operting period	0	67.00
	(line 12 x line 19)	Ü					07.00
68.00	Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 o	f the cost rep	orting period	0	68. 00
(0.00	(line 13 x line 20)		/7	(0)			/0.00
69.00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facility						70.00
71. 00	Adjusted general inpatient routine service co	ost per diem (li		,			71. 00
72.00	Program routine service cost (line 9 x line		(1)	05)			72.00
73. 00 74. 00	Medically necessary private room cost applications and Program general inpatient routine servi						73.00
75. 00	Capital-related cost allocated to inpatient				Part II. column		75. 00
	26, line 45)						
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der reco	rds)			79.00
80. 00	Total Program routine service costs for compa			,	nus line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on		•	,		81.00
82.00	Inpatient routine service cost limitation (li						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		>)				83. 00 84. 00
85.00	, , , , , , , , , , , , , , , , , , , ,		ns)				85.00
	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST					1_
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of		line 2)			896 1, 276. 06	1
	Observation bed cost (line 87 x line 88) (see	•	11110 2)			1, 276. 06	
	(30)					, ,	

Health Financial Systems MAF	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				To 12/31/2014	Date/Time Prep 5/19/2015 11:	pared: 49 am_
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	928, 970	6, 372, 667	0. 14577	4 1, 143, 350	166, 671	90.00
91.00 Nursing School cost	0	6, 372, 667	0.00000	1, 143, 350	0	91.00
92.00 Allied health cost	0	6, 372, 667	0.00000	1, 143, 350	0	92.00
93.00 All other Medical Education	0	6, 372, 667	0. 000000	1, 143, 350	0	93. 00

Heal th	Financial Systems	MARGARET MARY COMMUNI	TY HOSPI TAL	In Lie	u of Form CMS-2	552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provider CCN: 151329	Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/19/2015 11:4	oared: 19 am
			Title XIX	Hospi tal	Cost	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS					
1.00	Inpatient days (including private room	days and swing-bed days,	excluding newborn)		4, 994	1.00
2.00	Inpatient days (including private room	days, excluding swing-be	d and newborn days)		4, 994	2.00
3. 00	Private room days (excluding swing-bed do not complete this line.	and observation bed days). If you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swin	g-bed and observation bed	days)		4, 098	4.00
	l =				_	

	Cost Center Description		
	5551 55115.	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 994	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4, 994	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4, 098	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		7 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	J	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	209	9. 00
	newborn days)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
44.00	through December 31 of the cost reporting period (see instructions)		
11. 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)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Ü	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	988	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
17.00	reporting period		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)	6, 372, 667	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0, 372, 007	22. 00
22.00	5 x line 17)	Ü	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19)	0	25. 00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	U	25.00
26. 00	Total swing-bed cost (see instructions)	o	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6, 372, 667	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33. 00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	6, 372, 667	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 276. 06	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	266, 697	39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	200, 077	40. 00
41. 00		266, 697	

	Financial Systems MAR ATION OF INPATIENT OPERATING COST	RGARET MARY COMM		AL CCN: 151329	In Lie	eu of Form CMS-2 Worksheet D-1	
	. 2000				From 01/01/2014 To 12/31/2014		pared:
			Ti	tle XIX	Hospi tal	Cost	49 alli
	Cost Center Description	Total Inpatient Costl	Total npatient Day	Average Pers Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	1, 036, 872	98	8 1, 049.	47 0	0	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	720 (45	20	- 2 - 62	27 -	10.50/	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	739, 645	29	5 2, 507.	27 5	12, 536	43.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	line 200)			1. 00 129, 288	48. 00
	Total Program inpatient costs (sum of lines 4			ons)		408, 521	1
	PASS THROUGH COST ADJUSTMENTS			,			
50.00	Pass through costs applicable to Program inpa	atient routine s	services (fro	m Wkst. D, su	m of Parts I and	0	50.00
51. 00	Dass through costs applicable to Drogram inno	ationt ancillars	, corvicos (f	rom Wkst D	cum of Dorte II	0	51.00
51.00	Pass through costs applicable to Program inpa and IV)	atrent andiriary	services (i	TOIII WKSt. D,	Sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines 5	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclud		ated, non-ph	ysician anest	hetist, and	0	53.00
	medical education costs (line 49 minus line 5	52)					
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	, ,					0.00	
56.00	Target amount (line 54 x line 55)					0	56.00
57. 00	Difference between adjusted inpatient operati	ng cost and tar	get amount (line 56 minus	line 53)	0	
	Bonus payment (see instructions)	anting paried a	anding 100/	undated and a	ampaumdad by the	0	
59. 00	Lesser of lines 53/54 or 55 from the cost replanted basket	orting period e	enarng 1996,	upuateu anu c	bilipounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year of	cost report, upd	lated by the	market basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines					0	61.00
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% o	f the target		
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instruc	ctions)			Ö	
	PROGRAM INPATIENT ROUTINE SWING BED COST					,	
64. 00	Medicare swing-bed SNF inpatient routine cost	ts through Decem	ber 31 of th	e cost report	ing period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost</pre>	ts after Decembe	er 31 of the	cost reportin	a period (See	0	65. 00
00.00	instructions) (title XVIII only)	is arter becombe	. 01 01 1110	cost reportin	g period (see	Ĭ	00.00
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line	65)(title XVI	ll only). For	0	66. 00
47.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	costs through	Docombor 21	of the cost r	operting period	0	67. 00
67. 00	(line 12 x line 19)	costs through	pecelliber 31	or the cost i	eporting perrou		87.00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
(0.00	(line 13 x line 20)			(0)			/
69.00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facili						70.00
71. 00	Adjusted general inpatient routine service co	,					71. 00
72.00	Program routine service cost (line 9 x line 7		(1)	. 05)			72.00
73. 00 74. 00	Medically necessary private room cost application of the Total Program general inpatient routine servi						73.00
75. 00	Capital-related cost allocated to inpatient r				Part II. column		75.00
	26, line 45)		(,	,		
76. 00	Per diem capital-related costs (line 75 ÷ lin						76. 00
77. 00 78. 00	Program capital -related costs (line 9 x line						77.00
79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovi der recor	ds)			79.00
80.00	Total Program routine service costs for compa				nus line 79)		80.00
81.00	Inpatient routine service cost per diem limit						81.00
82.00	Inpatient routine service cost limitation (li						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		·)				83. 00 84. 00
	, , , , , , , , , , , , , , , , , , , ,		ıs)				85.00
	Total Program inpatient operating costs (sum						86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of		line 2)			896 1, 276. 06	1
	Observation bed cost (line 87 x line 88) (see	•	11116 Z)			1, 276. 06	
	(300					., ., ., ., ., ., ., ., ., ., ., ., ., .	

Health Financial Systems MAF	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/19/2015 11:	
		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 O	COST					
90.00 Capital -related cost	928, 970	6, 372, 667	0. 14577	4 1, 143, 350	166, 671	90.00
91.00 Nursing School cost	0	6, 372, 667	0.00000	1, 143, 350	0	91.00
92.00 Allied health cost	0	6, 372, 667	0.00000	1, 143, 350	0	92.00
93.00 All other Medical Education	0	6, 372, 667	0. 000000	1, 143, 350	0	93. 00

Health Financial Systems MARGARET MARY COMMUL INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	_	CCN: 151329	Peri od:	u of Form CMS-2 Worksheet D-3	
THE THE PARTY OF THE OWN OF THE OWN OWN DATE.	1.01.40.	00111 101027	From 01/01/2014		
			To 12/31/2014	Date/Time Pre 5/19/2015 11:	
	Ti tl	e XVIII	Hospi tal	Cost	77 aiii
Cost Center Description		Ratio of Cos		Inpati ent	
'		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LUDATI FUT DOUTLUE OFFICE OF COUT OF THE		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			0.575.0/4		
30. 00 03000 ADULTS & PEDI ATRI CS			2, 575, 961		30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY			346, 326		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 O5000 OPERATING ROOM		0. 2616	18 923, 803	241, 683	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 2493		187	52. 0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2555!			
60. 00 06000 LABORATORY		0. 2259		259, 787	
60. 01 06001 BLOOD LABORATORY		0. 00000		0	
65. 00 06500 RESPIRATORY THERAPY		0. 4666		522, 455	
66. 00 06600 PHYSI CAL THERAPY		0. 5935 ⁻	19 136, 885	81, 244	66.0
57. 00 06700 OCCUPATIONAL THERAPY		0. 6738	20 41, 668	28, 077	67.0
68. 00 06800 SPEECH PATHOLOGY		1. 02228			
69. 00 06900 ELECTROCARDI OLOGY		0. 3466		92, 982	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000		0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		1. 0162		575, 786	
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 34442	20 1, 335, 492	459, 970	73.00
OUTPATIENT SERVICE COST CENTERS			20		
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	
90. 00 09000 CLINI C		0. 51139			
90. 01 09001 WOUND CLINC		0. 49670		· ·	
P1.00 09100 EMERGENCY P2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.6477		6, 365 0	91.0
P2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) P200.00 Total (sum of lines 50-94 and 96-98)		0. 6422		·	
200.00 Total (Sum of Tines 50-94 and 96-98) 201.00 Less PBP Clinic Laboratory Services-Program only charges	(lino 61)		6, 259, 024		200. 0
202.00 Net Charges (line 200 minus line 201)	s (TITIE OI)		6, 259, 024		201.00
202.00 not onarges (Title 200 militids Title 201)		I	0, 237, 024	I	1202.0

Health Financial Systems MARGARET MARY COMM INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 151329	Peri od:	eu of Form CMS-2 Worksheet D-3	
INFAITENT ANGIELART SERVICE COST AFFORTIONMENT	Frovider	CCN. 151329	From 01/01/2014		
			To 12/31/2014	Date/Time Pre	
				5/19/2015 11:	49 am
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges		Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			396, 280		30.00
31. 00 03100 I NTENSI VE CARE UNI T			19, 219		31.00
43. 00 04300 NURSERY			0	l .	43. 0
ANCILLARY SERVICE COST CENTERS				'	
50. 00 05000 OPERATI NG ROOM		0. 2616	18 35, 936	9, 402	50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2493	92 46, 793	11, 670	52.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2555	56 29, 539	7, 549	54.0
50. 00 06000 LABORATORY		0. 2259	14 99, 752	22, 535	60.0
0. 01 06001 BL00D LABORATORY		0.0000	00 0	0	60.0
55. 00 06500 RESPI RATORY THERAPY		0. 4666	15 44, 560	20, 792	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 5935			
57. 00 06700 OCCUPATI ONAL THERAPY		0. 6738			
98. 00 06800 SPEECH PATHOLOGY		1. 0222			
59. 00 06900 ELECTROCARDI OLOGY		0. 3466	·		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000			
2.00 07200 I MPL. DEV. CHARGED TO PATIENT		1. 0162			
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3444	20 102, 452	35, 287	73. C
OUTPATIENT SERVICE COST CENTERS				1	
88. 00 08800 RURAL HEALTH CLINIC		1. 4344			
0. 00 09000 CLI NI C		0. 5113		0	
0. 01 09001 WOUND CLINC		0. 4967		0	
01. 00 09100 EMERGENCY		0. 6477			
12. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6422		_	1
Total (sum of lines 50-94 and 96-98)	(1: (4)		385, 793		
Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		205 702		201. 0
202.00 Net Charges (line 200 minus line 201)		l	385, 793	1	202. C

Health Financial Systems	MARGARET MARY COMMUNIT	Y HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 151329	From 01/01/2014	Worksheet E Part B Date/Time Prepared: 5/19/2015 11:49 am

			To 12/31/2014	Date/Time Pre 5/19/2015 11:		
	Title XVIII Hospital					
				1 00		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00		
1.00						
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	2. 00	
3.00	PPS payments			0	3.00	
4. 00 5. 00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instruct	ions)		0. 000	4. 00 5. 00	
6. 00						
7. 00	Sum of line 3 plus line 4 divided by line 6	0 0. 00	6. 00 7. 00			
8.00	Transitional corridor payment (see instructions)			0	8. 00	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	9. 00	
10. 00 11. 00	Organ acquisitions			11 242 102	10. 00 11. 00	
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			11, 243, 182	11.00	
	Reasonable charges					
12.00	Ancillary service charges			0	12. 00	
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	1. 4)		0	13. 00	
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00	
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	yment for services on	a charge hasis	0	15. 00	
16. 00	Amounts that would have been realized from patients liable for			0	16. 00	
	had such payment been made in accordance with 42 CFR §413.13(e)	. 3	g			
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	1	
18. 00	Total customary charges (see instructions)			0	18. 00	
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	if line 18 exceeds li	ne 11) (see	0	19. 00	
20. 00	Excess of reasonable cost over customary charges (complete only	ifline 11 exceeds li	ne 18) (see	0	20. 00	
20.00	instructions)	TT THE TT EXCECUS TT	110 10) (300	Ŭ	20.00	
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		11, 355, 614	21. 00	
22. 00	Interns and residents (see instructions)			0	22. 00	
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00	
24. 00					24. 00	
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			81, 995	25. 00	
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH. see instructions)		5, 886, 349	26. 00	
27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl		and 23) (for	5, 387, 270		
	CAH, see instructions)					
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00	
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 5, 387, 270	29. 00 30. 00	
31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			3, 367, 270 2, 927	31.00	
32. 00	Subtotal (line 30 minus line 31)			5, 384, 343	ł	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		27 22 17 2 12		
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00	
34. 00	Allowable bad debts (see instructions)			516, 782	34. 00	
35. 00	Adjusted reimbursable bad debts (see instructions)			392, 754	1	
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		388, 701 5, 777, 097		
37. 00 38. 00	· · · · · · · · · · · · · · · · · · ·				38.00	
39. 00					39.00	
39. 50	, , , , , , , , , , , , , , , , , , ,				39. 50	
39. 98					39. 98	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION				39. 99	
40.00	· · · · · · · · · · · · · · · · · · ·				40. 00	
40. 01					40. 01	
41. 00					41.00	
42.00				0 -605, 261	42.00	
43. 00 44. 00	, , ,			-605, 261	43. 00 44. 00	
- 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				77.00	
	TO BE COMPLETED BY CONTRACTOR				1	
90.00	Original outlier amount (see instructions)			0	90. 00	
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.00	
92. 00	The rate used to calculate the Time Value of Money			0.00		
93.00	Time Value of Money (see instructions)			0	93. 00 94. 00	
74. UU	00 Total (sum of lines 91 and 93) 0 94.					

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

Interim payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.						5/19/2015 11: 4	49 am
1.00			Ti t	le XVIII	Hospi tal	Cost	
1.00			Inpatie	nt Part A	Par	rt B	
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interim payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.						4.00	
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NoNE" or enter a zero	1.00	Total interim payments paid to provider		4, 198, 17	3	6, 059, 116	1. 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	2.00	Interim payments payable on individual bills, either			0	0	2.00
### Write "NONE" or enter a zero 1. 00 Ust separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 ADJUSTMENTS TO PROVIDER 3. 02 0 0 7717/2014 50,900 07/17/2014 207,700 3. 01 3. 03 .03 .04 3. 05 0 0 0 3. 03 3. 05 0 0 0 0 3. 03 3. 06 0 0 0 3. 03 3. 07 0 0 0 3. 05 Provider to Program 3. 50 0 0 0 0 3. 55 3. 50 0 0 0 0 3. 55 3. 51 0 0 0 0 3. 55 3. 53 0 0 0 0 0 3. 55 3. 54 0 0 0 0 3. 55 3. 55 0 0 0 0 0 3. 55 3. 50 0 0 0 0 3. 55 3. 50 0 0 0 0 3. 55 3. 50 0 0 0 0 3. 55 3. 50 0 0 0 0 3. 55 3. 50 0 0 0 0 3. 55 3. 50 0 0 0 0 3. 55 3. 50 0 0 0 0 3. 55 3. 50 0 0 0 0 0 3. 55 3. 50 0 0 0 0 0 3. 55 3. 50 0 0 0 0 0 3. 55 3. 50 0 0 0 0 0 3. 55 3. 50 0 0 0 0 0 0 3. 55 3. 50 0 0 0 0 0 0 3. 55 3. 50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		services rendered in the cost reporting period. If none,					
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 3.02 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROVIDER O 7/17/2014 50,900 0 7/17/2014 207,700 3.01 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM O 0 0 0 3.05 Provider to Program ADJUSTMENTS TO PROGRAM O 0 0 3.51 3.52 3.53 3.54 0 0 0 3.55 3.55 3.59 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50		write "NONE" or enter a zero					
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 207,700 3.01 3.02 3.03 3.04 3.05 3.06	3.00	List separately each retroactive lump sum adjustment					3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider ADJUSTMENTS TO PROVIDER 07/17/2014 50,900 07/17/2014 207,700 3. 01 3. 02 0 0 0 3. 03 3. 03 0 0 0 0 3. 04 3. 04 0 0 0 3. 04 3. 05 0 0 0 3. 04 3. 05 0 0 0 3. 04 3. 05 3. 05 0 0 0 0 3. 05 3. 05 3. 05 0 0 0 0 3. 05 3. 05 3. 05 0 0 0 0 3. 05 3. 05 3. 05 3. 05 0 0 0 0 3. 05 3. 05 3. 05 3. 05 0 0 0 3. 05 3. 05 3. 05 3. 05 0 0 0 3. 05							
3.01 ADJUSTMENTS TO PROVIDER 07/17/2014 50,900 07/17/2014 207,700 3.01 0.0 3.02 0.0 3.03 0.0 0.0 0.0 0.0 3.03 0.0 0.0 0							
3.02 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM Description of the program of t				_	_		
3.03 0 0 0 3.03 3.04 3.05 0 0 0 3.05 3.04 3.05 0 0 0 3.05		ADJUSTMENTS TO PROVIDER	07/17/2014	50, 90	0 07/17/2014		
3.04						- 1	
ADJUSTMENTS TO PROGRAM	3.03				0		
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 0 3.50						1	
ADJUSTMENTS TO PROGRAM	3.05				0	0	3. 05
3.51 3.52 3.53 0 0 3.51 3.52 3.53 0 0 0 3.52 3.53 3.53 0 0 0 3.53 3.53 3.54 0 0 0 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 5.09,900 3.50,9							
3.52 3.53 3.54 3.99 3.52 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50		ADJUSTMENTS TO PROGRAM		1			
3.53 3.54 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1	-	1 - 1	
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4,249,073 5,090 207,700 3.99 4,249,073 6,266,816 4.00 7						1 - 1	
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.05-3.98) 207,700 3.99 3.50-3.98) 4.249,073 6.266,816 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 4.249,073 6.266,816 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 4.249,073 6.266,816 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 4.249,073 6.266,816 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 4.249,073 6.266,816 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 4.249,073 6.266,816 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 4.249,073 6.266,816 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 4.249,073 6.266,816 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 4.249,073 6.266,816 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 4.249,073 6.266,816 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 4.249,073 6.266,816 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 4.249,073 6.266,816 4.00 10tal interim payments (sum of lines 1, 2, and 3.99 4.249,073 6.266,816 4.00 10tal interim payments (sum of lines 1, 2, and 3.99 4.249,073 6.266,816 4.00 6.20				1	-	1 - 1	
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99)						1 - 1	
A. 00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3. 99			50, 90	0	207, 700	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			4, 249, 07	3	6, 266, 816	4. 00
TO BE COMPLETED BY CONTRACTOR S. 00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER O							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NoNE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	F 00		I	1	1		г оо
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Program to Provider							
TENTATI VE TO PROVI DER							
5. 02 0	5 01			1		0	5 01
Solution Settlement amount (balance due) based on the cost report. (1) Settlement To PROGRAM S		TENTATIVE TO TROVIDER					
Provider to Program						1 - 1	
TENTATI VE TO PROGRAM 0	0.00	Provider to Program			<u> </u>		0.00
5.51 0	5.50				0	0	5. 50
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.50 minus sum of lines 7.50							5. 51
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 279, 634 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 605, 261 6. 02 7. 00 Total Medicare program liability (see instructions) 4, 528, 707 5, 661, 555 7. 00 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00							5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00		Subtotal (sum of lines 5.01-5.49 minus sum of lines			O	o	5. 99
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00		5. 50-5. 98)					
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6.00						6.00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
7.00 Total Medicare program liability (see instructions) 4,528,707 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6. 01	SETTLEMENT TO PROVIDER		279, 63	4	0	6. 01
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00	6.02	SETTLEMENT TO PROGRAM			0	605, 261	6. 02
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Total Medicare program liability (see instructions)		4, 528, 70	7	5, 661, 555	7. 00
0 1.00 2.00						NPR Date	
					Number	(Mo/Day/Yr)	
8.00 Name of Contractor 8.00				0	1. 00	2. 00	
	8.00	Name of Contractor					8. 00

Heal th	Financial Systems MARGARET MARY COMMUNI	TY HOSPITAL	In Lie	u of Form CMS-2	2552-10	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 151329	Peri od: From 01/01/2014 To 12/31/2014			
		Title XVIII	Hospi tal	Cost		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			1, 592	1. 00	
1. 00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	2		4, 393		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			130, 077, 989	5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lir	ne 20		2, 064, 139	6. 00	
7. 00	7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168					
8.00	8.00 Calculation of the HIT incentive payment (see instructions) 267,13					
9.00	9.00 Sequestration adjustment amount (see instructions)					
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					
	I NPATI ENT HOSPI TAL SERVI CES UNDER PPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00	
31.00	Other Adjustment (specify)			0	31.00	
22 00	2 00 Palance due provider (line 0 (en line 10) minus line 20 and line 21) (see instructions)					

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

0 30.00 0 31.00 261,791 32.00

Health Financial Systems	MARGARET MARY COMMUNIT	Y HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 151329	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/19/2015 11:49 am
		Title XVIII	Hospi tal	Cost

				5/19/2015 11:	49 am_
	Title XVIII Hospital		Cost		
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR V - CALCULATION OF REIMBURSEME	ART A SERVICES - COST	REI MBURSEMENT		
1.00	Inpatient services		5, 149, 163	1.00	
2.00	Nursing and Allied Health Managed Care payment (see instruction	s)		0	2.00
3.00	Organ acquisition	,		0	3. 00
4. 00	Subtotal (sum of lines 1 through 3)		5, 149, 163		
5. 00	Primary payer payments			0, 1.7, 100	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			5, 200, 655	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			0, 200, 000	0.00
	Reasonable 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	
				0	
10. 00	Total reasonable charges			U	10. 00
44 00	Customary charges				44 00
11.00	Aggregate amount actually collected from patients liable for pa				11.00
12. 00	Amounts that would have been realized from patients liable for	payment for services o	n a cnarge basis	0	12. 00
40.00	had such payment been made in accordance with 42 CFR 413.13(e)			0 000000	40.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
14.00	Total customary charges (see instructions)			0	
15. 00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15. 00
4, 00	instructions)		445 /		4. 00
16. 00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds lin	e 14) (see	0	16. 00
47.00	instructions)				47.00
17.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			_	
18. 00	Direct graduate medical education payments (from Worksheet E-4,	line 49)		0	
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			5, 200, 655	
20. 00	Deductibles (exclude professional component)			588, 156	
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			4, 612, 499	
23. 00	Coinsurance			5, 776	
24. 00	Subtotal (line 22 minus line 23)			4, 606, 723	
25. 00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		18, 957	25. 00
26. 00	Adjusted reimbursable bad debts (see instructions)			14, 407	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		-11, 109	27. 00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			4, 621, 130	28. 00
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 99					29. 99
30.00	1			4, 621, 130	30. 00
30. 01				92, 423	
31.00				4, 249, 073	
32. 00				0	
33. 00	· · · · · · · · · · · · · · · · · · ·			279, 634	33. 00
34. 00				0	
2 20	§115. 2				
	, ·		'	1	•

Health Financial Systems	MARGARET MARY COMMUNI	TY HOSPITAL	In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151329	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/19/2015 11:49 am		

			10 12/31/2014	5/19/2015 11:	
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		408, 521		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		408, 521	0	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		408, 521	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routine service charges		415, 500		8. 00
9.00	Ancillary service charges		385, 793	0	
10.00	Organ acquisition charges, net of revenue		0		10. 00
11. 00	Incentive from target amount computation		0	_	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		801, 293	0	12.00
40.00	CUSTOMARY CHARGES	<u>.</u>	F (0 0 4 0		40.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	560, 349	0	13. 00
14. 00	basis	normant for compless on	0	0	14. 00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42		0	Ü	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	CIR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		801, 293	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	392, 772	0	
17.00	line 4) (see instructions)	TT TTHE TO EXCEEDS	0,2,7,2	· ·	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	408, 521	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provide	ers.		
22. 00	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	
24. 00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		408, 521	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	20.00
30. 00 31. 00	Excess of reasonable cost (from line 18)		0 408, 521	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		408, 521	0	
33. 00	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
35. 00	Utilization review		0	Ü	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		408, 521	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	400, 321	0	
	Subtotal (line 36 ± line 37)		408, 521	0	
	Direct graduate medical education payments (from Wkst. E-4)		000, 021	O	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		408, 521	0	
41. 00	Interim payments		560, 349	0	
42. 00	Balance due provider/program (line 40 minus line 41)		-151, 828	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	
	chapter 1, §115.2	•			
	GHapter 1, \$110.2		1		I

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

Peri od: Worksheet G From 01/01/2014 To 12/31/2014 Date/Time Prepared:

In Lieu of Form CMS-2552-10

				0 12/31/2014	5/19/2015 11:	
		General Fund	Speci fi c	Endowment Fund		17 4111
		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	5, 447, 049		0	0	1.00
2.00	Temporary investments	0		0	0	
3.00	Notes receivable	0) (0	0	
4.00	Accounts receivable	9, 518, 196		0	0	
5.00	Other recei vable	0		0	0	1
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	2, 448, 105		0	0	
8. 00	Prepai d expenses	2,446,103				
9. 00	Other current assets	1, 651, 113	á a		Ö	
10.00	Due from other funds	O	1	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	19, 064, 463	3	0	0	11. 00
	FIXED ASSETS					
12.00	Land	2, 371, 158		-	-	
13.00	Land improvements	398, 310		0	0 0	1
14. 00 15. 00	Accumulated depreciation Buildings	-363, 773 72, 449, 652		0	0	
16. 00	Accumulated depreciation	-34, 653, 491	1		0	
17. 00	Leasehold improvements	0 1,000, 171		o o	Ö	
18. 00	Accumul ated depreciation	C		0	0	18. 00
19. 00	Fi xed equipment	6, 341, 285	5 (0	0	19. 00
20.00	Accumulated depreciation	-5, 032, 304		0	0	
21. 00	Automobiles and trucks	0		0	0	
22. 00	Accumulated depreciation	20 24/ 220	1	0	0	
23. 00 24. 00	Major movable equipment	38, 246, 330	1	0	0	
25. 00	Accumulated depreciation Minor equipment depreciable	-25, 346, 447				
26. 00	Accumulated depreciation				0	
27. 00	HIT designated Assets	Ö		o o	Ō	
28. 00	Accumulated depreciation	0		0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0) (0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	54, 410, 720) (0	0	30.00
21 00	OTHER ASSETS Investments	(0, (00, 000) (0	0	21 00
31. 00 32. 00	Deposits on Leases	69, 608, 089				
33. 00	Due from owners/officers			-	0	
34. 00	Other assets	273, 271		o o	Ö	
35. 00	Total other assets (sum of lines 31-34)	69, 881, 360		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	143, 356, 543	3	0	0	36. 00
	CURRENT LIABILITIES	1				
37. 00	Accounts payable	2, 492, 927	1	0		
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	5, 461, 815		0	0 0	
40. 00	Notes and Loans payable (short term)	1, 651, 113				
41. 00	Deferred income	1,031,113			Ö	
42. 00	Accel erated payments	Ö			_	42. 00
43.00	Due to other funds	0		0	0	
44. 00		2, 774, 806	1	0	0	
45. 00		12, 380, 661	(0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable	1 0	\		0	46. 00
47. 00	Notes payable	28, 167, 292				
48. 00	Unsecured Loans	20, 107, 272			Ö	1
49. 00	Other long term liabilities	2, 439, 561			Ö	1
50.00	Total long term liabilities (sum of lines 46 thru 49	30, 606, 853	1	0	0	
51.00	Total liabilites (sum of lines 45 and 50)	42, 987, 514	. (0	0	51.00
	CAPI TAL ACCOUNTS					
52. 00	General fund balance	100, 369, 029				52. 00
53.00	Specific purpose fund Donor created - endowment fund balance - restricted					53. 00 54. 00
54. 00 55. 00	Donor created - endowment fund balance - restricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				О	
58. 00	Plant fund balance - reserve for plant improvement,				Ō	
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	100, 369, 029		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	143, 356, 543	5	0	0	60.00
	[59]	I	I		I	I

Provider CCN: 151329 | Period: | Worksheet G-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					То	12/31/2014	Date/Time Pre 5/19/2015 11:	
		Genera	l Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) UNREALIZED LOSS ON INVESTMENTS	0 0 0 0	94, 673, 789 7, 616, 542 102, 290, 331		0 0 0 0 0	0	0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) UNREALIZED LOSS ON INVESTMENTS Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	1, 921, 302 0 0 0 0 0	0 102, 290, 331 1, 921, 302 100, 369, 029		0 0 0 0 0 0	0 0	0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) UNREALIZED LOSS ON INVESTMENTS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) UNREALIZED LOSS ON INVESTMENTS	0 0	0 0 0 0 0 0		0 0 0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
15. 00 16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	000000000000000000000000000000000000000		0			15. 00 16. 00 17. 00 18. 00 19. 00

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

			То	12/31/2014	Date/Time Prep 5/19/2015 11:4	
	Cost Center Description	I npati ent		Outpati ent	Total	17 (1111
		1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	4, 789, 3	68		4, 789, 368	1. 00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	4, 789, 3	68		4, 789, 368	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT	570, 1	63		570, 163	11. 00
12. 00	CORONARY CARE UNIT					12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL INTENSI VE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	570, 1	63		570, 163	16. 00
47.00	11-15)	F 050 5	0.4		F 050 504	47.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	5, 359, 5		00 040 400	5, 359, 531	17. 00
18.00	Ancillary services	18, 046, 2		92, 349, 602	110, 395, 833	
19. 00	Outpatient services	507, 2		17, 467, 386	17, 974, 641	19. 00
20.00	RURAL HEALTH CLINIC		0	656, 224	656, 224	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	1 05/ 550	1 05/ 550	21. 00
22. 00 23. 00	HOME HEALTH AGENCY AMBULANCE SERVICES			1, 856, 558	1, 856, 558	22. 00 23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPICE		0	1, 463, 001	1, 463, 001	26. 00
27. 00	PHYSICIAN OFFICES		0	13, 572, 351	13, 572, 351	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	23, 913, 0	-1	127, 365, 122	151, 278, 139	28. 00
20.00	G-3, line 1)	23, 713, 0	' /	127, 303, 122	131, 270, 137	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			73, 922, 996		29. 00
30. 00	ADD (SPECIFY)		0			30. 00
31. 00			0			31. 00
32. 00			0			32. 00
33.00			0			33. 00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36. 00
37.00	DEDUCT (SPECIFY)		0			37.00
38.00			0			38. 00
39. 00			0			39. 00
40.00			0			40.00
41.00			0			41.00
42. 00	Total deductions (sum of lines 37-41)			0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	fer		73, 922, 996		43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems MARGARET MARY COMMUNI	TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 151329 Period:		Worksheet G-3		
			From 01/01/2014		
			To 12/31/2014		
				5/19/2015 11:	49 am
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		151, 278, 139	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			73, 754, 500	•
3.00	Net patient revenues (line 1 minus line 2)			77, 523, 639	1
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	()		73, 922, 996	1
5.00	Net income from service to patients (line 3 minus line 4)			3, 600, 643	1
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	ervi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other than	n patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients	•		0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
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				0	23. 00
24.00				906, 796	24. 00
24. 01	INVESTMENT INCOME			3, 627, 718	
24. 02	NET ASSETS RELEASED FROM RESTRICTION			37, 893	24. 02
05 00				4 570 407	1 0- 00

37, 893 24. 02 4, 572, 407 25. 00 8, 173, 050 26. 00 556, 508 27. 00 556, 508 28. 00 7, 616, 542 29. 00

24.02 Net ASSETS RELEASED FROM RESTRICTION
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 UNREALIZED LOSS ON DERIVATIVE
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)

						Home Health	97 197 2015 11: PPS	49 alli
						Agency I	PPS	
		Sal ari es	Employee	Transportati on	Contracted/Pur		Total (sum of	
		Jai ai i cs	Benefits	(see	chased	Other costs	cols. 1 thru	
			Benefits	instructions)	Servi ces		5)	
		1.00	2. 00	3. 00	4.00	5. 00	6. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	0.00	
1.00	Capital Related - Bldg. &			C	N .	0	0	1.00
00	Fi xtures				1		Ĭ	
2.00	Capital Related - Movable			c		0	0	2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	C	ol o	0	0	3. 00
4.00	Transportation	0	0	C	ol o	0	0	4. 00
5.00	Administrative and General	370, 225	0	C		203, 262	573, 487	1
	HHA REIMBURSABLE SERVICES							1
6.00	Skilled Nursing Care	409, 111	0	C	0	0	409, 111	6.00
7.00	Physical Therapy	314, 903	0	C	0	0	314, 903	7. 00
8.00	Occupational Therapy	72, 057	0	C	0	0	72, 057	8. 00
9.00	Speech Pathology	5, 819	0	C	0	0	5, 819	9. 00
10.00	Medical Social Services	13, 783	0	C	0	0	13, 783	10.00
11.00	Home Health Aide	39, 034	0	C	0	0	39, 034	11. 00
12.00	Supplies (see instructions)	0	0	C	0	0	0	12. 00
13.00	Drugs	0	0	C	0	0	0	13. 00
14.00	DME	0	0	C	ol o	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	0	C	0	0	0	15. 00
16.00	Respiratory Therapy	0	0	C	1		0	16. 00
17.00	Private Duty Nursing	0	0	C	ol o	0	0	17. 00
18.00	Clinic	0	0	C	ol o	0	0	18. 00
19.00	Health Promotion Activities	0	0	C	ol o	0	0	19. 00
20.00	Day Care Program	0	0	C	ol o	0	0	20.00
21.00	Home Delivered Meals Program	0	0	C	ol o	0	0	21. 00
22. 00	Homemaker Service	0	0	C		0	0	
23. 00	All Others (specify)	0	0	C		0	0	23. 00
24.00	Total (sum of lines 1-23)	1, 224, 932	0	C	ol o	203, 262	1, 428, 194	24. 00
		Recl assi fi cati	Recl assi fi ed	Adjustments	Net Expenses			
		on	Trial Balance		for Allocation			
			(col. 6 +		(col. 8 + col.			
			col . 7)		9)			
		7.00	8. 00	9. 00	10.00			
	GENERAL SERVICE COST CENTERS					_		
1.00	Capital Related - Bldg. &	0	0	C	0			1. 00
	Fi xtures							
2.00	Capital Related - Movable	0	0	C	0			2. 00
	Equi pment	_	_	_	_			
3.00	Plant Operation & Maintenance	0	0	C	0			3. 00
4.00	Transportation	0	0	C				4. 00
5.00	Administrative and General	0	573, 487	C	573, 487			5.00
,	HHA REIMBURSABLE SERVICES	_	400 4::	-				,
6.00	Skilled Nursing Care	0	409, 111	C	1			6.00
7.00	Physi cal Therapy	0	314, 903					7. 00
8. 00	Occupational Therapy	0	72, 057					8. 00
9.00	Speech Pathology	0	5, 819		1			9.00
10.00	Medical Social Services	0	13, 783					10.00
11. 00	Home Heal th Ai de	0	39, 034	C	1,			11. 00
12.00	Supplies (see instructions)	0	0	C				12. 00
13. 00	Drugs	0	0	C	1			13. 00
14. 00	DME	0	0	C	0			14. 00
45.00	HHA NONREI MBURSABLE SERVI CES		0					45 00
15. 00	Home Dialysis Aide Services	0	0		•			15.00
16.00	Respiratory Therapy	0	0	C				16.00
17. 00	Private Duty Nursing	0	0	C	1			17.00
18.00	Clinic	0	0	0	<u> </u>			18.00
19.00	Health Promotion Activities	0	0	0	<u> </u>			19.00
20.00	Day Care Program	0	0		<u>0</u>			20.00
21. 00	Home Delivered Meals Program	0	0	C	1			21.00
22. 00	Homemaker Service	0	0	C	1			22. 00
23. 00	All Others (specify)	0	1 420 104	C	•			23. 00
∠4. UU	Total (sum of lines 1-23)	0	1, 428, 194	C	1, 428, 194	1		24. 00

			Capital Rela	ated Costs				
		Net Expenses for Cost Allocation	BI dgs & Fi xtures	Movable Equipment	PI ant Operation & Maintenance	Transportati on	Subtotal (cols. 0-4)	
		(from Wkst. H, col. 10)						
		0	1.00	2.00	3. 00	4. 00	4A. 00	
4 00	GENERAL SERVICE COST CENTERS	1	ما		T	I	^	1 00
1. 00	Capital Related - Bldg. & Fixtures	0	0				0	1. 00
2.00	Capital Related - Movable	0		0			0	2. 00
3.00	Equipment Plant Operation & Maintenance	0	0	0		,	0	3. 00
4. 00	Transportation	O	Ö	0		0		4. 00
5.00	Administrative and General	573, 487	0	0	0	0	573, 487	5. 00
4 00	HHA REIMBURSABLE SERVICES	400 111	ما	0	ol c		400 111	/ 00
6. 00 7. 00	Skilled Nursing Care Physical Therapy	409, 111 314, 903	0	0			409, 111 314, 903	6. 00 7. 00
8.00	Occupational Therapy	72, 057	ő	0	1		72, 057	•
9. 00	Speech Pathology	5, 819	ō	0	Ö	0	5, 819	•
10.00	Medical Social Services	13, 783	O	0) c	0	13, 783	10.00
11. 00	Home Health Aide	39, 034	0	0	1	0	39, 034	•
12. 00	Supplies (see instructions)	0	0	0	1	_	0	
13.00	Drugs	0	0	0			0	
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0) <u> </u>	0	0	14. 00
15. 00	Home Dialysis Aide Services	0	O	0) 0	0	0	15. 00
16.00	Respiratory Therapy	0	o	0	o	0	0	1
17. 00	Private Duty Nursing	0	O	0	0	0	0	17. 00
18. 00	Clinic	0	0	0	0	0	0	
19. 00	Health Promotion Activities	0	0	0	1	0	0	
20.00	Day Care Program	0	0	0	1	0	0	
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0	0	1	0	0	21. 00 22. 00
23. 00	All Others (specify)		o o	0	1	_	0	23. 00
24. 00	Total (sum of lines 1-23)	1, 428, 194	ō	0	Ö	0	1, 428, 194	1
		Admi ni strati ve						
		& General 5.00	4A + 5) 6.00					
	GENERAL SERVICE COST CENTERS	5.00	6.00					
1.00	Capital Related - Bldg. &							1.00
	Fixtures							
2. 00	Capital Related - Movable							2. 00
3.00	Equipment Plant Operation & Maintenance							3. 00
4. 00	Transportation							4. 00
5.00	Administrative and General	573, 487						5. 00
	HHA REIMBURSABLE SERVICES	,						
6.00	Skilled Nursing Care	274, 504	683, 615					6.00
7. 00 8. 00	Physical Therapy Occupational Therapy	211, 292 48, 348	526, 195 120, 405					7. 00 8. 00
9. 00	Speech Pathology	3, 904	9, 723					9. 00
	Medical Social Services	9, 248	23, 031					10.00
11. 00	Home Health Aide	26, 191	65, 225					11.00
12.00	Supplies (see instructions)	0	O					12.00
13. 00	Drugs	0	0					13. 00
14. 00	DME	0	0					14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15. 00
	Respiratory Therapy		o					16. 00
17. 00		l ől	o					17. 00
	Clinic	0	O					18. 00
19. 00	Health Promotion Activities	o	О					19. 00
	Day Care Program	0	0					20. 00
	Home Delivered Meals Program	0	0					21. 00
	Homemaker Service		0					22. 00
	All Others (specify) Total (sum of lines 1-23)	"	1, 428, 194					23. 00 24. 00
2 7. 00	1.013. (34 01 111103 1 20)	1 1	1, 120, 174					1 2 1. 00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	_	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HHA STATISTICAL BASIS	Provi der (HHA CCN:	CCN: 151329 157143	From 01/01/2014	Worksheet H-1 Part II Date/Time Prepared:
				5/19/2015 11:49 am

							5/19/2015 11:4	49 am_
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportati o	nReconciliation	Admi ni strati ve	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance			(ACCUM. COST)	
				(SQUARE FEET)				
		1.00	2.00	3. 00	4.00	5A. 00	5. 00	
-	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1. 00
	Fixtures							
2.00	Capital Related - Movable		0			0		2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	C	ol	0		3. 00
4.00	Transportation (see	l 0	0	C)		4. 00
	instructions)							
5.00	Administrative and General	0	0	C		-573, 487	854, 707	5. 00
	HHA REIMBURSABLE SERVICES	•			•			
6.00	Skilled Nursing Care	0	0	C		0	409, 111	6. 00
7. 00	Physical Therapy	0	0	Ċ		0	314, 903	7. 00
8. 00	Occupational Therapy	0	0	Ċ		0	72, 057	8. 00
9.00	Speech Pathology	0	0	Ċ		0	5, 819	9. 00
10.00	Medical Social Services	0	0	Ċ		0	13, 783	
11. 00	Home Heal th Aide	0	0	Ċ		0	39, 034	
12. 00	Supplies (see instructions)	0	0	Č		0	0,700.	12. 00
13. 00	Drugs	1 0	n o	Č		0	0	13. 00
14. 00	DME	1 0	0	`	1	0	ő	
11.00	HHA NONREIMBURSABLE SERVICES				<u>′</u> 1	<u> </u>	J	11.00
15. 00	Home Dialysis Aide Services	0	0	(0	0	15. 00
16. 00	Respiratory Therapy		0		1	0	0	16. 00
17. 00	Private Duty Nursing		0			0	0	17. 00
18. 00	Clinic		0				0	18. 00
19. 00	Health Promotion Activities		0			0	0	19. 00
20. 00	Day Care Program		0				0	20. 00
	Home Delivered Meals Program		0				0	21. 00
21. 00		0	0				0	
	Homemaker Service	0	0				0	22. 00
		0	0	(0	0	23. 00
	Total (sum of lines 1-23)	0	0	(-573, 487	854, 707	
25. 00	Cost To Be Allocated (per	0	0	(ין (ار	573, 487	25. 00
0, 0-	Worksheet H-1, Part I)		0.005					
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 000000	ון	0. 670975	26. 00

Heal th Financial Systems MARGARE ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 5/19/2015 11: 49 am Provi der CCN: 151329 Peri od: From 01/01/2014 To 12/31/2014 HHA CCN: 157143 Home Health PPS

						Agency I		
				CAPI TAL REI	LATED COSTS			
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	EMPLOYEE BENEFITS DEPARTMENT	
		0	1. 00	1. 01	2.00	2. 01	4. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 000 17. 00 18. 00 19. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	0 683, 615 526, 195 120, 405 9, 723 23, 031 65, 225 0 0 0 0 0 0 0 0 0 0	35, 663 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50, 717 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	376, 929 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
	6 decimal places. Cost Center Description	Subtotal	ADMI NI STRATI VE & GENERAL		OPERATION OF PLANT -OFFSITE	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	
		4A	5. 00	7. 00	7. 01	7. 02	8. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00	Home Delivered Meals Program Homemaker Service	463, 309 683, 615 526, 195 120, 405 9, 723 23, 031 65, 225 0 0 0 0 0 0 0 0 0 0 1, 891, 503 0. 0000000	83, 374 123, 020 94, 691 21, 667 1, 750 4, 145 11, 737 0 0 0 0 0 0 0 0 0 0 0 340, 384	73, 788 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00

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

Heal th Financial Systems MARGARE ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Peri od: Worksheet H-2
From 01/01/2014
To 12/31/2014 Date/Time Prepared: 5/19/2015 11: 49 am
Home Health PPS Provi der CCN: 151329 HHA CCN: 157143

						Home Health	PPS	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	Agency I CENTRAL	PHARMACY	
	oost center bescription	HOOSEKEELTING	DILIM	ON ETERNIA	ADMI NI STRATI ON		110000001	
						SUPPLY		
		9. 00	10.00	11. 00	13.00	14. 00	15. 00	
1. 00	Administrative and General	26, 918	0		- I	.,	0	
2.00	Skilled Nursing Care	0	0		·	-	0	
3.00	Physical Therapy	0	0			-	0	3.00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	0	1		1 1	0	4. 00 5. 00
6. 00	Medical Social Services	0	0	1		-	0	6.00
7. 00	Home Heal th Aide		0	1			0	7. 00
8. 00	Supplies (see instructions)	l o	0	1		ol ol	0	8. 00
9.00	Drugs	0	0			o	0	9. 00
10.00	DME	0	0	(o	o	0	10.00
11. 00	Home Dialysis Aide Services	0	0		0	-	0	11. 00
12. 00	Respiratory Therapy	0	0		0	-	0	12.00
13.00	Private Duty Nursing	0	0	1		-	0	13.00
14. 00 15. 00	Clinic Health Promotion Activities	0	0			-	0	14. 00 15. 00
16. 00	Day Care Program		0				0	16. 00
17. 00	Home Delivered Meals Program	l o	0			ol ol	0	17. 00
18. 00	Homemaker Service	O	0			o	0	18. 00
19.00	All Others (specify)	0	0	(0	o	0	19. 00
20.00	Total (sum of lines 1-19) (2)	26, 918	0	(0	1, 288	0	20. 00
21. 00	Unit Cost Multiplier: column							21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	MEDI CAL	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA	
		RECORDS &		Residents Cost	t	A&G (see Part	Costs	
		LI BRARY		& Post Stepdown		11)		
				Adjustments				
		16. 00	24. 00	25. 00	26.00	27. 00	28. 00	
1.00	Administrative and General	0	662, 839	(662, 839)		1. 00
2.00	Skilled Nursing Care	0	806, 635		806, 635		1, 123, 908	2. 00
3.00	Physi cal Therapy	0	620, 886		620, 886		865, 098	3. 00
4.00	Occupational Therapy	0	142, 072		142, 072		197, 953	4. 00
5. 00 6. 00	Speech Pathology Medical Social Services	0	11, 473 27, 176		۰., ۰.,		15, 986	5. 00 6. 00
7. 00	Home Heal th Aide	0	76, 962		27, 17 <i>6</i> 0 76, 962		37, 865 107, 233	7. 00
8. 00	Supplies (see instructions)		70, 702	l .) 70, 702	0	0 0	8. 00
9. 00	Drugs	O	0	d		o	0	9. 00
10.00	DME	0	0	(o	o	0	10. 00
11. 00	Home Dialysis Aide Services	0	0	1	0	0	0	11. 00
12. 00	Respiratory Therapy	0	0	1	0	0	0	12. 00
13.00	Private Duty Nursing	0	0	1		0	0	13.00
14. 00 15. 00	Clinic Health Promotion Activities	0	0				0	14. 00 15. 00
16. 00	Day Care Program		0				0	16. 00
17. 00	Home Delivered Meals Program	Ö	0			ol ol	0	17. 00
18. 00	Homemaker Service	o	0			o	0	18. 00
19. 00	All Others (specify)	0	0	(0	0	0	19. 00
20. 00	Total (sum of lines 1-19) (2)	0	2, 348, 043	(2, 348, 043		2, 348, 043	
21. 00	Unit Cost Multiplier: column					0. 393329		21. 00
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
		·				·		

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

Provi der CCN: 151329 BASIS 157143 HHA CCN:

						Home Health	PPS	
			CADLTAL DEL	LATED COSTS		Agency I		
			CAPITAL REI	LATED COSTS				
	Cost Center Description	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE	EMPLOYEE	Reconciliation	
	·	FLXT	BLDG	EQUI P	EQUIP OFFSIT	BENEFI TS		
		(SQUARE	(SQUARE	(SQUARE	(SQUARE	DEPARTMENT		
		FEET)	FEET)	FEET)	FEET)	(GROSS		
		1.00	1. 01	2.00	2. 01	SALARI ES) 4. 00	5A	
1.00	Administrative and General	3, 415	0.01		2.01	1, 224, 932	0	1. 00
2.00	Skilled Nursing Care	0	0	l ·	0		0	2. 00
3.00	Physical Therapy	0	0	0	0	0	0	3. 00
4.00	Occupational Therapy	0	0	0	0	0	0	4. 00
5.00	Speech Pathology	0	0	_	0	0	0	5. 00
6.00	Medical Social Services	0	0	_	0	0	0	6. 00
7.00	Home Heal th Ai de	0	0		0	0	0	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs		0			0	0	8. 00 9. 00
10. 00	DME		0			0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	_	· -	_	_	11. 00
12. 00	Respiratory Therapy	0	0		Ö	0	o	12. 00
13.00	Private Duty Nursing	0	0	0	0	0	0	13. 00
14.00	Clinic	0	0	0	0	0	0	14. 00
15. 00	Health Promotion Activities	0	0	0	0	0	0	15.00
16. 00	Day Care Program	0	0	0	0	0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18. 00 19. 00	Homemaker Service All Others (specify)	0	0	0	0	0	0	18. 00 19. 00
20. 00	Total (sum of lines 1-19)	3, 415	0	3, 415		1, 224, 932	l	20. 00
21. 00	Total cost to be allocated	35, 663	0			376, 929		21. 00
22. 00	Unit cost multiplier	10. 443045	0. 000000		•			22. 00
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	PLANT	PLANT -OFFSITE		LINEN SERVICE	(SQUARE	
		(ACCUM.	(SQUARE	(COLLADE	HOSPITAL &	(POUNDS OF	FEET)	
		COST)	FEET)	(SQUARE FEET)	OFFS (SQUARE	LAUNDRY)		
				1 221)	FEET)			
		5. 00	7. 00	7. 01	7. 02	8. 00	9. 00	
1.00	Administrative and General	463, 309	3, 415	l .	-,		3, 415	1. 00
2.00	Skilled Nursing Care	683, 615	0		0	_	0	2. 00
3.00	Physical Therapy	526, 195	0		0	0	0	3. 00
4. 00 5. 00	Occupational Therapy Speech Pathology	120, 405 9, 723	0	_		0	0	4. 00 5. 00
6. 00	Medical Social Services	23, 031	0	_		0	0	6. 00
7. 00	Home Heal th Ai de	65, 225	0		Ö	0	ő	7. 00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8. 00
9.00	Drugs	0	0	0	0	0	0	9. 00
10.00	DME	0	0		0	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	_	0	0	0	11. 00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13. 00 14. 00	Private Duty Nursing Clinic	0	0	0	0	0	0	13. 00 14. 00
15. 00	Health Promotion Activities		0		0	0	0	15. 00
16. 00	Day Care Program	l ő	0			0	o o	16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18. 00	Homemaker Service	0	0	0	0	0	0	18. 00
19. 00	All Others (specify)	0	0	0	0	0	0	19. 00
20.00	Total (sum of lines 1-19)	1, 891, 503	3, 415		3, 415		3, 415	
21. 00	Total cost to be allocated	340, 384	73, 788		14, 162			21. 00
22.00	Unit cost multiplier	0. 179954	21. 607028	0. 000000	4. 146999	0. 000000	7. 882284	22.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu	of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COS	CENTERS STATISTICAL Provider CCN:		Worksheet H-2
BASIS		From 01/01/2014	
	HHA CCN:	157143 To 12/31/2014	Date/Time Prepared:

5/19/2015 11:49 am Home Health PPS Agency I Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL (MEALS (HOURS OF ADMI NI STRATI ON SERVICES & (100% RECORDS & SERVED) SERVICE) SUPPLY PHARMACY) LI BRARY (HOURS OF (TIME SPENT) (COSTED SERVICE) REQUIS.) 10.00 11.00 13.00 14.00 15.00 16.00 1.00 Administrative and General 20, 833 1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 2.00 Ω 0 ol 2.00 Skilled Nursing Care 3.00 Physical Therapy 0 0 3.00 Occupational Therapy 4.00 000000000000000 0 0 0 0 4.00 5.00 Speech Pathology 0 5.00 ol Medical Social Services 0 6.00 6.00 7.00 Home Heal th Aide 0 7.00 0 0 8.00 Supplies (see instructions) 8.00 0 9.00 0 9.00 Drugs 10.00 DMF 0 10.00 11.00 Home Dialysis Aide Services 0 0 11.00 12.00 Respiratory Therapy 0 12.00 0 0 0 Private Duty Nursing 0 13.00 13.00 14.00 Clinic 0 14.00 15.00 Health Promotion Activities 15.00 0 Day Care Program 0 16.00 16, 00 17.00 Home Delivered Meals Program 0 17.00 0 18.00 Homemaker Service 0 18.00 19.00 All Others (specify) 0 0 0 19.00 0 0 0 Total (sum of lines 1-19) 20.00 20.00 0 20,833 21.00 Total cost to be allocated 1, 288 21.00

0.000000

0.000000

0.061825

0.000000

0. 000000

22.00

0.000000

22.00

Unit cost multiplier

Heal th	Financial Systems	MAF	RGARET MARY COM	MUNITY HOSPITA	.L	In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 151329	Peri od:	Worksheet H-3	
				HHA CCN:	157143	From 01/01/2014 To 12/31/2014		
				Ti tl	e XVIII	Home Health	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Agency I Total Visits	Average Cost	
	•	H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
		0	1.00	Part II) 2.00	3.00	4. 00	4) 5. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							
1. 00	Cost Per Visit Computation Skilled Nursing Care	2. 00	1, 123, 908		1, 123, 90	08 5, 898	190. 56	1.00
2.00	Physical Therapy	3. 00						
3.00	Occupational Therapy	4. 00	· ·		1			
4.00	Speech Pathology	5. 00			1			
5.00	Medical Social Services	6. 00			37, 80			
6. 00 7. 00	Home Health Aide Total (sum of lines 1-6)	7. 00	107, 233 2, 348, 043		107, 23 2, 348, 0			6. 00 7. 00
7.00	Total (sum of filles 1 o)		2, 340, 043		Program Visi			7.00
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject Deductibles Coinsurance	& Deductibles		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Limitation Cost Computation	I	T			T	ı	
8. 00 8. 01	Skilled Nursing Care Skilled Nursing Care		17140 99915					8. 00 8. 01
9. 00	Physical Therapy		17140			35		9. 00
9. 01	Physical Therapy		99915	Ċ	1			9. 01
10.00	Occupational Therapy		17140	C	1	29		10. 00
10. 01	Occupational Therapy		99915	C	1	54		10. 01
11. 00 11. 01	Speech Pathology Speech Pathology		17140 99915	(1	32 16		11. 00 11. 01
12. 00			17140			2		12.00
12. 01	Medical Social Services		99915	C		6		12. 01
13. 00	l .		17140	C	1	37		13. 00
13. 01	Home Heal th Aide		99915		•	36		13. 01
14.00	Total (sum of lines 8-13) Cost Center Description	From Wkst H-2	Facility Costs		6, 08 Total HHA		Ratio (col. 3	14. 00
	oost conten beschiption	Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Record)		
		0	1.00	Part II) 2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Computa		1.00	2.00	3.00	4.00	5.00	
15. 00		8. 00		C		0 20, 833		
16. 00	Cost of Drugs	9. 00				0 0	0. 000000	16. 00
			Program Visits		Cost of Services			
			Par	t B	J Sel VI Ces	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
			Deductibles &			Deductibles &		
		6.00	Coi nsurance 7.00	Coi nsurance 8.00	0.00	Coi nsurance 10.00	Coi nsurance 11.00	
	PART I - COMPUTATION OF LESSER				9.00 F PROGRAM LIN			
	BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0				0 639, 329		1.00
2. 00 3. 00	Physical Therapy Occupational Therapy	0	'			0 500, 942 0 106, 352		2. 00 3. 00
4. 00	Speech Pathology	Ö				0 8, 163		4. 00
5.00	Medical Social Services	0	8			0 25, 243		5. 00
6.00	Home Heal th Ai de	0				0 48, 983		6. 00
7. 00	Total (sum of lines 1-6)	0	6, 082	1	I	0 1, 329, 012		7. 00

Heal th	Financial Systems	MAF	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-	2552-10
	TIONMENT OF PATIENT SERVICE COST	S		Provi der HHA CCN:	CCN: 151329 157143	Peri od: From 01/01/2014 To 12/31/2014	Worksheet H-3 Part I Date/Time Pre	pared:
				Ti tl	e XVIII	Home Health Agency I	5/19/2015 11: PPS	49 am_
	Cost Center Description	(00	7.00	0.00	0.00		11 00	
	Limitation Cost Computation	6.00	7. 00	8. 00	9. 00	10.00	11. 00	
8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 01 12. 00 12. 01 13. 00 13. 01 14. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)							8.00 8.01 9.00 9.01 10.00 11.00 11.01 12.00 12.01 13.00 14.00
11.00	Tretar (Sam of Trines o Te)	Progi	ram Covered Cha	nrges	Cost of			11.00
					Servi ces			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance	Subj ect to	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
15.00	Supplies and Drugs Cost Computation Cost of Medical Supplies	ations 0	0			0	0	15.00
16. 00	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00	0	0			U	16. 00
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION		PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LII	MITATION COST, OR		
1. 00	Cost Per Visit Computation Skilled Nursing Care	639, 329						1.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	500, 942 106, 352 8, 163 25, 243 48, 983 1, 329, 012						2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
		12. 00						
0.66	Limitation Cost Computation							0.05
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 12. 01 13. 00 13. 01	Medical Social Services							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 11. 00 12. 01 13. 00 13. 01

Heal th	Financial Systems	MAF	RGARET MARY COM	MUNITY HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 151329	Peri od:	Worksheet H-3	
				HHA CCN:	157143	From 01/01/2014 To 12/31/2014	Part II Date/Time Prep 5/19/2015 11:4	
				Ti tl	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3.00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physi cal Therapy	66. 00	0. 593519	C		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67. 00	0. 673820	C		0 col. 2, line 3	. 00	2. 00
3.00	Speech Pathology	68. 00	1. 022285	C		0 col. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71. 00	0. 000000	C		0 col. 2, line 1	5. 00	4.00
5. 00	Cost of Drugs	73. 00	0. 344420	C		0 col. 2, line 1	6. 00	5. 00

Ith Financial Systems MARGARET MARY COMMUNI CULATION OF HHA REIMBURSEMENT SETTLEMENT	TY HOSPITA	CCN: 151329	In Lie	Worksheet H-4	
SOLITION OF THIS RETURBONSEMENT SETTEEMENT	HHA CCN:	157143	From 01/01/2014	Part I-II	epare
	Ti tl	e XVIII	Home Health Agency I	PPS	
	,		Par	t B	
		Part A	Not Subject to Deductibles &		
			Coi nsurance	Coi nsurance	
		1.00	2. 00	3. 00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTON	MARY CHARGE	S			4
Reasonable Cost of Part A & Part B Services		I			4.
0 Reasonable cost of services (see instructions) 0 Total charges			0 0	0	
0 Total charges Customary Charges			0 0	0	1
O Amount actually collected from patients liable for payment for	servi ces		0 0	0	1 :
on a charge basis (from your records)	33. 1. 333			ū	`
O Amount that would have been realized from patients liable for p	payment		0 0	0) 4
for services on a charge basis had such payment been made in a					
with 42 CFR §413.13(b)					
Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000		0. 000000	
O Total customary charges (see instructions)	nomplete		0 0	0	
Excess of total customary charges over total reasonable cost (only if line 6 exceeds line 1)	comprete		9	U	
0 Excess of reasonable cost over customary charges (complete only	vifline			0	,
1 exceeds line 6)	,				
O Primary payer amounts			0 0	0	
			Part A	Part B	
			Servi ces 1.00	Servi ces 2. 00	\vdash
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	т
00 Total reasonable cost (see instructions)			0	0	10
00 Total PPS Reimbursement - Full Episodes without Outliers			0	942, 225	1
00 Total PPS Reimbursement - Full Episodes with Outliers			0	1, 671	
00 Total PPS Reimbursement - LUPA Episodes			0	16, 926	
OO Total PPS Reimbursement - PEP Episodes			0	7, 273	
OO Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	103	
00 Total PPS Outlier Reimbursement - PEP Episodes			0	0	
00 Total Other Payments 00 DME Payments			0	0	
00 Oxygen Payments				0	
00 Prosthetic and Orthotic Payments			Ö	0	
00 Part B deductibles billed to Medicare patients (exclude coinsur	rance)			0	
00 Subtotal (sum of lines 10 thru 20 minus line 21)	,		o	968, 198	
00 Excess reasonable cost (from line 8)			o	0	2
00 Subtotal (line 22 minus line 23)			O	968, 198	2
OO Coinsurance billed to program patients (from your records)				0	2
00 Net cost (line 24 minus line 25)			0	968, 198	
OO Reimbursable bad debts (from your records)					2
On Reimbursable bad debts for dual eligible beneficiaries (see ins)		0/0 400	28
On Total costs - current cost reporting period (line 26 plus line	27)		0	968, 198	
OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	0	
50 Pioneer ACO demonstration payment adjustment (see instructions))		0	069 109	
00 Subtotal (see instructions) 01 Seguestration adjustment (see instructions)			0	968, 198 19, 364	
01 Sequestration adjustment (see instructions) 00 Interim payments (see instructions)				948, 834	
00 Tentative settlement (for contractor use only)			0	946, 634	
,				0	
00 Balance due provider/program (line 31 minus lines 31 01 - 32 - am	nd 33)				
00 Balance due provider/program (line 31 minus lines 31.01, 32, amo Protested amounts (nonallowable cost report items) in accordance		S Pub. 15-2.	0	0	

HHA CCN:

PROGRAM BENEFICIARIES

				Agency I	FFS	
		Inpatien	it Part A	Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		C		948, 834	1. 00
2.00	Interim payments payable on individual bills, either		()	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01			C		0	3. 01
3. 02 3. 03					0	3. 02 3. 03
3. 03					0	3. 03
3. 05					0	3. 05
0.00	Provider to Program			1	Ŭ.	0.00
3.50			C)	0	3.50
3. 51			C		0	3. 51
3. 52			(0	3. 52
3.53					0	3. 53 3. 54
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines					3. 54 3. 99
3. 77	3. 50-3. 98)			,		3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)				948, 834	4. 00
	(transfer to Wkst. H-4, Part II, column as appropriate,					
	line 32)					
	TO BE COMPLETED BY CONTRACTOR	ı	1			
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			C)	0	5. 01
5.02			(0	5. 02
5. 03			()	0	5. 03
5. 50	Provider to Program	l		1	0	5. 50
5. 51						5. 51
5. 52					Ö	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		ď)	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
/ O1	the cost report. (1)		,			/ O1
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM				0	6. 01 6. 02
7. 00	Total Medicare program liability (see instructions)				948, 834	7. 00
	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor	()	1. 00	2. 00	0.00
8.00	Name of Contractor	l				8. 00

			nospi ce (JON. 151551	10 12/31/2014	5/19/2015 11:	
					Hospi ce I	9, 11, 2010 111	
		Salaries (from	Empl oyee	Transportati o	<u> </u>	Other	
			Benefits (from		Services (from		
		_	Wkst. K-2)		Wkst. K-3)		
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			()	0	1. 00
2.00	Capital Related Costs-Movable Equip.				O	0	2. 00
3.00	Plant Operation and Maintenance	0	0) (0	0	3. 00
4.00	Transportation - Staff	0	0) (0	0	4. 00
5.00	Volunteer Service Coordination	o	0) (0	0	5. 00
6.00	Administrative and General	187, 310	0	670	6	252, 642	6. 00
	INPATIENT CARE SERVICE				_		
7.00	Inpatient - General Care	0	0)	0	0	7. 00
8.00	Inpatient - Respite Care	0	0	(0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0		0	0	9. 00
10.00	Nursing Care	244, 617	0	30, 23	7 0	0	10. 00
11. 00	Nursing Care-Continuous Home Care	0	0) (0	0	11. 00
12.00	Physi cal Therapy	0	0) (0	0	12. 00
13.00	Occupational Therapy	0	0) (0	0	13. 00
14.00	Speech/ Language Pathology	0	0) (0	0	14. 00
15.00	Medical Social Services	54, 705	0	5, 778	3 0	0	15. 00
16.00	Spiritual Counseling	0	0) (0	0	16. 00
17. 00	Di etary Counseling	0	0) (0	0	17. 00
18.00	Counseling - Other	0	0) (0	0	18. 00
19.00	Home Health Aide and Homemaker	74, 419	0	20, 288	3 0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	1	0	-	20. 00
21. 00	Other	22, 113	0	2, 340	6 0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy	0	0		0		22. 00
23. 00	Anal gesi cs	0	0		0	_	23. 00
24. 00	Sedatives / Hypnotics	0	0		0	0	24. 00
25. 00	Other - Specify	0	0	1	0	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0	l .	0	0	26. 00
27. 00	Patient Transportation	0	0	1	0	0	27. 00
28. 00	I maging Services	0	0	1	0	0	28. 00
29. 00	Labs and Diagnostics	0	0		0	0	29. 00
30. 00	Medical Supplies	0	0	1	0	0	30. 00
31. 00	Outpatient Services (including E/R Dept.)	0	0	1	0	0	31. 00
32. 00	Radiation Therapy	0	0	1	0	0	32. 00
33. 00	Chemotherapy	0	0	1	0	-	33. 00
34.00	Other	0	0	(0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE	T		T	T		
35. 00	Bereavement Program Costs	0	0	1	0		35. 00
36.00	Volunteer Program Costs	0	0	(0	0	36. 00
37. 00	Fundrai si ng	0	0	'	0	0	37. 00
38. 00	Other Program Costs	0	0		0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	583, 164	0	59, 32!	5 0	252, 642	39.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 151329	Peri od: Worksheet K
		From 01/01/2014
	U! CON 151551	T- 10/01/0011 D-+-/T: D

Date/Time Prepared: Hospi ce CCN: 151551 To 12/31/2014 5/19/2015 11:49 am Hospi ce I Reclassificati Subtotal (col Total (cols. Total (col. 8 Adiustments ± col . 9) 1-5)on 6 ± col. 7) 9. 00 7 00 6 00 8 00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 0 1.00 0 0 0 2.00 Capital Related Costs-Movable Equip. 0 0 2.00 0 3 00 3 00 Plant Operation and Maintenance 0 0 0 4.00 Transportation - Staff 0 0 0 0 4.00 Volunteer Service Coordination 5.00 0 5.00 6.00 Administrative and General 440, 628 0 440, 628 440, 628 6.00 INPATIENT CARE SERVICE 7.00 Inpatient - General Care 0 0 0 0 0 7.00 8.00 Inpatient - Respite Care 0 0 0 0 0 8.00 VISITING SERVICES 9.00 Physi ci an Servi ces 0 Ω 9.00 10.00 Nursing Care 274, 854 0 274, 854 0 274, 854 10.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 0 11.00 0 11.00 0 Physical Therapy 0 0 12.00 0 12.00 13.00 Occupational Therapy 0 0 0 0 13.00 Speech/ Language Pathology 14.00 14.00 Medical Social Services 0 15.00 15.00 60, 483 60, 483 60, 483 16.00 Spiritual Counseling 0 0 0 Ω 16.00 17.00 Dietary Counseling 0 0 17.00 0 0 18.00 Counseling - Other 0 0 18.00 Home Heal th Aide and Homemaker 19.00 94, 707 0 94, 707 94, 707 19.00 20.00 HH Aide & Homemaker - Cont. Home Care Ω 0 0 20.00 21.00 24, 459 24, 459 24, 459 21.00 OTHER HOSPICE SERVICE COSTS 0 22.00 Drugs, Biological and Infusion Therapy Λ 22.00 23.00 Anal gesi cs 0 0 0 0 23.00 Sedatives / Hypnotics 0 0 0 0 0 0 0 0 0 0 24.00 0000000000 24.00 0 0 25.00 Other - Specify 0 25.00 0 Durable Medical Equipment/Oxygen 0 26.00 0 26.00 27.00 Patient Transportation 0 0 27.00 0 0 28. 00 Imaging Services 0 28.00 0 29 00 Labs and Diagnostics 0 29.00 0 0 30.00 Medical Supplies 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 Radiation Therapy 32.00 0 0 0 32.00 0 0 33.00 Chemotherapy 0 33.00 34.00 0ther 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35 00 0 0 O n 35.00 Bereavement Program Costs 0 0 0 36.00 Volunteer Program Costs 0 0 36.00 37.00 Fundrai si ng 0 0 0 0 37.00 0 38.00 Other Program Costs 0 0 0 0 38.00 895, 131 895, 131 895, 131 39. 00 39.00 Total (sum of lines 1 thru 38) O

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

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151329 | Period: From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: 5/19/2015 11: 49 am

			Hospi ce C	CN: 151551 1	0 12/31/2014	5/19/2015 11:	
					Hospi ce I	0/1//2010 11.	17 4111
		Admi ni strator	Di rector	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	O	0	C	0	0	3.00
4.00	Transportation - Staff	O	0	C	0	0	4. 00
5.00	Volunteer Service Coordination	0	0	C	0	0	5. 00
6.00	Administrative and General	0	187, 310	C	0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	C	0	0	7. 00
8.00	Inpatient - Respite Care	0	0	C	0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0	C	0	0	9. 00
10.00	Nursing Care	0	0	C	0	244, 617	10.00
11. 00	Nursing Care-Continuous Home Care	0	0	C	0	0	11. 00
12.00	Physi cal Therapy	0	0	C	0	0	12. 00
13.00	Occupational Therapy	0	0	C	0	0	13. 00
14.00	Speech/ Language Pathology	0	0	C	_	0	14. 00
15.00	Medical Social Services	0	0	54, 705	0	0	15. 00
16.00	Spiritual Counseling	0	0	0	0	0	16. 00
17. 00	Di etary Counseling	0	0	0	0	0	
18. 00	Counseling - Other	0	0	0		0	18. 00
19. 00	Home Health Aide and Homemaker	0	0	0		0	
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		-		
21. 00	Other	0	0	C	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS	T		T			
22. 00	Drugs, Biological and Infusion Therapy						22. 00
23. 00	Anal gesi cs						23. 00
24. 00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26. 00	Durable Medical Equipment/Oxygen		•				26. 00
27. 00	Pati ent Transportation	0	0			0	1
28. 00	I maging Services	0	0	C	_	0	
29. 00	Labs and Diagnostics	0	0		_	0	
30.00	Medical Supplies	0	0	1 0		_	
31.00	Outpatient Services (including E/R Dept.)	0	0	l ~		0	
32. 00	Radi ati on Therapy	0	0	C		0	
33.00	Chemotherapy	0	0		-		
34. 00	Other HOSPICE NONREIMBURSABLE SERVICE	l U	0		U	0	34. 00
35. 00		0	0	C	0	0	35. 00
36. 00	Volunteer Program Costs		0				
37. 00	Fundrai si ng		0		-	_	
38. 00	Other Program Costs		0		_	_	
	Total (sum of lines 1 thru 38)		187, 310	~	_	_	
	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	١	.0.,010	0.,700	١	2,317	,

Health Financial Systems	MARGARET MARY COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGE	:S	Provi der CCN:	151329	Peri od: From 01/01/2014	Worksheet K-1
		Hospi ce CCN:	151551		Date/Time Prepared:

			Hospi ce C	CN: 151551	0 12/31/2014	5/19/2015 11:49 am
					Hospi ce I	37 177 2013 11. 47 dill
		Total Therapi sts	Ai des	All-Other	Total (1)	
		6.00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	1	,			
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2. 00
3.00	Plant Operation and Maintenance		0	(o	3.00
4.00	Transportation - Staff		O	(o o	4. 00
5.00	Volunteer Service Coordination		0	(o	5. 00
6.00	Administrative and General		O	(187, 310	6. 00
	INPATIENT CARE SERVICE					
7.00	Inpatient - General Care		0	(0	7. 00
8.00	Inpatient - Respite Care		0	(0	8. 00
	VISITING SERVICES					
9.00	Physi ci an Servi ces		0	(0	9. 00
10.00	Nursi ng Care		0	(244, 617	10.00
11.00	Nursing Care-Continuous Home Care		0	(0	11.00
12.00	Physi cal Therapy	0	0	(0	12. 00
13.00	Occupational Therapy	0	0	(0	13. 00
14.00	Speech/ Language Pathology	0	0	(0	14. 00
15.00	Medical Social Services		0	(54, 705	15. 00
16.00	Spiritual Counseling		0	(0	16. 00
17. 00	Di etary Counseling		0	(0	17. 00
18.00	Counseling - Other		0	(0	18. 00
19. 00	Home Health Aide and Homemaker		74, 419	(74, 419	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care		0	(0	20.00
21. 00	Other		0	22, 113	22, 113	21. 00
	OTHER HOSPICE SERVICE COSTS					
	Drugs, Biological and Infusion Therapy					22. 00
	Anal gesi cs					23. 00
24. 00	71					24. 00
	Other - Specify					25. 00
26. 00	Durable Medical Equipment/Oxygen					26. 00
27. 00	•		0	(1	27. 00
28. 00	I maging Services		0	(0	28. 00
29. 00	9		0	(0	29. 00
30. 00	Medical Supplies		0		0	30. 00
31. 00	Outpatient Services (including E/R Dept.)		0		0	31. 00
32. 00	Radiation Therapy		0		0	32. 00
33. 00	Chemotherapy		0		0	33. 00
34. 00	Other		0	(0	34. 00
	HOSPI CE NONREI MBURSABLE SERVI CE		_1		.11	
35. 00	Bereavement Program Costs		0	(0	35.00
36.00	9		0	(<u>ا</u>	36.00
37. 00	Fundrai si ng		0	(<u>ا</u>	37. 00
38. 00	Other Program Costs		0	00.11	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	74, 419	22, 113	583, 164	39.00

Health Financial Systems
COST ALLOCATION - HOSPICE GENERAL SERVICE COST

						5/19/2015 11:	49 am
					Hospi ce I		
	·		CAPI TAL RE	LATED COST			
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATION	
		FOR COST	FI XTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MAI NT.		
		0	1.00	2. 00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1. 00
2.00	Capital Related Costs-Movable Equip.	0			0		2. 00
3.00	Plant Operation and Maintenance	0	0		0 0		3. 00
4.00	Transportation - Staff	0	0		0 0	0	4. 00
5.00	Volunteer Service Coordination	0	0		0 0	0	5. 00
6.00	Administrative and General	440, 628	0		0 0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0		0 0	0	7. 00
8.00	Inpatient - Respite Care	0	0		0 0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0		0 0	0	9. 00
10.00	Nursi ng Care	274, 854	0		0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	11. 00
12.00	Physical Therapy	0	0		0 0	0	12.00
13.00	Occupational Therapy	0	0		0 0	0	13.00
14.00	Speech/ Language Pathology	o	0		0 0	0	14. 00
15.00	Medical Social Services	60, 483	0		0 0	0	15. 00
16.00	Spiritual Counseling	0	0		0 0	0	16.00
17.00	Di etary Counsel i ng	o	0		0 0	0	17. 00
18.00	Counseling - Other	o	0		0 0	0	18. 00
19.00	Home Health Aide and Homemaker	94, 707	0		0 0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	o	0		0 0	0	20. 00
21.00	Other	24, 459	0		0 0	0	21. 00
	OTHER HOSPICE SERVICE COSTS	,			-		
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22. 00
23.00	Anal gesi cs	o	0		0 0	0	23. 00
24.00	Sedatives / Hypnotics	o	0		0 0	0	24.00
25.00	Other - Specify	o	0		0 0	0	25. 00
26.00	Durable Medical Equipment/Oxygen	o	0		0 0	0	26. 00
27.00	Patient Transportation	o	0		0 0	0	27. 00
28.00	I maging Services	o	0		0 0	0	28. 00
29.00	Labs and Diagnostics	o	0		0 0	0	29. 00
30.00	Medical Supplies	o	0		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	o	0		0 0	0	31.00
32.00	Radiation Therapy	o	0		0 0	0	32. 00
33.00	Chemotherapy	o	0		0 0	0	33. 00
34.00	Other	0	0		0 0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE	'					
35. 00	Bereavement Program Costs	O	0		0 0	0	35. 00
36. 00	Volunteer Program Costs	0	0		0 0		36. 00
37. 00	Fundrai si ng		0		0 0	Ö	37. 00
38. 00	Other Program Costs	1 0	0		0 0	Ö	38. 00
	Total (sum of lines 1 thru 38)	895, 131	0		0 0		1
	/		ŭ	'	'	'	

 TY HOSPITAL
 In Lieu of Form CMS-2552-10

 Provi der CCN: 151329
 Peri od: From 01/01/2014
 Worksheet K-4 Part I Date/Time Prepared: Properties

 Hospi ce CCN: 151551
 To 12/31/2014
 Date/Time Prepared: Prepared: Properties

			Hospi ce (CCN: 151551	To 12/31/2014	Date/Time Prepared: 5/19/2015 11:49 am
					Hospi ce I	37 177 2013 11: 47 411
		VOLUNTEER	SUBTOTAL	ADMI NI STRATI V	ETOTAL (col. 5A	
		SERVI CES	(cols. 0 - 5)	& GENERAL	± col. 6)	
		COORDI NATOR	,			
		5. 00	5A	6.00	7. 00	
	GENERAL SERVICE COST CENTERS	<u> </u>				
1.00	Capital Related Costs-Bldg and Fixt.					1. 00
2.00	Capital Related Costs-Movable Equip.					2. 00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5. 00
6.00	Administrative and General	0	440, 628	440, 62	8	6. 00
	INPATIENT CARE SERVICE					
7.00	Inpatient - General Care	0	0		0 0	7. 00
8.00	Inpatient - Respite Care	0	0		0 0	8. 00
	VISITING SERVICES					
9.00	Physi ci an Servi ces	0	0)	0 0	9. 00
10.00	Nursi ng Care	0	274, 854	266, 46	3 541, 317	10.00
11. 00	Nursing Care-Continuous Home Care	0	0	1	이	11. 00
12.00	Physi cal Therapy	0	0	1	이	12.00
13.00	Occupational Therapy	0	0	1	이	13.00
14.00	Speech/ Language Pathology	0	0	1	이	14. 00
15. 00	Medical Social Services	0	60, 483	58, 63	7 119, 120	15. 00
16. 00	Spiritual Counseling	0	0)	이	16. 00
17. 00	Di etary Counsel i ng	0	0)	0 0	17. 00
18. 00	Counseling - Other	0	0		0 0	18. 00
19. 00	Home Health Aide and Homemaker	0	94, 707	91, 81	6 186, 523	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0	1	0 0	20. 00
21. 00	Other	0	24, 459	23, 71	2 48, 171	21. 00
	OTHER HOSPICE SERVICE COSTS					
22. 00	Drugs, Biological and Infusion Therapy	0	0		0 0	22. 00
23. 00	Anal gesi cs	0	0		0 0	23. 00
24. 00	Sedatives / Hypnotics	0	0		0 0	24. 00
25. 00	Other - Specify	0	0		0 0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0		0 0	26. 00
27. 00	Pati ent Transportation	0	0		0 0	27. 00
28. 00	I maging Services	0	0	1	0 0	28. 00
29. 00	Labs and Diagnostics	0	0	1	0 0	29. 00
30.00	Medi cal Supplies	0	0	1	0 0	30. 00
31. 00	Outpatient Services (including E/R Dept.)	0	0		0 0	31.00
32. 00	Radi ati on Therapy	0	0	1	0 0	32. 00
33. 00	Chemotherapy	0	0	1	0 0	33. 00
34.00	Other	0	0	1	0 0	34.00
05.00	HOSPI CE NONREI MBURSABLE SERVI CE					05.00
35. 00	Bereavement Program Costs	0	0		0 0	35. 00
36. 00	Volunteer Program Costs	0	0		0 0	36.00
37. 00	Fundrai si ng	0	0		0	37. 00
38. 00	Other Program Costs	0	005 101	1	005 404	38.00
39.00	Total (sum of lines 1 thru 38)	0	895, 131	1	895, 131	39.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

			·			5/19/2015 11:	49 am
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON		
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
				FT.)		(HOURS)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2. 00
3.00	Plant Operation and Maintenance	0	0	(3. 00
4.00	Transportation - Staff	0	0	(0		4. 00
5.00	Volunteer Service Coordination	0	0	(0	0	5. 00
6.00	Administrative and General	0	0	(0	0	6. 00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0	0	(0	0	7. 00
8.00	Inpatient - Respite Care	0	0		ol ol	0	8. 00
	VI SI TI NG SERVI CES	•					
9.00	Physi ci an Servi ces	0	0	(0	0	9. 00
10.00	Nursing Care	0	0		ol ol	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		ol ol	0	11. 00
12.00	Physical Therapy	0	0		ol	0	12.00
13.00	Occupational Therapy	0	0		ol	0	13. 00
14. 00	Speech/ Language Pathology	0	0	1	o	0	14. 00
15. 00	Medical Social Services	0	Ö		ol	0	15. 00
16. 00	Spiritual Counseling	0	0			0	16.00
17. 00	Di etary Counsel i ng	0	0		ol ol	0	17. 00
18. 00	Counseling - Other	0	0	1	ol ol	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0		ol ol	0	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	Ö		ol ol	0	20.00
21. 00	Other	0	Ö		ol ol	0	21.00
21.00	OTHER HOSPICE SERVICE COSTS	,		,	۷		21.00
22. 00	Drugs, Biological and Infusion Therapy	0	0	(ol	0	22. 00
23. 00	Anal gesi cs	0	0		ol ol	0	23. 00
24. 00	Sedatives / Hypnotics	0	0		ol ol	0	24. 00
25. 00	Other - Specify	0	0		ol ol	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0		ol ol	0	26.00
27. 00	Patient Transportation	0	0		ol ol	0	27. 00
28. 00	Imaging Services	0	0		ol ol	0	28. 00
29. 00	Labs and Diagnostics		0			0	29.00
30. 00	Medical Supplies		0			0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0			0	31.00
32.00	Radi ati on Therapy	0	0			0	32.00
		0		•			33.00
33.00	Chemotherapy	0	0		0 0	0	ı
34. 00	Other HOSPICE NONREIMBURSABLE SERVICE	0	0		0	0	34. 00
25 00		1		1		0	25 00
35. 00	Bereavement Program Costs	0	0	1	0	0	35. 00
36.00	Volunteer Program Costs	0	0	1	0	0	36.00
37. 00	Fundrai si ng	0	0	9		0	37. 00
38. 00	Other Program Costs	0	0]	0	0	38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)	0 000000	0 000000	0.00000	0 000000	0 000000	39.00
40.00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0. 000000	0. 000000	40. 00

			nospi ce (CN. 151551	10 12/31/2014	5/19/2015 11: 49 am	
					Hospi ce I		_
		RECONCI LI ATI ON	ADMI NI STRATI VE				
			& GENERAL				
			(ACC. COST)				
		6A	6. 00				
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0				1. C	00
2.00	Capital Related Costs-Movable Equip.	0				2.0	00
3.00	Plant Operation and Maintenance	0				3. C	00
4.00	Transportation - Staff	0				4. C	00
5.00	Volunteer Service Coordination					5. C	00
6.00	Administrative and General	-440, 628	454, 503			6. C	00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0			7. C	00
8.00	Inpatient - Respite Care	o	0			8.0	00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	0	0			9. 0	00
10.00	Nursi ng Care	o	274, 854			10.0	00
11.00	Nursing Care-Continuous Home Care	o	0			11. C	00
12.00	Physical Therapy	o	0			12.0	00
13.00	Occupational Therapy	O	0			13.0	00
14.00	Speech/ Language Pathology	O	0			14. C	00
15.00	Medical Social Services	o	60, 483			15. C	00
16.00	Spiritual Counseling	o	0	•		16.0	00
17.00	Di etary Counseling	o	0			17. C	00
18.00	Counseling - Other	o	0			18.0	00
19.00	Home Health Aide and Homemaker	o	94, 707			19.0	00
20.00	HH Aide & Homemaker - Cont. Home Care	o	0			20.0	00
21.00	Other	o	24, 459			21.0	00
	OTHER HOSPICE SERVICE COSTS	'		·			
22. 00	Drugs, Biological and Infusion Therapy	0	0			22. C	00
23.00	Anal gesi cs	O	0			23. 0	00
24.00	Sedatives / Hypnotics	0	0			24. C	00
25.00	Other - Specify	o	0			25. 0	00
26, 00	Durable Medical Equipment/Oxygen	O	0			26.0	00
27. 00	Pati ent Transportation	O	0			27. C	00
28. 00	I maging Services	o	0			28.0	00
29. 00	Labs and Diagnostics	o	0			29.0	00
30.00	Medical Supplies	o	0			30. C	00
31. 00	Outpatient Services (including E/R Dept.)	0	0			31.0	00
32. 00	Radiation Therapy	0	0			32.0	00
33. 00	Chemotherapy	0	0	•		33. C	
34.00	Other	0	0			34. C	00
2 30	HOSPI CE NONREI MBURSABLE SERVI CE	<u> </u>				0.1.0	
35. 00	Bereavement Program Costs	0	0			35. C	00
36. 00	Volunteer Program Costs	O	0	1		36.0	
37. 00	Fundrai si ng	O	0			37. 0	
38. 00	Other Program Costs		0			38.0	
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)		440, 628			39. 0	
	Unit Cost Multiplier		0. 969472			40. 0	
	I compared to the compared to			1		1 .5.5	-

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

					Hospi ce I		
				CAPITAL REL	ATED COSTS		
	Cost Center Description	Hospice Trial	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE	
	cost center bescription	Bal ance (1)	FLXT	BLDG	EQUI P	EQUIP OFFSIT	
		0	1. 00	1. 01	2. 00	2. 01	
1.00	Administrative and General	Ü	1.00	1.01	2.00	0.01	1. 00
2. 00	Inpatient - General Care	0	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4. 00	Physician Services	0	0	0	0	0	4. 00
5. 00	Nursi ng Care	541, 317	0	Ö	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	Ö	0	0	6. 00
7. 00	Physical Therapy	0	0	Ö	0	0	7. 00
8.00	Occupational Therapy	0	0	Ö	0	0	8. 00
9.00	Speech/ Language Pathology	o	0	o	0	0	9.00
10.00	Medical Social Services	119, 120	0	o	0	0	10.00
11. 00	Spiritual Counseling	O	0	o	0	0	11. 00
12.00	Di etary Counseling	o	0	О	0	0	12. 00
13.00	Counseling - Other	o	0	О	0	0	13. 00
14.00	Home Health Aide and Homemaker	186, 523	0	0	0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15. 00
16.00	Other	48, 171	0	0	0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18.00	Anal gesi cs	o	0	0	0	0	18. 00
19.00	Sedatives / Hypnotics	o	0	0	0	0	19. 00
20.00	Other - Specify	o	0	0	0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22.00	Patient Transportation	o	0	0	0	0	22. 00
23.00	I maging Services	o	0	0	0	0	23. 00
24.00	Labs and Diagnostics	0	0	0	0	0	24. 00
25.00	Medical Supplies	0	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27.00	Radi ati on Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30. 00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32. 00	Fundrai si ng	0	0	0	0	0	32. 00
33.00	Other Program Costs	0	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	895, 131	0	0	0	0	34. 00
35. 00	Unit Cost Multiplier (see instructions)						35. 00

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

					5/19/2015 11:4	<u>49 am</u>	
					Hospi ce I		
	Cost Center Description	EMPLOYEE	Subtotal	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	
		BENEFITS		& GENERAL	PLANT	PLANT -OFFSITE	
		DEPARTMENT					
		4. 00	4A	5. 00	7. 00	7. 01	
1.00	Administrative and General	179, 448	179, 448	32, 292	0	0	1. 00
2.00	Inpatient - General Care	0	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	0	0	0	4. 00
5.00	Nursi ng Care	0	541, 317	97, 412	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	0	119, 120	21, 436	0	0	10.00
11. 00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	186, 523	33, 566	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	48, 171	8, 669	0	0	16.00
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18.00	Anal gesi cs	0	0	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22. 00	Patient Transportation	0	0	0	0	0	22. 00
23.00	I maging Services	0	0	0	0	0	23. 00
24. 00	Labs and Diagnostics	0	0	0	0	0	24. 00
25. 00	Medical Supplies	0	0	0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27. 00	Radi ati on Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31. 00	Volunteer Program Costs	0	0	0	0	0	31. 00
32.00	Fundrai si ng	0	0	0	0	0	32. 00
33.00	Other Program Costs	0	0	0	0	0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	179, 448	1, 074, 579	·	0	0	34. 00
35. 00	Unit Cost Multiplier (see instructions)		0. 000000	1			35. 00

Health Financial Systems MARGARET MA
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provi der CCN: 151329 | Peri od: From 01/01/2014 | Worksheet K-5 | Part I | To 12/31/2014 | Date/Time Prepared: 5/19/2015 11: 49 am

					5/19/2015 11:	49 am	
					Hospi ce I		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT - HOSPITAL &	LINEN SERVICE	,			
		OFFS					
		7. 02	8. 00	9.00	10.00	11.00	
1.00	Administrative and General	C		0	0	0	1. 00
2.00	Inpatient - General Care	C		0 (c	0	0	2. 00
3.00	Inpatient - Respite Care	C)	o (c	0	0	3. 00
4.00	Physi ci an Servi ces	C)	0 (c	0	0	4. 00
5.00	Nursing Care	C)	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	C)	0 0	0	0	6. 00
7.00	Physi cal Therapy	C)	0	0	0	7. 00
8.00	Occupational Therapy	C)	0 0	0	0	8. 00
9.00	Speech/ Language Pathology	C)	0 0	0	0	9. 00
10.00	Medical Social Services	C)	0 0	0	0	10. 00
11. 00	Spiritual Counseling	C)	0 0	0	0	11. 00
12.00	Di etary Counseling	C)	0 0	0	0	12. 00
13.00	Counseling - Other	C)	0 0	0	0	13. 00
14.00	Home Health Aide and Homemaker	C)	0 0	0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	C)	0 (0	0	0	15. 00
16.00	Other	C)	0 (0	0	0	
17. 00	Drugs, Biological and Infusion Therapy	C)	0 (0	0	0	17. 00
18. 00	Anal gesi cs	C)	0 (0	0	0	18. 00
19. 00	Sedatives / Hypnotics	C)	0 (0	0	0	19. 00
20.00	Other - Specify	C)	0 0	0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	C)	0 0	0	0	21. 00
22. 00	Patient Transportation	C)	0 (0	0	0	22. 00
23.00	I magi ng Servi ces	C)	0 (0	0	0	23. 00
24. 00	Labs and Diagnostics	C)	0 0	0	0	24. 00
25.00	Medical Supplies	C)	0 0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	C)	0 0	0	0	26. 00
27. 00	Radiation Therapy	C)	0 0	0	0	27. 00
28. 00	Chemotherapy	C)	0 0	0	0	28. 00
29. 00	Other	C)	0 0	0	0	29. 00
30. 00	Bereavement Program Costs	C)	0	0	0	30. 00
31. 00	Volunteer Program Costs	C)	0 0	0	0	31.00
32. 00	Fundrai si ng	C)	0 0	0	0	32. 00
33.00	Other Program Costs	C)	0 0	0	0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	C)	0 0	0	0	
35. 00	Unit Cost Multiplier (see instructions)		I	1		ĺ	35. 00

near the Financial Systems	WARGARET WART COMMUNICINT	IT HUSPITAL			III LI E	u 01 F01111 CW3-2332-10
ALLOCATION OF GENERAL SERVICE COSTS TO HO	OSPICE COST CENTERS	Provi der CCN: 1	151329	Peri oc	d:	Worksheet K-5
		Hospi ce CCN:	151551	To 1	12/31/2014	Date/Time Prepared:
						5/19/2015 11:49 am

						5/19/2015 11:	49 am
					Hospi ce I		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	(col s. 4A-23)	
			SUPPLY		LI BRARY		
		13.00	14. 00	15. 00	16.00	24. 00	
1.00	Administrative and General	0	6, 303	3	0 0	218, 043	1. 00
2.00	Inpatient - General Care	0	(0 0	0	2. 00
3.00	Inpatient - Respite Care	0	(0 0	0	3. 00
4.00	Physici an Services	0	(0 0	0	4.00
5.00	Nursi ng Care	0	(0 0	638, 729	5. 00
6.00	Nursing Care-Continuous Home Care	0	(0 0	0	6.00
7.00	Physical Therapy	0	(0 0	0	7. 00
8.00	Occupational Therapy	0	(0 0	0	8. 00
9.00	Speech/ Language Pathology	0	(0 0	0	9. 00
10.00	Medical Social Services	0	(0 0	140, 556	10.00
11.00	Spiritual Counseling	0	(0 0	0	11. 00
12.00	Di etary Counseling	0	(0 0	0	12. 00
13.00	Counseling - Other	0	(0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	(0 0	220, 089	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	(0 0	0	15. 00
16.00	Other	0	(0 0	56, 840	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	(0 0	0	17. 00
18.00	Anal gesi cs	0	(D	0 0	0	18. 00
19.00	Sedatives / Hypnotics	0	(D	0 0	0	19. 00
20.00	Other - Specify	0	(D	0 0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	(0 0	0	21. 00
22. 00	Patient Transportation	0	(0 0	0	22. 00
23.00	I maging Services	0	(0 0	0	23. 00
24.00	Labs and Diagnostics	0	(0 0	0	24. 00
25.00	Medical Supplies	0	(0 0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	(0 0	0	26. 00
27. 00	Radiation Therapy	0	(0 0	0	27. 00
28. 00	Chemotherapy	0	(0 0	0	28. 00
29.00	Other	0	(0 0	0	29. 00
30.00	Bereavement Program Costs	0	(0 0	0	30.00
31.00	Volunteer Program Costs	0	(0 0	0	31.00
32.00	Fundrai si ng	0	(0 0	0	32. 00
33.00	Other Program Costs	0	(0 0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	6, 303	3	0	1, 274, 257	34.00
35.00	Unit Cost Multiplier (see instructions)						35. 00

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

						5/19/2015 11:49 am
					Hospi ce I	
	Cost Center Description	Intern &	Subtotal	Allocated	Total Hospice	
		Residents Cost	(cols. 24 ±	Hospi ce A&G	Costs (cols.	
		& Post	25)	(See Part II)	26 ± 27)	
		Stepdown				
		Adjustments				
		25. 00	26.00	27. 00	28. 00	
1.00	Administrative and General					1.00
2.00	Inpatient - General Care	0	C		0	2.00
3.00	Inpatient - Respite Care	o	C) (0	3.00
4.00	Physi ci an Servi ces	o	C) (0	4.00
5.00	Nursing Care	o	638, 729	131, 858	770, 587	5.00
6.00	Nursing Care-Continuous Home Care	o	C		0	6.00
7.00	Physical Therapy	o	C		0	7.00
8.00	Occupational Therapy	o	C		0	8.00
9.00	Speech/ Language Pathology	o	C		0	9.00
10.00	Medical Social Services	o	140, 556	29, 016	169, 572	10.00
11. 00	Spiritual Counseling	o	C		0	11.00
12.00	Di etary Counseling	o	C		0	12.00
13.00	Counseling - Other	o	C		0	13.00
14.00	Home Health Aide and Homemaker	o	220, 089	45, 435	265, 524	14.00
15. 00	HH Aide & Homemaker - Cont. Home Care	ol) . (0	15.00
16.00	Other	o	56, 840	11, 734	68, 574	16.00
17. 00	Drugs, Biological and Infusion Therapy	o	C)	0	17. 00
18. 00	Anal gesi cs	o	C		0	18.00
19.00	Sedatives / Hypnotics	l ol	C) (0	19.00
20. 00	Other - Specify	o	C		0	20.00
21. 00	Durable Medical Equipment/Oxygen	o	C		0	21.00
22. 00	Patient Transportation	o	C		0	22.00
23.00	I maging Services	l ol	C) (0	23.00
24.00	Labs and Diagnostics	o	C		0	24.00
25. 00	Medical Supplies	o	C		0	25.00
26.00	Outpatient Services (including E/R Dept.)	o	C		0	26.00
27. 00	Radiation Therapy	o	C		0	27.00
28. 00	Chemotherapy	l ol	C) (0	28.00
29. 00	Other	o	C		0	29.00
30. 00	Bereavement Program Costs	o	C		0	30.00
31. 00	Volunteer Program Costs	o	C		0	31.00
32. 00	Fundrai si ng	l ol	C		ol o	32.00
33. 00	Other Program Costs	0	Ċ		ol	33.00
34. 00	Total (sum of lines 1 thru 33) (2)	l ol	1, 274, 257	,	1, 274, 257	34.00
	Unit Cost Multiplier (see instructions)		, = : :, = = :	0. 206438		35. 00
		'			1	

						5/19/2015 11:4	<u>49 am</u>
					Hospi ce I		
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE	EMPLOYEE	
		FLXT	BLDG	EQUI P	EQUIP OFFSIT	BENEFI TS	
		(SQUARE	(SQUARE	(SQUARE	(SQUARE	DEPARTMENT	
		FEET)	FEET)	FEET)	FEET)	(GROSS	
						SALARI ES)	
		1. 00	1. 01	2.00	2. 01	4. 00	
1.00	Administrative and General	0	0	C	0	577, 266	1. 00
2.00	Inpatient - General Care	0	0	C	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	C	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	C	0	0	4. 00
5.00	Nursing Care	0	0	C	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	C	0	0	6. 00
7.00	Physi cal Therapy	0	0	C	0	0	7. 00
8.00	Occupational Therapy	0	0	C	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	C	0	0	9. 00
10.00	Medical Social Services	0	0	C	0	0	10. 00
11. 00	Spiritual Counseling	0	0	C	0	0	11. 00
12.00	Di etary Counsel i ng	0	0	C	0	0	12. 00
13.00	Counseling - Other	0	0	C	0	0	13. 00
14.00	Home Health Aide and Homemaker	0	0	C	0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	C	0	0	15. 00
16.00	Other	0	0	C	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	C	0	0	17. 00
18. 00	Anal gesi cs	0	0	C	0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	C	0	0	19. 00
20.00	Other - Specify	0	0	C	0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0	C	0	0	21. 00
22. 00	Pati ent Transportation	0	0	C	0	0	22. 00
23. 00	I maging Services	0	0	C	0	0	23. 00
24.00	Labs and Diagnostics	0	0	C	0	0	24. 00
25. 00	Medi cal Supplies	0	0	C	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	C	0	0	26. 00
27. 00	Radi ati on Therapy	0	0	C	0	0	27. 00
28. 00	Chemotherapy	0	0	C	0	0	28. 00
29. 00	Other	0	0	C	0	0	29. 00
30.00	Bereavement Program Costs	0	0	(0	0	30. 00
31.00	Volunteer Program Costs	0	0	(0	0	31. 00
32. 00	Fundrai si ng	0	0	(0	0	32. 00
33.00	Other Program Costs	0	0	(0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	(0	577, 266	34. 00
35.00	Total cost to be allocated	0	0	C	0	179, 448	35. 00
36. 00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0.000000	0. 000000	0. 310858	36. 00

 TY HOSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 151329
 Period: From 01/01/2014 To 12/31/2014
 Worksheet K-5 Part II Date/Time Prepared: 5/19/2015 11: 49 am
 STATISTICAL BASIS

						5/19/2015 11:	49 am_
					Hospi ce I		
	Cost Center Description	Reconciliation	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	OPERATION OF	
			& GENERAL	PLANT	PLANT -OFFSITE	PLANT -	
			(ACCUM.	(SQUARE		HOSPITAL &	
			COST)	FEET)	(SQUARE	0FFS	
			0031)	''''	FEET)	(SQUARE	
					I LLI)	FEET)	
		5A	5. 00	7. 00	7. 01	7. 02	
1 00	Administrative and Consum	-			7.01		1 00
1.00	Administrative and General	0	179, 448		0	0	1.00
2.00	Inpatient - General Care	0	C		0	0	2. 00
3.00	Inpatient - Respite Care	0	C)	0	0	3. 00
4.00	Physi ci an Servi ces	0	C)	0	0	4. 00
5.00	Nursi ng Care	0	541, 317	' (0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	C) (0	0	6. 00
7.00	Physi cal Therapy	0	C) (0	0	7. 00
8.00	Occupational Therapy	0	C) (0	0	8. 00
9.00	Speech/ Language Pathology	o	C	ol c	0	0	9. 00
10.00	Medical Social Services	o	119, 120	ol c	0	0	10.00
11. 00	Spiritual Counseling	0	,		0	0	11. 00
12. 00	Di etary Counsel i ng	0	Č		n n	0	12. 00
13. 00	Counseling - Other		Č			0	13. 00
14. 00	Home Health Aide and Homemaker		186, 523			0	14. 00
15. 00	HH Ai de & Homemaker - Cont. Home Care	0	100, 523		1	0	15. 00
16. 00		0	48, 171	1	1		
	Other District Laboratory	0	48, 171	1	_	0	16.00
17. 00	Drugs, Biological and Infusion Therapy	0	C		0	0	17. 00
18. 00	Anal gesi cs	0	C		0	0	18. 00
19. 00	Sedatives / Hypnotics	0	C		0	0	19. 00
20.00	Other - Specify	0	C)	0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	C) (0	0	21. 00
22. 00	Patient Transportation	0	C) (0	0	22. 00
23.00	I maging Services	0	C) (0	0	23.00
24.00	Labs and Diagnostics	0	C) (0	0	24.00
25.00	Medical Supplies	0	C		0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	o	C) (0	0	26. 00
27.00	Radi ati on Therapy	o	C	ol c	0	0	27. 00
28. 00	Chemotherapy	0	C		0	0	28. 00
29. 00	Other	0	Ċ		0	0	29. 00
30. 00	Bereavement Program Costs	0	Č		il o	0	30.00
31. 00	Volunteer Program Costs					0	31. 00
32. 00	Fundrai si ng					0	32.00
33. 00						0	32.00
	Other Program Costs	ا	1 074 570		íl ú	_	
34.00	Total (sum of lines 1 thru 33) (2)		1, 074, 579	III	1	0	34. 00
35. 00	Total cost to be allocated		193, 375	•	0	0	35. 00
36. 00	Unit Cost Multiplier (see instructions)		0. 179954	0.000000	0. 000000	0. 000000	36. 00

						5/19/2015 11:	49 am
					Hospi ce I		
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	·	LINEN SERVICE	(SQUARE	(MEALS	(HOURS OF	ADMI NI STRATI ON	
		(POUNDS OF	FEET)	SERVED)	SERVICE)		
		LAUNDRY)	·			(HOURS OF	
						SERVICE)	
		8. 00	9. 00	10.00	11. 00	13.00	
1.00	Administrative and General	0	0	C) (0	1. 00
2.00	Inpatient - General Care	0	0	ol c)	0	2.00
3.00	Inpatient - Respite Care	0	0	ıl c)	0	3. 00
4.00	Physi ci an Servi ces	0	0	ol c		0	4.00
5.00	Nursing Care	0	0			0	5.00
6.00	Nursing Care-Continuous Home Care	0	l o			ol o	6.00
7. 00	Physical Therapy	0	0				7. 00
8. 00	Occupational Therapy	0	0				8. 00
9.00	Speech/ Language Pathology	0	0				9, 00
10. 00	Medical Social Services	0	0	d		ol o	10.00
11. 00	Spiritual Counseling	0	0	d		ol o	11. 00
12. 00	Di etary Counsel i ng	0	0	d			12. 00
13. 00	Counseling - Other	0	0	i c	1		13. 00
14. 00	Home Health Aide and Homemaker	0	0	i c			14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	١				15. 00
16. 00	Other	0	١				16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	١				17. 00
18. 00	Anal gesi cs	0	١		1		18.00
19. 00	Sedatives / Hypnotics	0	١		1		19.00
20. 00	Other - Specify		١		1		20.00
21. 00	Durable Medical Equipment/Oxygen		١				21. 00
22. 00	Patient Transportation	0	0				22.00
23. 00	I maging Services	0	0		1		23. 00
24. 00	Labs and Diagnostics	0	0				24. 00
25. 00	Medical Supplies	0	0				25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0				26. 00
27. 00	Radi ati on Therapy	0	0		1		27. 00
28. 00	Chemotherapy	0	0				28. 00
29. 00	Other	0					29. 00
30. 00	Bereavement Program Costs	0					30.00
31. 00	Volunteer Program Costs						31.00
32. 00	Fundrai si ng				1		32.00
33. 00	Other Program Costs				1		33. 00
34. 00	Total (sum of lines 1 thru 33) (2)						34. 00
35. 00	Total cost to be allocated						35. 00
	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	1	Ί	ή	
30.00	Join Coost Multiplier (See Histractions)	0.000000	0.00000	J 0.00000C	, U. UUUUUL	/I 0.000000	30.00

5/19/2015 11:49 am

32 00

33.00

34.00

35.00

36.00

Hospi ce I CENTRAL PHARMACY MEDI CAL Cost Center Description RECORDS & SERVICES & (100% SUPPLY LI BRARY PHARMACY) (COSTED (TIME REQUIS.) SPENT) 14.00 15.00 16.00 1.00 Administrative and General 101, 953 1.00 0 2.00 Inpatient - General Care 0 2.00 Inpatient - Respite Care 0 3.00 3.00 4.00 Physician Services 0 0 4.00 5.00 Nursing Care 0 0 5.00 01 0 6.00 Nursing Care-Continuous Home Care 6.00 7.00 Physical Therapy 0 7.00 0 8.00 Occupational Therapy 8.00 Speech/ Language Pathology Medical Social Services 0 9.00 9 00 0 0 10.00 10.00 11.00 Spiritual Counseling 0 11.00 0 0 12.00 Dietary Counseling 12.00 0 13.00 Counseling - Other 0 13 00 14.00 Home Health Aide and Homemaker 0 14.00 HH Aide & Homemaker - Cont. Home Care 0 15.00 0 0 0 15.00 0 16 00 Other 16 00 0) 17.00 Drugs, Biological and Infusion Therapy 17.00 18.00 Anal gesi cs 0 18.00 Sedatives / Hypnotics 0 19.00 0 0 0 19.00 Other - Specify 0 20.00 20 00 0 21.00 Durable Medical Equipment/Oxygen 21.00 22.00 Patient Transportation 22.00 0 23.00 Imaging Services 0 0 0 23.00 Labs and Diagnostics 0 24.00 24.00 0 25.00 Medical Supplies 25.00 26.00 Outpatient Services (including E/R Dept.) 0 26.00 Radiation Therapy 0 0 0 0 27.00 27.00 01 28. 00 Chemotherapy 28.00 29. 00 0ther 0 29.00 Bereavement Program Costs 30.00 30.00 31.00 Volunteer Program Costs 0 0 31.00

0

101, 953

0.061823

6, 303

0

0

0.000000

0

0

0.000000

32.00

33.00

34.00

35.00

Fundrai si ng

Other Program Costs

Total (sum of lines 1 thru 33) (2)

36.00 Unit Cost Multiplier (see instructions)

Total cost to be allocated

Health Financial Systems	MARGARET MARY COMMUNITY HOSPI	In Lieu of Form CMS-2552-10			
COMPUTATION OF TOTAL HOSPICE SHARED COSTS	Provi de	er CCN: 151329	Period: From 01/01/2014	Worksheet K-5 Part III	
	Hospi co		To 12/31/2014		pared: 49 am
			Hospi ce I		
Cost Center Description	Wkst. C, Pa	t Cost to Charg	je Total Hospice	Hospi ce Shared	
	I, col. 11	Ratio	Charges	Ancillary	
	line			Costs (cols. 1	
			Records)	x 2)	
	0	1.00	2. 00	3. 00	
ANCILLARY SERVICE COST CENTERS					
1. 00 PHYSI CAL THERAPY	66.		9 0	0	1. 00
2. 00 OCCUPATI ONAL THERAPY	67.	0. 67382	20 0	0	2. 00
3. 00 SPEECH PATHOLOGY	68.	00 1. 02228	35 0	0	3. 00
4.00 DRUGS CHARGED TO PATIENTS	73.	0. 34442	20 0	0	4.00
5.00 DURABLE MEDICAL EQUIP-RENTED	96.	00			5. 00
6. 00 LABORATORY	60.	0. 22591	4 0	0	6. 00
6. 01 BLOOD LABORATORY	60.	0. 00000	0 0	0	6. 01
7.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	71.	0. 00000	00	0	7. 00
8.00 OTHER OUTPATIENT SERVICE COST CENTER	93.	00			8. 00
9. 00 RADI OLOGY-THERAPEUTI C	55.	00			9. 00
10.00 OTHER ANCILLARY SERVICE COST CENTERS	76.	00			10.00
11.00 Totals (sum of lines 1-10)				0	11. 00
•	·	•	•	•	

Heal th	Financial Systems MARGARET MARY COM	MUNI ⁻	TY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
CALCULATION OF HOSPICE PER DIEM COST			Provi der CCN: 151329		Peri od: From 01/01/2014	Worksheet K-6	
			Hospi ce C		To 12/31/2014	Date/Time Prep 5/19/2015 11:	
					Hospi ce I		
		Ti t	le XVIII	Title XIX	Other	Total	
			1. 00	2.00	3. 00	4. 00	
1.00	Total cost (see instructions)					1, 274, 257	1. 00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)					7, 806	2.00
3.00	Average cost per diem (line 1 divided by line 2)					163. 24	3.00
4. 00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)		6, 828				4. 00
5.00	Aggregate Medicare cost (line 3 time line 4)	İ	1, 114, 603				5. 00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line			24	6		6. 00

40, 157

0

732

119, 492

3, 299

538, 529

7.00

8.00

9.00

10. 00 11. 00

12.00

13.00

7. 00 8. 00

9.00

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

Aggregate SNF cost (line 3 time line 8)

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

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

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

Health Financial Systems	MARGARET M	MARY COMMUNIT	Y HOSPITAL	-		In Lie	u of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED RURAL H	HEALTH CLINIC/FEDERALLY QU	UALI FI ED	Provi der (CCN: 151329	Period From C	l: 01/01/2014	Worksheet M-1
HEALTH SENTER GOSTS			Component	CCN: 158511	To 1	2/31/2014	Date/Time Prepared: 5/19/2015 11:49 am
						l Health	Cost
					Clini	c (RHC) I	

					Rural Health Clinic (RHC) I	Cost	
		Compensation	Other Costs		Reclassi fi cati	Recl assi fi ed	
		oompensati on	other dosts	+ col . 2)	ons	Trial Balance	
				' ' ' ' ' ' ' '		(col. 3 + col.	
						4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS			•		•	
1.00	Physi ci an	174, 223	C	174, 223	3 0	174, 223	1. 00
2.00	Physician Assistant	113, 060	Ö	113, 060	0	113, 060	2. 00
3.00	Nurse Practitioner	5, 945	0	5, 94!	5 0	5, 945	3. 00
4.00	Visiting Nurse	0	0) (0	0	4. 00
5.00	Other Nurse	0	0) (0	0	5. 00
6.00	Clinical Psychologist	0	0) (0	0	6. 00
7.00	Clinical Social Worker	0	0) (0	0	7. 00
8.00	Laboratory Techni ci an	0	0) (0	0	8. 00
9.00	Other Facility Health Care Staff Costs	64, 017	0	64, 01	7 0	64, 017	9. 00
10.00	Subtotal (sum of lines 1 through 9)	357, 245	0	357, 24!	5 0	357, 245	10. 00
11.00	Physician Services Under Agreement	0	0) (0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0) (0	0	12. 00
13.00	Other Costs Under Agreement	0	0) (0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0) (0	0	14. 00
15.00	Medical Supplies	0	0) (0	0	15. 00
16.00	Transportation (Health Care Staff)	0	0) (0	0	16. 00
17.00	Depreciation-Medical Equipment	0	0) (0	0	17. 00
18.00	Professional Liability Insurance	0	0) (0	0	18. 00
19.00	Other Health Care Costs	0	0)	0	0	19. 00
20.00	Allowable GME Costs	0	0) (0	0	20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	0) (0	0	21. 00
22.00	Total Cost of Health Care Services (sum of	357, 245	0	357, 24!	5 0	357, 245	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0) (0	0	23. 00
24.00	Dental	0	0	(0	0	24. 00
25.00	Optometry	0	0) (0	0	25. 00
26.00	All other nonreimbursable costs	0	0) (0	0	26. 00
27. 00	Nonallowable GME costs	0	0) (0	0	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0) (0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	58, 665	0	,			29. 00
30. 00	Administrative Costs	128, 143	0	1 .20,		1 7	
31.00	Total Facility Overhead (sum of lines 29 and	186, 808	0	186, 808	0	186, 808	31. 00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	544, 053	0	544, 053	0	544, 053	32. 00
	and 31)			1		l	

Health Financial Systems	MARGARET	MARY COMMUNIT	TY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED RURAL HEALTH CENTER COSTS	HEALTH CLINIC/FEDERALLY	QUALI FI ED	Provi der CCN: 151329	Period: From 01/01/2014	Worksheet M-1
HEALITI CENTER COSTS			Component CCN: 158511		
				Rural Health	Cost

					Rural Health	Cost	
		۸ -۱: الحب الح	N-+	F	Clinic (RHC) I		
		Adjustments		Expenses			
				Ilocation			
			(COI .	5 + col.			
	•	6. 00		6) 7. 00			
	FACILITY HEALTH CARE STAFF COSTS	6.00	l	7.00			
1.00	Physi ci an	0		174, 223			1.00
2.00	Physician Assistant	0		113, 060			2.00
3.00	Nurse Practitioner	0		5, 945			3.00
4.00	Visiting Nurse	0		0, 749			4. 00
5.00	Other Nurse	0		0			5.00
6.00	Clinical Psychologist	0		0			6. 00
7. 00	Clinical Social Worker	0		0			7.00
8. 00	Laboratory Techni ci an	0		0			8. 00
9. 00	Other Facility Health Care Staff Costs	0		64, 017			9.00
10.00	Subtotal (sum of lines 1 through 9)	0		357, 245			10.00
11. 00	Physician Services Under Agreement	0		337, 243			11.00
12. 00		0		0			12.00
12.00	Physician Supervision Under Agreement	0		0			12.00
14. 00	Other Costs Under Agreement	0		0			14. 00
15. 00	Subtotal (sum of lines 11 through 13) Medical Supplies	0		0			15. 00
16. 00	Transportation (Health Care Staff)	0		0			16. 00
17. 00	Depreciation-Medical Equipment	0		0			17. 00
18. 00	Professional Liability Insurance	0		0			18.00
19. 00	Other Health Care Costs	0		0			19.00
20. 00	Allowable GME Costs	0		0			20.00
21. 00	Subtotal (sum of lines 15 through 20)	0		0			21.00
22. 00	Total Cost of Health Care Services (sum of	0		357, 245			22.00
22.00	lines 10, 14, and 21)	O		007, 210			22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0		0			23. 00
24.00	Dental	0	ĺ	o			24. 00
25.00	Optometry	0		0			25. 00
26.00	All other nonreimbursable costs	0		0			26. 00
27.00	Nonallowable GME costs	0		0			27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23)	0		0			28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0		58, 665			29. 00
30. 00	Administrative Costs	0		128, 143			30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	0	1	186, 808			31. 00
00.00	30)			E44.050			00.00
32. 00	Total facility costs (sum of lines 22, 28	0	1	544, 053			32. 00
	and 31)		1	ı			l

		RGARET MARY COM					u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES		Pro	ovi der	CCN: 151329	Peri od:	Worksheet M-2	
			Con	mnonont	CCN: 158511	From 01/01/2014 To 12/31/2014	Date/Time Pre	narod:
			COII	пропен	. CCN. 130311	10 12/31/2014	5/19/2015 11:	
						Rural Health	Cost	
						Clinic (RHC) I		
		Number of FTE	Total V	isits'		/ Minimum Visits		
		Personnel			Standard (1)	(col. 1 x col.		
		1.00	0.0		0.00	3)	4	
	VISITS AND PRODUCTIVITY	1.00	2.0	00	3. 00	4. 00	5. 00	
	Positions							ļ
1. 00	Physi ci an	0. 61	I	2, 898	4, 20	2, 562		1.00
2. 00	Physician Assistant	0. 61		1, 534				2.00
3.00	Nurse Practitioner	0. 93		1, 334				3.00
4. 00	Subtotal (sum of lines 1 through 3)	1. 59	l .	4, 560		4, 620		4.00
5. 00	Visiting Nurse	0.00	l	4, 300		4, 020	4, 020	5.00
6. 00	Clinical Psychologist	0.00	l	0			0	6.00
7. 00	Clinical Social Worker	0.00	l .	0			0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	•	0			Ö	7. 01
7. 02	Di abetes Self Management Training (FQHC	0.00	1	0			0	7. 02
02	only)	0.00		Ū				/. 02
8. 00	Total FTEs and Visits (sum of lines 4	1. 59		4, 560			4, 620	8.00
	through 7)						•	
9. 00	Physician Services Under Agreements			0			0	9. 00
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO							
10. 00				22)			357, 245	
11. 00	Total nonreimbursable costs (from Wkst. M-1,							11.00
12.00	Cost of all services (excluding overhead) (s		and 11)				357, 245	
13.00	Ratio of RHC/FQHC services (line 10 divided						1.000000	
14.00	Total facility overhead - (from Wkst. M-1, c						186, 808	
15.00	Parent provider overhead allocated to facili	ty (see Instruc	ctions)				397, 273	15. 00 16. 00
16. 00 17. 00	Total overhead (sum of lines 14 and 15) Allowable GME overhead (see instructions)						584, 081	
17.00	,						0 584, 081	17. 00 18. 00
	Subtotal (see instructions) Overhead applicable to RHC/FQHC services (li	no 12 v lino 10	2)				584, 081	19.00
	Total allowable cost of RHC/FQHC services (s						941, 326	
20.00	Tiotal allowable cost of kilozivilo services (s	um of filles to	anu 17)				741, 320	1 20.00

Hoal th	Financial Systems MARGARET MARY COMMUN	ILT IDSOL VT II	Inlia	u of Form CMS-2	0552_10
	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provi der CCN: 151329	Peri od:	Worksheet M-3	2332-10
OALOUL	ATTOM OF RETHINGRISHMENT SETTEMBENT FOR RIGHT SERVICES	Component CCN: 158511	From 01/01/2014 To 12/31/2014	Date/Time Prep 5/19/2015 11:4	
		Title XVIII	Rural Health Clinic (RHC) I	Cost	47 alli
			CITITE (KIIC) I		
				1. 00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, li			941, 326	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		4, 273	2. 00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			937, 053	3. 00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)	0)		4, 620 0	4. 00 5. 00
5. 00 6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	The 9)		4, 620	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			202. 83	7. 00
7.00	Adjusted cost per visit (Time 3 di vided by Time 9)		Cal cul ati on		7.00
			Prior to	On on After	
			January 1	January 1	
	I		1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	79. 80	79. 80	8. 00
9.00			202. 83	202. 83	9. 00
10 00		contractor records)	0	1, 235	10. 00
11. 00					11. 00
12. 00	10.00 Program covered visits excluding mental health services (from contractor records) 11.00 Program cost excluding costs for mental health services (line 9 x line 10) 12.00 Program covered visits for mental health services (from contractor records) 13.00 Program covered cost from mental health services (line 9 x line 12) 0				
13.00	Program covered cost from mental health services (line 9 x line	ne 12)	O	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15. 00	Graduate Medical Education Pass Through Cost (see instructions			0	
16. 00				250, 495	
16. 01	Total program charges (see instructions) (from contractor's re-			171, 676	
16. 02 16. 03	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times			2, 313 3, 375	16. 02 16. 03
16. 03	Total Program non-preventive costs ((line 16.02/11/le 16.01) times			185, 179	16. 03
10.04	(Titles V and XIX see instructions.)	and roy trines . ooy		105, 177	10.04
16. 05	Total program cost (see instructions)			188, 554	16. 05
17.00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		15, 646	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		30, 743	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			188, 554	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		3, 792	
22. 00	Total reimbursable Program cost (line 20 plus line 21)	,		192, 346	22. 00
23.00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)				23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-)			25. 00 25. 50
25. 50 26. 00	Pioneer ACO demonstration payment adjustment (see instructions) Net reimbursable amount (see instructions)	>)		0 192, 346	
26. 00	Sequestration adjustment (see instructions)			3, 847	
27. 00				174, 292	
28. 00				0	28. 00
29. 00	1	and 28)		14, 207	
30. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-II,		0	30. 00
	chapter I, §115.2				

	Financial Systems MARGARET MARY COMMUNI			u of Form CMS-2	2002-10
COMPUT	ATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provi der CCN: 151329	Period: From 01/01/2014	Worksheet M-4	
		Component CCN: 158511	To 12/31/2014	Date/Time Pre	nared:
		Component Colv. 130311	10 12/31/2014	5/19/2015 11:4	
		Title XVIII	Rural Health	Cost	
			Clinic (RHC) I		
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		357, 245	357, 245	
2.00	Ratio of pneumococcal and influenza vaccine staff time to total		I I	0. 003133	
3.00	Pneumococcal and influenza vaccine health care staff cost (line		503	1, 119	
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fro		0	0	4. 00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	line 4)	503	1, 119	5. 00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line	22)	357, 245	357, 245	6. 00
7.00	00 Total overhead (from Wkst. M-2, line 16)		584, 081	584, 081	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tota	I direct cost (line 5	0. 001408	0. 003132	8. 00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x li		822	1, 829	
10.00	Total pneumococcal and influenza vaccine cost and its (their) a	dministration (sum of	1, 325	2, 948	10.00
	lines 5 and 9)				
	Total number of pneumococcal and influenza vaccine injections (22		11. 00
	Cost per pneumococcal and influenza vaccine injection (line 10/		60. 23		12. 00
13. 00	Number of pneumococcal and influenza vaccine injections adminis	tered to Program	20	43	13. 00
	benefi ci ari es				
14. 00	Program cost of pneumococcal and influenza vaccine and its (the	ir) administration	1, 205	2, 587	14. 00
	(line 12 x line 13)				
15. 00	Total cost of pneumococcal and influenza vaccine and its (their			4, 273	15. 00
44 00	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,			0.700	4, 00
16.00	Total Program cost of pneumococcal and influenza vaccine and it			3, 792	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this a	mount to WKst. M-3,			
	line 21)			l	

Health Financial Systems	MARGARET MARY COMMUNIT	ΓΥ HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RH	HC/FQHC PROVIDER FOR SERVICES	Provider CCN: 151329	Peri od: From 01/01/2014	Worksheet M-5
RENDERED TO PROGRAM BENEFICIARIES		Component CCN: 158511		
			Rural Health	Cost

			Rural Health	Cost	
			Clinic (RHC) I		
				t B	
			mm/dd/yyyy	Amount	
4 00			1. 00	2. 00	4 00
1.00	Total interim payments paid to provider			95, 492 0	1.00
2.00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting;			U	2. 00
	"NONE" or enter a zero	berrou. It hone, write			
3.00	List separately each retroactive lump sum adjustment amount	hasad on subsequent			3. 00
3.00	revision of the interim rate for the cost reporting period.	Also show date of each			3.00
	payment. If none, write "NONE" or enter a zero. (1)	711 30 3110W date of eden			
	Program to Provider				
3. 01			07/17/2014	78, 800	3. 01
3. 02				0	3. 02
3. 03				l ol	3. 03
3.04				0	3. 04
3. 05				0	3. 05
	Provider to Program				
3.50				0	3. 50
3. 51				0	3. 51
3.52				0	3. 52
3.53				0	3. 53
3.54				0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.49	98)		78, 800	3. 99
4.00	10 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line			174, 292	4. 00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desleach payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date of			5. 00
	Program to Provider				
5. 01	Program to Provider			0	5. 01
5. 01					5. 01
5. 02					5. 02
5. 05	Provider to Program				3.03
5. 50	1 Tovi dei to i rogi diii			0	5. 50
5. 51				0	5. 51
5. 52				0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the				6.00
6. 01	SETTLEMENT TO PROVIDER			14, 207	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			188, 499	
	, , , , , , , , , , , , , , , , , , , ,		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
8. 00	Name of Contractor				8. 00