This report is required by Iaw (42 USC 1395g; 42 CF payments made since the beginning of the cost report	R 413.20(b)). I ting period bei	ing deemed over	rt can result i payments (42 US	n all interim SC 1395g).	u of Form CMS-2 FORM APPROVED OMB NO. 0938-0	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPO AND SETTLEMENT SUMMARY	RT CERTIFICATI(ON Provider		riod: om 05/01/2015 04/30/2016	Worksheet S Parts I-III Date/Time Prep 9/28/2016 3:51	
PART I - COST REPORT STATUS						
Provider 1. [X] Electronically filed cost rep	port			Date: 9/28/20	16 Time: 3:	51 pm
use only 2. [] Manually submitted cost repo	~t					
3.[0]If this is an amended report 4.[F]Medicare Utilization. Enter	'F" for full or	er of times the "L" for low.	1		ost report	
	Received: actor No. Initial Report	for this Provi	10. NPR 11. Cont der CCN 12. [0	ractor's Vende	or Code: olumn 1 is 4: En	4 ter
(3) Settled with Audit 9. [N]	Final Report f	or this Provide	er CCN		nes reopened = 0	
(4) Reopened						
(5) Amended						
PART 11 - CERTIFICATION		N THIS COST DED				\ \
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATI ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UND						
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY O						
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MA			WERE OTHERWISE			
	in heoden					
CERTIFICATION BY OFFICER OR ADMINI	STRATOR OF PROV	VI DER(S)				
I HEREBY CERTIFY that I have read the above	e certification	statement and	that I have exa	amined the acc	ompanyi ng	
electronically filed or manually submitted	cost report an	d the Balance S	heet and Stater	ment of Revenu	e and	
Expenses prepared by COMMUNITY HOSPITAL OF						
05/01/2015 and ending 04/30/2016 and to the						
correct, complete and prepared from the boo						
instructions, except as noted. I further of provision of health care services, and that						
compliance with such laws and regulations.	t the services		nis cost report	t were provide	u in	
compirance with such raws and regulations.						
	(Si an	and)				
	(Si gr		er or Administr	ator of Provid	ler(s)	
		011100	of Administr			
		Title				
		Date				
		Title	V//			
Cost Center Description	Title V	Part A	Part B	ні т	Title XIX	
cost center bescription					5.00	
	1 1 00	1 200 1	3 00	4 ()()		
PART III - SETTLEMENT SUMMARY	1.00	2.00	3.00	4.00	0.00	
PART III - SETTLEMENT SUMMARY 1.00 Hospital	0	133, 280	-44, 478	4.00	-995	1.00
	1	133, 280				1.00 2.00
1.00 Hospi tal	0	133, 280 0	-44, 478		- 995	
1.00 Hospi tal 2.00 Subprovider - IPF	0	133, 280 0	-44, 478 0		-995 0	2.00
1.00Hospital2.00Subprovider - IPF3.00Subprovider - IRF5.00Swing bed - SNF6.00Swing bed - NF	0	133, 280 0 0 10, 105	-44, 478 0		-995 0 0 0 0	2.00 3.00 5.00 6.00
1.00Hospi tal2.00Subprovi der - I PF3.00Subprovi der - I RF5.00Swi ng bed - SNF6.00Swi ng bed - NF200.00Total	0 0 0 0 0 0 0 0	133, 280 0 0 10, 105 143, 385	-44, 478 0 0 0 -44, 478	0	- 995 0 0 0 0 - 995 2	2.00 3.00 5.00
1.00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 5.00 Swing bed - SNF 6.00 Swing bed - NF 200.00 Total The above amounts represent "due to" or "due from"	0 0 0 0 0 0 0 0 0 0 0 0 0	133, 280 0 0 10, 105 143, 385 program for th	-44,478 0 0 0 -44,478 e element of th	0 ne above comple	-995 0 0 0 0 -995 2 ex indicated.	2.00 3.00 5.00 6.00 200.00
1.00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 5.00 Swing bed - SNF 6.00 Swing bed - NF 200.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	133, 280 0 10, 105 143, 385 program for th required to res	-44,478 0 0 -44,478 e element of th pond to a colle	0 ne above compl ection of info	-995 0 0 0 0 -995 2 x indicated. rmation unless i	2.00 3.00 5.00 6.00 200.00
1.00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 5.00 Swing bed - SNF 6.00 Swing bed - NF 200.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r displays a valid OMB control number. The valid OME	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	133, 280 0 0 10, 105 143, 385 program for th required to res r for this info	-44,478 0 0 -44,478 e element of th pond to a collect rmation collect	0 ne above comple cction of info ion is 0938-00	-995 0 0 0 0 -995 2 ex indicated. rmation unless i 050. The time	2.00 3.00 5.00 6.00 200.00
 1.00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 5.00 Swing bed - SNF 6.00 Swing bed - NF 200.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r displays a valid OMB control number. The valid OME required to complete and review the information col 	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	133, 280 0 0 10, 105 143, 385 program for th required to res r for this info imated 673 hour:	-44,478 0 0 -44,478 e element of th pond to a colle rmation collect s per response,	0 ne above comple sction of info tion is 0938-00 including the	-995 0 0 0 0 -995 2 ex indicated. rmation unless i 050. The time e time to review	2.00 3.00 5.00 6.00 200.00 t
 00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 5.00 Swing bed - SNF 6.00 Swing bed - NF 200.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r displays a valid OMB control number. The valid OME required to complete and review the information col instructions, search existing resources, gather the 	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	133,280 0 10,105 143,385 program for th required to res r for this info imated 673 hour: and complete and	-44,478 0 0 -44,478 e element of tr pond to a colle rmation collect s per response, d review the ir	0 ne above comple cction of info ion is 0938-00 including th including th	-995 0 0 0 -995 2 ex indicated. rmation unless i 050. The time 550. The time to review e time to review ection. If you	2.00 3.00 5.00 6.00 200.00 t
 00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 5.00 Swing bed - SNF 6.00 Swing bed - NF 200.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r displays a valid OMB control number. The valid OME required to complete and review the information col instructions, search existing resources, gather the have any comments concerning the accuracy of the ti 	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	133, 280 0 10, 105 143, 385 program for the required to res r for this info imated 673 hours and complete an- or suggestions	-44,478 0 0 -44,478 e element of th pond to a collect rmation collect s per response, d review the ir for improving	0 ne above comple cction of infor including the including the formation coll the form, plea	-995 0 0 0 -995 2 ex indicated. rmation unless i 050. The time be time to review ection. If you ase write to: CM	2.00 3.00 5.00 6.00 200.00 t
 00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 5.00 Swing bed - SNF 6.00 Swing bed - NF 200.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r displays a valid OMB control number. The valid OME required to complete and review the information col instructions, search existing resources, gather the have any comments concerning the accuracy of the ti 7500 Security Boul evard, Attn: PRA Report Clearance 	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	133, 280 0 10, 105 143, 385 program for the required to resp r for this info imated 673 hours and complete and or suggestions Stop C4-26-05,	-44,478 0 0 -44,478 e element of th pond to a collect rmation collect s per response, d review the ir for improving Baltimore, Mar	0 ne above comple ection of infor including the formation coll the form, plea ryland 21244-18	-995 0 0 0 -995 2 ex indicated. rmation unless i D50. The time to review lection. If you ase write to: CM 350.	2.00 3.00 5.00 6.00 200.00 t
 00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 5.00 Swing bed - SNF 6.00 Swing bed - NF 200.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r displays a valid OMB control number. The valid OME required to complete and review the information col instructions, search existing resources, gather the have any comments concerning the accuracy of the ti 7500 Security Boul evard, Attn: PRA Report Clearance Please do not send applications, claims, payments, 	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	133, 280 0 10, 105 143, 385 program for th required to res r for this info imated 673 hour and complete an or suggestions Stop C4-26-05, s or any docume	-44,478 0 0 -44,478 e element of th pond to a collect rmation collect s per response, d review the ir for improving Baltimore, Mar nts containing	0 ne above comple ection of infor ion is 0938-00 including the iformation coll the form, ple yl and 21244-18 sensitive info	-995 0 0 0 -9952 ex indicated. rmation unless i 050. The time e time to review lection. If you ase write to: CM 350. prmation to the	2.00 3.00 5.00 6.00 200.00 t
 00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 5.00 Swing bed - SNF 6.00 Swing bed - NF 200.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r displays a valid OMB control number. The valid OME required to complete and review the information col instructions, search existing resources, gather the have any comments concerning the accuracy of the ti 7500 Security Boul evard, Attn: PRA Report Clearance 	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	133,280 0 0 10,105 143,385 program for th required to res r for this info imated 673 hour: and complete an or suggestions Stop C4-26-05, s or any docume t pertaining to	-44,478 0 0 -44,478 e element of th pond to a collect rmation collect s per response, d review the ir for improving Baltimore, Mar nts containing the informatic	0 ne above comple ection of infor ion is 0938-00 including the incruding the formation coll the form, plea yl and 21244-11 sensitive infor on collection l	-995 0 0 0 <u>-995</u> 2 ex indicated. rmation unless i 050. The time e time to review lection. If you ase write to: CM 350. ormation to the ourden approved	2.00 3.00 5.00 6.00 00.00 t t r
 1.00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 5.00 Swing bed - SNF 6.00 Swing bed - NF 200.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r displays a valid OMB control number. The valid OME required to complete and review the information col instructions, search existing resources, gather the have any comments concerning the accuracy of the ti 7500 Security Boulevard, Attn: PRA Report Clearance Please do not send applications, claims, payments, Reports Clearance Office. Please note that any cor 	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	133, 280 0 10, 105 143, 385 program for the required to res r for this info imated 673 hour- and complete and or suggestions Stop C4-26-05, s or any document t pertaining to not be reviewed	-44,478 0 0 -44,478 e element of th pond to a colle rmation collect s per response, d review the ir for improving Baltimore, Mar nts containing the informatic , forwarded, or	0 ne above comple ection of infor ion is 0938-00 including the incruding the formation coll the form, plea yl and 21244-11 sensitive infor on collection l	-995 0 0 0 <u>-995</u> 2 ex indicated. rmation unless i 050. The time e time to review lection. If you ase write to: CM 350. ormation to the ourden approved	2.00 3.00 5.00 6.00 00.00 t t r

HOSPI 7	n Financial Systems	COMMUNI TY HO	SPITAL OF	BREMEN,	INC.			n Lieu	u of Fo	rm CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA	TA	Provi d	ler CCN:	151300	Period: From 05/01	/2015	Worksh Part I	eet S-2	
								/2016	Date/T	ime Pre 016 3:4	
	1.00	2.	00	3	. 00			4.00	772072	010 3.4	
1 00	Hospital and Hospital Health Care Co		, I			-					1 00
1.00 2.00	Street: 1020 HIGH RD City: BREMEN	PO Box:8 State: I		ip Code:	46506-	Coun	ty: MARSHAL				1.00
		Component Na	ime	CCN	CBSA	Provi der	Date	Payme	ent Sys		
			N	umber	Number	Туре	Certified	T V	, 0, or		-
		1.00		2.00	3.00	4.00	5.00	6. 00	XVIII 7.00		-
-	Hospital and Hospital-Based Componen	t Identification:									
3.00	Hospi tal	COMMUNITY HOSPITA BREMEN, INC.	AL OF 1	51300	99915	1	07/01/196	5 N	0	0	3.00
4.00	Subprovider - IPF	DREMEN, TNC.									4.00
5.00	Subprovider - IRF										5.00
6.00 7.00	Subprovider - (Other) Swing Beds - SNF	COMMUNI TY HOSPI TA		5Z300	99915		05/01/198	4 N	0	N	6.00 7.00
7.00		SWING BED		02000	,,,,,						/.00
8.00	Swing Beds - NF										8.00
9.00 10.00	Hospi tal -Based SNF Hospi tal -Based NF										9.00
11.00											11.00
12.00	Hospi tal -Based HHA										12.00
13.00 14.00	1 5										13.00
15.00											15.00
16.00 17.00											16.00
17.00	Hospital-Based (CMHC) I Renal Dialysis										17.00
19.00	5										19.00
							From			o: 00	-
20.00	Cost Reporting Period (mm/dd/yyyy)						1.0			/2016	20.00
21.00	Type of Control (see instructions)						2				21.00
22.00	<u>Inpatient PPS Information</u> Does this facility qualify and is it	currently receiv	ing navmor	te for (dienron	ortionato	e N		,	N	22.00
22.00	share hospital adjustment, in accord								1	N	22.00
	for yes or "N" for no. Is this facil				106(c)	(2) (Pi ckl	e				
22. 01	amendment hospital?) In column 2, en Did this hospital receive interim un				cost re	eportina	N		1	N	22.01
22.01	period? Enter in column 1, "Y" for y	es or "N" for no	for the po	ortion of	f the co	ost					22.01
	reporting period occurring prior to				2						
	for no for the portion of the cost r (see instructions)	eporting period o				UDEI I.					
22. 02	5 5 1						N		1	N	22.02
	determined at cost report settlement or "N" for no, for the portion of th	•				2	s				
	in column 2, "Y" for yes or "N" for						n				
	or after October 1.		c								0.000
22.03	Did this hospital receive a geograph of the OMB standards for delineating								I	N	22.03
	in column 1, "Y" for yes or "N" for	no for the portio	n of the c	cost repo	orting p	period					
	prior to October 1. Enter in column cost reporting period occurring on o						ie				
	hospital contain at least 100 but no						h				
	42 CFR 412.105)? Enter in column 3,										0.000
23.00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i							3	I	N	23.00
	method of identifying the days in th	is cost reporting	period di	fferent	from th	he method					
	used in the prior cost reporting per	iod? In column 2	<u>, enter "Y</u> In-State	/" for ye In-Sta		<u>N" for no</u> ut-of		Medi ca	id ()ther	
			Medi cai d	Medi ca		State		HMO da		di cai d	
			paid days				Medi cai d			days	
				unpai days	1.	d days	eligible unpaid				
			1.00	2.00		3.00	4.00	5.00		6.00	
24 05			(0	0	0		0	C	24.00
24.00	in-state Medicaid paid days in colum										
24.00				1							1
24.00	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c	olumn 3,							1		
24.00	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai	olumn 3, d days in column									
24.00	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu	olumn 3, d days in column t unpaid days in									
24. 00 25. 00	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th	olumn 3, d days in column t unpaid days in column 6. e in-state	C	D	0	0	0		0		25.00
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the	olumn 3, d days in column t unpaid days in column 6. e in-state in-state	C	D	0	0	0		0		25.00
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th	olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2,	C	D	0	0	O		0		25.00
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state umn 4, Medicaid	C)	0	0	0		0		25. 00

	Financial Systems COMMUNITY HO AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		OF BREMEN, INC Provider (CCN: 151300 P	eriod: rom 05/01/ o 04/30/	2015	u of For Workshe Part I Date/Ti	et S-2	
							9/28/20	016 3:4	
					Urban/Rur 1.00		Date of 2.0		
26.00	Enter your standard geographic classification (not wa			inning of the		2		-	26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	ge) sta "2" fo	atus at the end or rural. If ap			2			27.00
35.00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35.00
					Beginni		Endi		
36.00	Enter applicable beginning and ending dates of SCH st	atus (Subscript line	36 for number	1.00		2.0	00	36.00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	s.	·			0			37.00
37. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo				N				37.01
	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38. 00
	enter subsequent dates.				Y/N		Y/		
39.00	Does this facility qualify for the inpatient hospital	navmer	at adjuctment f	or Low volume	1.00 N		2.0 N		39.00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Ente uiremer or "N"	er in column 1 nts in accordan for no. (see i	"Y" for yes ce with 42 nstructions)					
40.00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. E	Enter "Y" for y		N		N		40.00
						V 1.00	XVIII 2.00	XI X 3.00	
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	it for a	di sproporti onat	e share in ac	cordance	N	N	N	45.00
	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46.00
	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47.00 48.00
56.00	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y"	for yes	N			56.00
	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of th ", comp	r "N" for no in his cost report plete Worksheet	column 1. If ing period?	column 1 Enter "Y"				57.00
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemer complet	nt for physicia te Wkst. D-5.		as				58.00
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health					N N			59.00 60.00
	provider-operated criteria under §413.85? Enter "Y"				ctions) IME		Direct	GME	
		1.00	2.00	3.00	4.00		5.0		
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.0	d				61.01
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0. 00	0.0	þ				61. 02
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.0	d				61.03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	þ				61.04
61.05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0. 00	0.0	o				61.05

	AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA	Provider (eriod: om 05/01/2015	Worksheet S-2 Part I	
					To			
			Y/N	I ME	Direct GME	I ME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
use	ter the amount of ACA §5503 aw ed for cap relief and/or FTEs re or general surgery. (see in	that are nonprimary		0.00	0.00			61.
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
spe for col pro unv FTE	the FTEs in line 61.05, speci ecialty, if any, and the numbe r each new program. (see instr lumn 1, the program name, ente ogram code, enter in column 3, weighted count and enter in co E unweighted count. the FTEs in line 61.05, speci	r of FTE residents uctions) Enter in r in column 2, the the IME FTE lumn 4, direct GME				0.00		
pro res i ns ent 3,	structions) Enter in column 2, the program specialty, if any, and t sidents for each expanded prog structions) Enter in column 1, ter in column 2, the program c the IME FTE unweighted count <u>direct GME FTE unweighted cou</u>	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00	0.00	01.
							1.00	
	A Provisions Affecting the Hea ter the number of FTE resident					od for which	0.00	62
. 01 Ent	ur hospital received HRSA PCRE ter the number of FTE resident	funding (see instruc s that rotated from a	ctions) a Teachi	ng Health Cent	er (THC) into			62.
	<u>ring in this cost reporting pe</u> aching Hospitals that Claim Re				S)			
	s your facility trained reside " for yes or "N" for no in col					eriod? Enter	N	63.
					Unweighted FTEs	FTEsin	Ratio (col. 1/ (col. 1 + col.	
					Nonprovider Site	Hospi tal	2))	
C.c.	ction 5504 of the ACA Base Yea	r FTF Dagi danta in Na		lan Cattinga T	1.00	2.00	3.00	
. 00 Ent i n res set res	riod that begins on or after J ter in column 1, if line 63 is the base year period, the num sident FTEs attributable to ro ttings. Enter in column 2 the sident FTEs that trained in yo (column 1 divided by (column	uly 1, 2009 and befor yes, or your facilit ber of unweighted nor tations occurring in number of unweightec ur hospital. Enter ir	<u>re June</u> ty train a-primar all non d non-pr n column	30, 2010. ed residents y care provider imary care 3 the ratio	0.00	0.00		64.
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site		Ratio (col. 3/ (col. 3 + col. 4))	
. 00 Ent	ter in column 1, if line 63	1.00		2.00	3.00	4.00	5.00 0.000000	45
	yes, or your facility ained residents in the base ar period, the program name sociated with primary care Es for each primary care ogram in which you trained				0.00	0.00	0.00000	05.

Heal th	Financial Systems	COMMUNI TY HO				1	n Lie	u of Form	n CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	ΤΑ	Provi der	F	eriod: rom 05/01/ o 04/30/		Workshe Part I Date/Ti 9/28/20	me Pre	
					Unweighted FTEs Nonprovider Site	Unwei gh FTEs i Hospi t	n al	Ratio (c (col. 1 2))	+ col.)	
	Section 5504 of the ACA Current	Year FTE Residents ir	n Nonprovide	r Setting	1.00 sEffective f	2.00 or cost re		3.0 ng perio		
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	10 unweighted non-primar ccurring in all nonpr	ry care resi rovider sett	dent i ngs.	0.00		0.00	<u> </u>		66.00
	FTEs that trained in your hospit (column 1 divided by (column 1 +	al. Enter in column 3	3 the ratio							
		Program Name	Program	Code	Unweighted FTEs Nonprovider Site	Unweigh FTEs i Hospit	n	Ratio (c (col. 3 4))	+ col.	
		1.00	2.0	0	3.00	4.00		5.0		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.00		0.00	0.	000000	67.00
							1.00) 2.00	3.00	
	Inpatient Psychiatric Facility P							, 2.00	0.00	
70.00	ls this facility an Inpatient Ps Enter "Y" for yes or "N" for no		PF), or doe	s it conta	ain an IPF subj	provi der?	N			70.00
71.00	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, indi (see instructions)	efore November 15, 20 Lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	D04? Enter lity train (D)? Enter	"Y" for ye residents "Y" for ye	es or "N" for i in a new teacl es or "N" for i	no. (see ni ng no.			0	71.00
75.00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re	habilitation Facility	(IRF), or	does it co	ontain an IRF		N		_	75.00
	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	mber 15, 20 new teachin for no. Col	04? Enter g program umn 3: If	"Y" for yes of in accordance column 2 is Y	r "N" for with 42			0	76. 00
								1.0	0	
	Long Term Care Hospital PPS								0	
	Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers					period? Ei	nter	N		80. 00 81. 00
	ls this a new hospital under 42 Did this facility establish a ne	w Other subprovider ((excluded un				no.	N		85. 00 86. 00
87.00	§413.40(f)(1)(ii)? Enter "Y" fo Is this hospital a "subclause (I for yes or "N" for no.			n 1886(d)	(1)(B)(iv)(II)	? Enter "Y		N		87.00
						V		XIX		
90.00	Title V and XIX Services Does this facility have title V	and/or XIX innatient	bosnital se	rvi ces? Fi	nter "V" for	1.00		2.0	0	90.00
	yes or "N" for no in the applica Is this hospital reimbursed for	ble column.	·			N		Y Y		90.00 91.00
	full or in part? Enter "Y" for y	es or "N" for no in t	the applicab	le column.						
92.00	Are title XIX NF patients occupy instructions) Enter "Y" for yes				ion)? (see			N		92.00
93.00	Does this facility operate an IC "Y" for yes or "N" for no in the		urposes of t	itle V and	d XIX? Enter	N		N		93.00
94.00	Does title V or XIX reduce capit. applicable column.		or yes, and	"N" for no	o in the	N		N		94.00

Heal th Financial Systems COMMUNITY HOSPITAL				Lieu	u of For		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	F	Period: From 05/01/2 To 04/30/2		Workshe Part I Date/Ti	me Pre	pared:
			V		9/28/20 XI X		8 pm
			1.00		2.0		
95.00 If line 94 is "Y", enter the reduction percentage in the appl96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N		0. 0 N	0	95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the appl Rural Providers	licable columr	ı.	0.00		0.0	0	97.00
105.00 Does this hospital qualify as a critical access hospital (CAI 106.00 of this facility qualifies as a CAH, has it elected the all-		nod of payment	Y N				105.00 106.00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see instr	ructions) If	N				107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N				108.00
-	Physi cal 1.00	Occupational 2.00	Speech 3.00	<u>ו</u>	Respira 4.0		
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	Y	Y		4.0 N		109. 00
				ŀ	1.0	0	
110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N"		on project (41	OA Demo)for		N		110. 00
			-	1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					2.00	0.00	
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" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1.	lf column 2 i t for long ter	s "E", enter m care (inclu	in column des	N		0	115.00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insura	2		"N" for	N Y			116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence poli		5		1			118.00
claim-made. Enter 2 if the policy is occurrence.		Premiums	Losses	;	Insura	ance	
		1.00	2.00		3.0	0	
118.01 List amounts of malpractice premiums and paid losses:		110, 50	1	0		0	118.01
			1.00		2.0	0	
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein.			N				118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" alifies for th	' for yes or ne Outpatient	N		Ν		119.00 120.00
121.00 Did this facility incur and report costs for high cost impla	ntable devices	s charged to	Y				121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? I for no in column 1. If column 1 is "Y", enter in column 2 the			N				122.00
where these taxes are included. Transplant Center Information							
125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	r yes and "N"	for no. If	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.		fication date					126. 00
127.00 If this is a Medicare certified heart transplant center, entering in column 1 and termination date, if applicable, in column 2.	er the certifi						127.00
128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2.							128.00
 129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, or content of the second se							129.00 130.00
date in column 1 and termination date, if applicable, in column 131.00 of this is a Medicare certified intestinal transplant center, of	umn 2.						131.00
date in column 1 and termination date, if applicable, in colu 132.00 If this is a Medicare certified islet transplant center, enter	umn 2. er the certifi						132.00
in column 1 and termination date, if applicable, in column 2.			1				

Health Financial Systems COMMUNITY HOSPITAL OF BREMEN, INC. In Lieu of Form CM	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151300 Period: Worksheet S From 05/01/2015 Part I	5-2
To 04/30/2016 Date/Time F	
9/28/2016 3	3:48 pm
1.00 2.00	_
133.00 If this is a Medicare certified other transplant center, enter the certification date	133.00
in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1	134.00
and termination date, if applicable, in column 2.	
All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, N	140.00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs	140.00
are claimed, enter in column 2 the home office chain number. (see instructions)	
1.00 2.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the	
home office and enter the home office contractor name and contractor number.	
141.00 Name: Contractor's Name: Contractor's Number: 142.00 Street: P0 Box: Contractor's Number:	141.00 142.00
142. 00 Street: P0 Box: 143. 00 City: Zip Code:	142.00
1.00 144.00 Are provider based physicians' costs included in Worksheet A? Y	144.00
	144.00
1.00 2.00	
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for N inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is	145.00
no, does the dialysis facility include Medicare utilization for this cost reporting	
period? Enter "Y" for yes or "N" for no in column 2.	1.1. 00
146.00 Has the cost allocation methodology changed from the previously filed cost report? N Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	146.00
yes, enter the approval date (mm/dd/yyyy) in column 2.	
1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N	147.00
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N	148.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N Part A Part B Title V	149.00
1.00 2.00 3.00 4.00	<u> </u>
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs	
or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)155.00 HospitalNNN	155.00
156.00 Subprovider - IPF N N N N	156.00
157.00 Subprovider - IRF N N N N	157.00
158. 00 SUBPROVIDER 159. 00 SNF N N N N	158.00 159.00
160. 00 HOME HEALTH AGENCY N N N	160.00
161. OO CMHC N N N	161.00
1.00	-
Multicampus	
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N Enter "Y" for yes or "N" for no.	165.00
Name County State Zip Code CBSA FTE/Campus	5
0 1.00 2.00 3.00 4.00 5.00	001// 00
166.00 If line 165 is yes, for each campus enter the name in column	00 166. 00
0, county in column 1, state in	
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	
column 5 (see instructions)	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act	
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. Y	167.00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0168.00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship	168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	. 00169. 00

Health Financial Systems	COMMUNI TY	HOSPI TAL OF	BREMEN, INC.		In Lieu	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	ENTI FI CATI ON	DATA	Provider CCN: 15		eriod:	Worksheet S-2			
				T	rom 05/01/2015	Date/Time Pre	narod		
	9/28/2016 3:4								
					Begi nni ng	Endi ng			
	1.00								
170.00 Enter in columns 1 and 2 the EHR begin period respectively (mm/dd/yyyy)	170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 05/01/2015 period respectively (mm/dd/yyyy)								
						1.00			
171.00 If line 167 is "Y", does this provider Medicare cost plans reported on Wkst. (see instructions)						Ν	171.00		

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der		Period: From 05/01/2015 To 04/30/2016		epared:
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	esponses. Ente			
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	boginning of	the cost	N		1.0
. 00	reporting period? If yes, enter the date of the change in c					1.0
	Troporting portour in yoo, ontor the date of the endige in t		Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	For Compiled,	Y	A	08/25/2016	4.0
. 00	Are the cost report total expenses and total revenues diffe	erent from	N			5.0
	those on the filed financial statements? If yes, submit rec					
				Y/N	Legal Oper.	
				1.00	2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lf vos is th	o providor is	N		6.0
. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	5		N		7.0
. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	0	Ν		8.0
. 00 0. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c	is.		N		9.0
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N		11.0
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
					1.00	
2.00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s see instruct	ions		Y	12.0
3.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			st reporting	N	13.0
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14.0
5.00	Did total beds available change from the prior cost reporti		yes, see inst t A Date		t B Date	15.0
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	07/26/2016	Y	07/26/2016	16.0
7 66	date of the PS&R Report used in columns 2 and 4 .(see instructions)					
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17. (
8. 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 this cost report? If yes, see instructions.	N		N		18. (
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		Ν		19. (

Health Financial Syste

COMMUNI TY	HOSPI TAL	0F	BREMEN,	I NC.

In Lieu of Form CMS_2552_10

Health	Financial Systems COMMUNITY HOSPITA	AL OF BREMEN, IN	IC.	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der		Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part II Date/Time Pre 9/28/2016 3:4	epared:
		Descr	iption	Y/N	Y/N	
			0	1.00	3.00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			Ν	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		Ν		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS H	HOSPLTALS)		1.00	
	Capital Related Cost					1
22.00	Have assets been relifed for Medicare purposes? If yes, se	ee instructions			Ν	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		sals made duri	ng the cost	Ν	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost rep	orting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during instructions.	g the cost repor	rting period?	lfyes, see	Ν	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	the cost reporti	ng period? If	yes, see	Ν	26.00
27.00	instructions. Has the provider's capitalization policy changed during th	ne cost reportir	ng period?lf	yes, submit	Ν	27.00
	copy. Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	entered into dur	ring the cost	reporting	Ν	28.00
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	•	ebt Service Re	serve Fund)	Ν	29.00
30.00	Has existing debt been replaced prior to its scheduled mat instructions.		debt? If yes,	see	Ν	30.00
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see	Ν	31.00
	instructions. Purchased Services					-
32.00	Have changes or new agreements occurred in patient care se	ervi ces furni she	ed through con	tractual	N	32.00
	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap	ructions.	0		Ν	33.00
	no, see instructions. Provider-Based Physicians		<u> </u>	J. J		
34 00	Are services furnished at the provider facility under an a	arrangement with	nrovi der-bas	ed physicians?	Y	34.00
	If yes, see instructions.	0				35.00
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i				N	35.00
				Y/N	Date	
	Homo Offico Costs			1.00	2.00	
36 00	Home Office Costs Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	N		37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	ffice different	from that of	N		38.00
39.00	the provider? If yes, enter in column 2 the fiscal year er If line 36 is yes, did the provider render services to oth			N		39.00
	see instructions. If line 36 is yes, did the provider render services to the		<u> </u>	N		40.00
+0.00	instructions.		i yes, see	IN		40.00
		1.	00	2.	00	
	Cost Report Preparer Contact Information					-
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	MI CHAEL		ALESSANDRI NI		41.00
42.00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LL	_C			42.00
43.00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRI NI @	BLUEANDCO. COM	43.00

Heal th	Financial Systems	COMMUNI TY HOSPI TAL	OF I	BREMEN, INC.		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provider CCN	151300	Period:	Worksheet S-2	
						From 05/01/2015 To 04/30/2016		pared: 8 pm
				3.00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the	title/position	SENI (OR MANAGER				41.00
	held by the cost report preparer in colu	mns 1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the c	ost report						42.00
	preparer.	-						
43.00	Enter the telephone number and email add	ress of the cost						43.00
	report preparer in columns 1 and 2, resp	ecti vel y.						

	Financial Systems COMM TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	IUNI TY HOSPI TAL AL DATA	-	Provi der	CCN: 151300	Pe	eriod:	Worksheet S-3	3	
							rom 05/01/2015	Part I		
						To	04/30/2016	Date/Time Pro 9/28/2016 3:4	epare 48 pr	ea: m
								1/P Days / 0/F		
								Visits / Trips		
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V		
		Line Number			Avai I abl e					
		1.00		2.00	3.00		4.00	5.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		24	8, 7	84	20, 688. 00	() 1	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	2. 0
3.00	HMO I PF Subprovi der									±.00 3.00
4.00	HMO I RF Subprovi der									1. O(
5.00	Hospital Adults & Peds. Swing Bed SNF							(5.0
5.00 5.00	Hospital Adults & Peds. Swing Bed NF							(5. O
7.00	Total Adults and Peds. (exclude observation			24	8.7	84	20, 688. 00			7.0
	beds) (see instructions)									
B. 00	INTENSIVE CARE UNIT								8	3. 0
9.00	CORONARY CARE UNIT								9	9.0
10.00	BURN INTENSIVE CARE UNIT								10). O
11.00	SURGICAL INTENSIVE CARE UNIT								11	1.0
12.00	OTHER SPECIAL CARE (SPECIFY)								12	2. 0
13.00	NURSERY	43.00						(3.00
14.00	Total (see instructions)			24	8, 7	84	20, 688. 00	(4. 0
15.00	CAH visits							(5.00
16.00	SUBPROVIDER - IPF									5.0
17.00	SUBPROVIDER - IRF									7.0
18.00	SUBPROVI DER									3. O
19.00	SKILLED NURSING FACILITY									9.0
20.00	NURSING FACILITY									0.0
21.00 22.00	OTHER LONG TERM CARE									1.0 2.0
22.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)									2.0 3.0
24.00	HOSPICE									3.0 1.0
24.10	HOSPICE (non-distinct part)	30.00								4.0 4.1
25.00	CMHC - CMHC	30.00								5. O
26.00	RURAL HEALTH CLINIC									5.0 5.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER									5.0 5.2
27.00	Total (sum of lines 14-26)			24						7.0
28.00	Observation Bed Days			2.				(3. O
29.00	Ambulance Trips									9.0
30.00	Employee discount days (see instruction)). 0
31.00	Employee discount days - IRF								31	1.0
2.00	Labor & delivery days (see instructions)			0		0			32	2.0
32.01	Total ancillary labor & delivery room								32	2.0
	outpatient days (see instructions)									
3 00	LTCH non-covered days								33	3. C

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 151300		ri od: om 05/01/2015 04/30/2016	Worksheet S-3 Part I Date/Time Pre 9/28/2016 3:4	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E	qui val ents	
	Component	Title XVIII	Title XIX	Total All Patients		otal Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	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	396	15		52	7.00	10.00	1.00
2.00	for the portion of LDP room available beds) HMO and other (see instructions)	0	102					2.00
3.00	HMO IPF Subprovider	0	0					3.00
4.00	HMO IRF Subprovider	0	0					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	189	0	19	98			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	8	37			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	585	15	1, 14	47			7.00
8.00	INTENSIVE CARE UNIT							8.00
9.00	CORONARY CARE UNIT							9.00
0.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGI CAL INTENSI VE CARE UNI T							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	5.05	8		36		400.40	13.00
14.00	Total (see instructions)	585	23			0.00	128.13	
15.00	CAH visits	0	0		0			15.00
16.00	SUBPROVIDER - IPF							16.00
17.00 18.00	SUBPROVIDER - IRF							17.00
19.00	SUBPROVIDER SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							20.00
22.00	HOME HEALTH AGENCY							22.0
2.00	AMBULATORY SURGICAL CENTER (D. P.)							23.0
24.00	HOSPI CE							24.00
24.10	HOSPICE (non-distinct part)	0	0		0			24.10
25.00	CMHC - CMHC	-	-		-			25.00
26.00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 2
27.00	Total (sum of lines 14-26)					0.00	128.13	27.0
28.00	Observation Bed Days		0	40)5			28.00
29.00	Ambulance Trips	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 outpatient days (see instructions)				0			32. 01
33.00	LTCH non-covered days	0						33.0

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der	CCN: 151300	Period: From 05/01/2015 To 04/30/2016		pared:
		Full Time		Di s	charges		
	Component	Equi val ents Nonpai d Workers	Title V	Title 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 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0		33 15		1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider				0 50		2.00 3.00 4.00
5.00 6.00 7.00 8.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT						5. 00 6. 00 7. 00 8. 00
9.00 10.00 11.00 12.00 13.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						9.00 10.00 11.00 12.00 13.00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY	0.00	c	1	33 15	379	
23. 00 24. 00 24. 10 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0. 00					22. 00 24. 00 24. 10 25. 00 26. 02 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00

Heal th	Financial Systems COMMUNITY HOSPITAL OF B	REMEN, INC		In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider (Peri od:	Worksheet S-1	0
				From 05/01/2015 To 04/30/2016		narod
				10 04/ 30/ 2010	9/28/2016 3:4	
	In a second				1.00	
1.00	Uncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	dod by Lin	0 202 column	0)	0. 462704	1.00
1.00	Medicaid (see instructions for each line)	deu by III		0)	0.402704	1.00
2.00	Net revenue from Medicaid				488, 324	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N 400, 324	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental	payments f	From Medicaid	?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from		i olir mour our u		0	5.00
6.00	Medi cai d charges				2, 422, 362	6.00
7.00	Medicaid cost (line 1 times line 6)				1, 120, 837	7.00
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 minu	us sum of lin	es 2 and 5; if	632, 513	
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ich line)		-	
9.00	Net revenue from stand-alone SCHIP				0	9.00
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 (line 11 mi	nus line 9;	if < zero then	0	12.00
	enter zero)					
10.00	Other state or local government indigent care program (see instr			<u>`</u>		1 1 0 00
13.00	Net revenue from state or local indigent care program (Not inclu				0	
14.00	Charges for patients covered under state or local indigent care 10)	program (N	lot included	In Tines 6 or	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)				0	15.00
16.00	Difference between net revenue and costs for state or local indi		program (lin	o 15 minus lino	0	
10.00	13; if < zero then enter zero)	gent care			0	10.00
	Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to fun	ding chari	ty care		0	17.00
18.00	Government grants, appropriations or transfers for support of ho				0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local			s (sum of lines	632, 513	19.00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
20.00	Tetel initial abligation of mations, and for short to one (-+ -6-11	1.00	2.00	3.00	20.00
20.00	Total initial obligation of patients approved for charity care (1, 079, 62	1 0	1, 079, 621	20.00
21.00	charges excluding non-reimbursable cost centers) for the entire Cost of initial obligation of patients approved for charity care		499, 54	5 0	499, 545	21 00
21.00	times line 20)		477, 34	5 0	499, 545	21.00
22.00	Partial payment by patients approved for charity care			0 0	0	22.00
	Cost of charity care (line 21 minus line 22)		499, 54			
		I.	,		,	
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patient	days beyon	nd a length o	f stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care p		-	•		
25.00	If line 24 is "yes," charges for patient days beyond an indigen		ogram's lengt	h of stay limit	0	
26.00	Total bad debt expense for the entire hospital complex (see inst				321, 716	
27.00	Medicare bad debts for the entire hospital complex (see instruct	,			138, 997	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (lin				182, 719	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	nse (line	1 times line	28)	84, 545	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				584,090	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus lin	e 30)			1, 216, 603	31.00

		MUNITY HOSPITAL C				u of Form CMS-2	2552-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	IF EXPENSES	Provi der	CCN: 151300	Period: From 05/01/2015	Worksheet A	
					To 04/30/2016	Date/Time Pre 9/28/2016 3:4	pared: 8 pm
	Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi ficati	Reclassi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	1	1 702 274	1 702 2	/4 0	1 702 274	1.00
2.00	00200 NEW CAP REL COSTS-BLDG & FIXT		1, 702, 374 0	1, 702, 37	4 0 0 0	1, 702, 374 0	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS		0		0 0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	86, 384	2, 103, 265	2, 189, 64	0	2, 189, 649	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 305, 787	1, 471, 836			2, 778, 167	5.00
7.00	00700 OPERATION OF PLANT	179, 142	455, 075			627, 880	
8.00	00800 LAUNDRY & LINEN SERVICE	0	130, 093			130, 093	8.00
9.00	00900 HOUSEKEEPI NG	154, 705	20, 169			168, 163	9.00
10.00		216, 615	249, 524			94, 846	
11.00		210,010	217,021	100, 10	0 371, 293	371, 293	
13.00		149, 703	6, 602	156, 30		156, 305	
16.00		244, 730	113, 691	358, 42		358, 421	16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	211,700	110,071	000, 12		000, 121	1
30.00		833, 649	149, 546	983, 19	-99, 286	883, 909	1 30. 00
43.00		0	0		0 39, 799	39, 799	
	ANCI LLARY SERVI CE COST CENTERS	· · · · · ·		1			
50.00		1,001,358	988, 633	1, 989, 99	-489, 381	1, 500, 610	1 50. OC
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 41, 517	41, 517	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	471, 955	341, 311	813, 26	-89	813, 177	54.00
57.00	05700 CT SCAN	53, 341	314, 682	368, 02	-7, 313	360, 710	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	60, 229	303, 648	363, 87	-4, 778	359, 099	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	885, 286	1, 035, 076	1, 920, 36	-12	1, 920, 350	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	60. O1
64.00		3, 159	37, 705			40, 864	64.00
65.00		0	19, 482	19, 48		19, 482	65.00
66.00		265, 648	13, 579	279, 22	-3, 122	276, 105	66.00
67.00		0	0		0 0	0	67.00
68.00		0	0		0 0	0	68.00
69.00		0	0		0 0	0	69.00
69. 02		0	29, 210	29, 21		29, 210	
70.00		0	0		0 0	0	70.00
71.00		110, 411	21, 916	132, 32		450, 504	
72.00		0	0		0 222, 511	222, 511	72.00
73.00		214, 935	500, 284	715, 21	9 0	715, 219	73.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS					0	
90.00		0	0		0 0	0	90.00
91.00		1, 562, 834	516, 088	2, 078, 92	-15, 630	2, 063, 292	
92.00							92.00
110 0	SPECIAL PURPOSE COST CENTERS	7 700 071	10 500 700	10 222 (/	0 10 111	10 212 540	110 00
118.0	0 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	7, 799, 871	10, 523, 789	18, 323, 66	-10, 111	18, 313, 549	1118.00
100 0	019000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0	0	190. 00
	019200 PHYSICIANS' PRIVATE OFFICES	566, 816	378, 253			955, 180	
200.0		8, 366, 687	378, 253				
200. U		0, 300, 007	10, 702, 042	17,200,72	. 7 0	17,200,729	1200. UL

		MUNITY HOSPITAL				u of Form CMS-2552	52-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provi der	CCN: 151300	Peri od:	Worksheet A	
					From 05/01/2015 To 04/30/2016	Date/Time Prepare	rod
					10 04/ 30/ 2010	9/28/2016 3:48 pr	
	Cost Center Description	Adjustments	Net Expenses				
		(See A-8) F	or Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-384,444	1, 317, 930	1			1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0				3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-104, 468	2, 085, 181				4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-353, 195	2, 424, 972				5.00
7.00	00700 OPERATION OF PLANT	0	627, 880				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	130, 093			8	8.00
9.00	00900 HOUSEKEEPI NG	0	168, 163			9	9.00
10.00	01000 DI ETARY	-6, 487	88, 359			10	10.00
11.00	01100 CAFETERI A	-165, 977	205, 316			11	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	156, 305			13	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-2, 887	355, 534			16	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	883, 909	1		30	30.00
43.00	04300 NURSERY	0	39, 799			43	43.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	-441, 343	1, 059, 267			50	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	41, 517			52	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	813, 177			54	54.00
57.00	05700 CT SCAN	0	360, 710			57	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	359, 099			58	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	1		59	59.00
60.00	06000 LABORATORY	0	1, 920, 350			60	50.00
60. 01	06001 BLOOD LABORATORY	0	0			60	50. 01
64.00	06400 INTRAVENOUS THERAPY	0	40, 864			64	54.00
65.00	06500 RESPI RATORY THERAPY	0	19, 482			65	65.00
66.00	06600 PHYSI CAL THERAPY	0	276, 105			66	56. OC
67.00	06700 OCCUPATI ONAL THERAPY	0	0	1		67	57.00
68.00	06800 SPEECH PATHOLOGY	0	0			68	58.00
69.00	06900 ELECTROCARDI OLOGY	0	0			69	59.00
69. 02	06902 SLEEP LAB	0	29, 210			69	59. 02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	1		70	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	450, 504			71	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	222, 511			72	72.00
	07300 DRUGS CHARGED TO PATIENTS	-3, 582	711, 637				73.00
	OUTPATIENT SERVICE COST CENTERS	· · ·					
90.00	09000 CLINIC	0	0			90	90.00
	09100 EMERGENCY	-839, 604	1, 223, 688	•			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>					2.5
118.00		-2, 301, 987	16, 011, 562			118	18.00
	NONREI MBURSABLE COST CENTERS		,,	1			
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0			190	90.00
190,00							
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	955, 180	•			2.00

ECLASS	SI FI CATI ONS			Provi der	CCN: 151300	Period: From 05/01/2015 To 04/30/2016	Worksheet A Date/Time P 9/28/2016 3	repared
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00	1			
	A - IMPLANTABLE DEVICES							
00	IMPL. DEV. CHARGED TO	72.00	0	222, 511				1.
	PATI ENTS							
	0			222, 511	1			
	B - CHARGABLE SUPPLIES		· · ·					
00	MEDICAL SUPPLIES CHARGED TO	71.00	0	540, 688				1.
	PATI ENTS							
00		0.00	0	C				2.
00		0.00	0	C				3.
00		0.00	0	C				4.
00		0.00	0	C				5.
00		0.00	0	C				6.
00		0.00	0	C				7.
00		0.00	0	C				8.
00		0.00	0	0				9.
. 00		0.00	0	0				10.
. 00		0.00	0	0				11.
				540, 688				
	C - OB/NURSERY RECLASS			0.07000				
	DELIVERY ROOM & LABOR ROOM	52.00	26, 594	14, 923				1.
	NURSERY	43.00	25, 494	14, 305				2.
			52,088	29, 228				
	D - CAFETERIA RECLASS		02,000	277220				
	CAFETERIA	11.00	172, 540	198, 753				1.
			172, 540	198, 753				
	E - YELLOW PAGES		1727010	170,700				
	ADMI NI STRATI VE & GENERAL	5.00	0	553				1.
00				553				
	F - HOUSEKEEPING RECLASS	I	<u> </u>	000				
	PHYSICIANS' PRIVATE OFFICES	192.00	6, 711					1.
	TOTALS		<u> </u>	C	-			1 .
	G - MAINTENANCE RECLASS		0, 711	U	1			-
	PHYSICIANS' PRIVATE OFFICES	192.00	6, 326	0	1			1.
	TOTALS		<u> </u>	0	-			1 .
	Grand Total: Increases		237, 665	991, 733				500.

Heal th	Fi nanci al	Systems
DECLAS	STELCATION	c

	COMMUNI TY	HOSPI TAL	0F	BREMEN,	INC.	
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ECLAS	SI FI CATI ONS			Provi der	- CCN: 151300	Period: From 05/01/2015 To 04/30/2016	Worksheet A-6 Date/Time Prep 9/28/2016 3:48	parec
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	,		
	6.00	7.00	8.00	9.00	10.00			
	A - IMPLANTABLE DEVICES							
. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	222, 511		0		1.
	PATI ENTS				<u> </u>			
	0		0	222, 511				
	B - CHARGABLE SUPPLIES				_			
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	ç)	0		1.
2.00	OPERATION OF PLANT	7.00	О	11		0		2.
. 00	ADULTS & PEDIATRICS	30.00	0	17, 970)	0		3.
. 00	OPERATING ROOM	50.00	0	489, 381		0		4.
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	. 89)	0		5.
. 00	CT SCAN	57.00	0	7, 313	3	0		6.
. 00	MAGNETIC RESONANCE IMAGING	58.00	0	4, 778		0		7.
	(MRI)	00100		1,776				
8. 00	LABORATORY	60.00	0	12	, ,	0		8.
. 00	PHYSICAL THERAPY	66.00	0	3, 122		0		9.
0.00	EMERGENCY	91,00	0	15, 630		0		10.
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2, 373		0		11.
1.00				540, 688				
	C - OB/NURSERY RECLASS	I		010,000				
. 00	ADULTS & PEDIATRICS	30.00	52,088	29, 228	3	0		1.
. 00		0.00	02,000	27, 220		0		2.
. 00			52,088	29, 228				2.
	D - CAFETERIA RECLASS		32,000	27,220				
. 00	DI ETARY	10.00	172, 540	198, 753	2	0		1.
. 00			172, 540	198, 753				
	E - YELLOW PAGES		172, 340	170,700				
. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	553	2	0		1.
. 00			of	553				1.
	F - HOUSEKEEPING RECLASS		0	553				
. 00	HOUSEKEEPING RECLASS	9.00	6, 711	C		0		1.
. 00				C		<u>u</u>		1.
	TOTALS		6, 711	C				
00	G - MAINTENANCE RECLASS	7 00	(00/			0		
. 00	OPERATION_OF_PLANT	7.00	<u>6, 326</u>	C		<u>o</u>		1.
	TOTALS		6, 326	C	וו			

Heal th	Financial Systems COMM	/UNI TY HOSPI TAL	OF BREMEN, IN	C.	In Lie	eu of Form CMS-2	2552-10
RECONC	LLIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151300	Period: From 05/01/2015 To 04/30/2016		pared:
				Acqui si ti on			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES					
1.00	Land	440, 039	0		0 0	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	0	0		0 0	0	3.00
4.00	Building Improvements	17, 818, 821	192, 240		0 192, 240	0	4.00
5.00	Fixed Equipment	5, 922, 805	157, 460		0 157, 460	65, 598	5.00
6.00	Movable Equipment	0	0		0 0	0	6.00
7.00	HIT designated Assets	1, 289, 248	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25, 470, 913	349, 700		0 349, 700	65, 598	8.00
9.00	Reconciling Items	0	0		0 0	0	
10.00	Total (line 8 minus line 9)	25, 470, 913	349, 700		0 349, 700	65, 598	10.00
		Endi ng Bal ance	Fully				
		J	Depreciated				
			Assets				
		6.00	7.00	1			
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		•			
1.00	Land	440, 039	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	18, 011, 061	0				4.00
5.00	Fixed Equipment	6,014,667	0				5.00
6,00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	1, 289, 248	0				7.00
8.00	Subtotal (sum of lines 1-7)	25, 755, 015	0				8.00
9.00	Reconciling Items	20,700,010	0				9.00
10.00	Total (line 8 minus line 9)	25, 755, 015	0				10.00
10.00		20, 100, 010	0	I			1 10.00

Heal th	Financial Systems COM	MUNI TY HOSPI TAL	OF BREMEN, IN	С.	In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
					From 05/01/2015 To 04/30/2016		pared:
						9/28/2016 3:4	8 pm
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,066,553	0	585, 12	27 0	50, 694	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0)	0 0	0	2.00
3.00	Total (sum of lines 1-2)	1,066,553	0	585, 12	27 0	50, 694	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUN	IN 2, LINES 1 a	ind 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1, 702, 374				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1, 702, 374				3.00

Health Financial Systems COM	/UNI TY HOSPI TAL	. OF BREMEN, IN	C.	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 05/01/2015 Fo 04/30/2016		
	COM	PUTATION OF RAT	-1 0S	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 NEW CAP REL COSTS-BLOG & FIXT 2.00 NEW CAP REL COSTS-MUBLE EQUIP 3.00 Total (sum of lines 1-2)	25, 654, 084 1, 289, 248 26, 943, 332	0	25, 654, 084 1, 289, 248 26, 943, 332 CAPI TAL	0. 047850	0 0	1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		-				
1.00NEW CAP REL COSTS-BLDG & FIXT2.00NEW CAP REL COSTS-MVBLE EQUIP3.00Total (sum of lines 1-2)	0			0 807, 819 0 0 807, 819	0	1.00 2.00 3.00
		SL	IMMARY OF CAPI		10,010	0.00
Cost Center Description	Interest	Insurance (see instructions)			Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	536, 292	0	50, 694	1 0	1, 317, 930	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	(0 0	0	2.00
3.00 Total (sum of lines 1-2)	536, 292	0	50, 694	4 0	1, 317, 930	3.00

	COMMUNI TY	HOSPI TAL	0F	BREMEN,	INC.	
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Health Financial Systems

In Lieu	u of	Form	CMS-2552-10	

				Т	rom 05/01/2015 p 04/30/2016	Date/Time Prep 9/28/2016 3:48	pared 8 pm
				Expense Classification on To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
00	Investment income - NEW CAP	1.00 B	2.00	3.00 NEW CAP REL COSTS-BLDG &	4.00	5.00 11	1. (
00	REL COSTS-BLDG & FIXT (chapter		10,000	FIXT			
00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2. (
00	Investment income - other		C		0.00	0	3. (
00	(chapter 2) Trade, quantity, and time		C		0.00	0	4.0
00	discounts (chapter 8)		C		0.00	0	7.
00	Refunds and rebates of expenses (chapter 8)	В	-16, 129	ADMINISTRATIVE & GENERAL	5.00	0	5.
00	Rental of provider space by		C		0.00	0	6.
00	suppliers (chapter 8) Telephone services (pay		C		0.00	0	7.0
00	stations excluded) (chapter				0.00	U	
00	21) Television and radio service		C		0.00	0	8.
	(chapter 21)		-				
00 0.00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -906, 778		0.00	0	9. 10.
	adjustment						
1.00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.
2.00	Related organization	A-8-1	C			0	12.
3. 00	transactions (chapter 10) Laundry and linen service		C		0.00	0	13.
4.00	Cafeteria-employees and guests	В	-165, 977	CAFETERI A	11.00	0	14.
5.00	Rental of quarters to employee and others		C		0.00	0	15.
5.00	Sale of medical and surgical		C		0.00	0	16.
	supplies to other than patients						
. 00	Sale of drugs to other than	В	-3, 582	DRUGS CHARGED TO PATIENTS	73.00	0	17.
3. 00	patients Sale of medical records and	В	-2, 887	MEDICAL RECORDS & LIBRARY	16.00	0	18.
9.00	abstracts Nursing school (tuition, fees,		0		0.00	0	19.
7.00	books, etc.)		C		0.00	0	19.
0. 00 . 00	Vending machines	В	C 700	ADMI NI STRATI VE & GENERAL	0.00 5.00	0	20. 21.
. 00	Income from imposition of interest, finance or penalty	D	- 700	ADMINISTRATIVE & GENERAL	5.00	0	21.
2. 00	charges (chapter 21) Interest expense on Medicare		C		0.00	0	22.
2.00	overpayments and borrowings to		C		0.00	0	22.
3. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	C	RESPI RATORY THERAPY	65.00		23.
5. 00	therapy costs in excess of	X 0 3	C		00.00		20.
1 00	limitation (chapter 14) Adjustment for physical	A-8-3	C	PHYSICAL THERAPY	66.00		24.
	therapy costs in excess of		-				
5. 00	limitation (chapter 14) Utilization review –		C	*** Cost Center Deleted ***	114.00		25.
	physicians' compensation						
. 00	(chapter 21) Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26.
00	COSTS-BLDG & FIXT				2.00		07
. 00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		L.	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.
. 00 . 00	Non-physician Anesthetist Physicians' assistant		C	*** Cost Center Deleted ***	19.00 0.00	0	28. 29.
00 0.00	Physicians' assistant Adjustment for occupational	A-8-3	C	OCCUPATI ONAL THERAPY	67.00	0	29. 30.
	therapy costs in excess of						
). 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30.
	instructions)						
I. 00	Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.
	limitation (chapter 14)		000 000		4 6 6	_	
2.00	CAH HIT Adjustment for Depreciation and Interest	A	-239, 008	NEW CAP REL COSTS-BLDG &	1.00	9	32.

Heal th	Financial Systems	COMM	UNI TY HOSPI TAL	OF BREMEN, INC.	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 05/01/2015 To 04/30/2016	Date/Time Pre 9/28/2016 3:43	
				Expense Classification or	Norksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3.00	4, 00	5, 00	
33.00	MEALS ON WHEELS	B		DI ETARY	10.00		33.00
34.00	HAF PROVIDER ASSESSMENT	Ā		ADMI NI STRATI VE & GENERAL	5.00		34.00
35.00	INVOLCE PENALTIES	A		ADMI NI STRATI VE & GENERAL	5.00		35.00
36.00	RECRUI TI NG/MD_SUPPORT	А		ADMI NI STRATI VE & GENERAL	5.00		36.00
37.00	LOBBYING EXP IN DUES	А		ADMI NI STRATI VE & GENERAL	5.00		37.00
38.00	PLYMOUTH ST CLINIC DEPR	А	-19, 726	NEW CAP REL COSTS-BLDG &	1.00	9	38.00
				FLXT			
39.00	MISC INCOME	В	-27, 411	ADMINISTRATIVE & GENERAL	5.00	0	39.00
41.00	SALES TAX	В	-83	ADMINISTRATIVE & GENERAL	5.00	0	41.00
45.00	OTHER OPER REV-COMMUNITY GR	В	-120	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	RENTAL REVENUE-SPECIALI STS	В		NEW CAP REL COSTS-BLDG &	1.00	10	45.01
				FLXT			
45.03	CRNA SALARI ES	A		OPERATING ROOM	50.00		45.03
45.04	CRNA BENEFITS	A		EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	10101
50.00	TOTAL (sum of lines 1 thru 49)		-2, 301, 987				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.
Note: See instructions for column 5 referencing to Worksheet A-7.

Health Financial Systems

COMMUNITY HOSPITAL OF BREMEN, INC. In Lieu of Form CMS-2552-10

PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provi der		Peri od:	Worksheet A-8	3-2
						From 05/01/2015 To 04/30/2016	Date/Time Pre	narad
						10 04/30/2010	9/28/2016 3:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				•	•		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		OPERATING ROOM	67, 174				0	1.00
2.00		EMERGENCY	1, 541, 973				0	2.00
3.00		LABORATORY	26, 000	0	26,000	0 0	0	3.00
4.00	0.00		0	0			0	4.00
5.00	0.00		0	0	C	0 0	0	5.00
6.00	0.00		0	0	C	0 0	0	6.00
7.00	0.00		0	0	C	0 0	0	7.00
8.00	0.00	4	0	0	0	0 0	0	8.00
9.00	0.00	4	0	0	0	0 0	0	9.00
10.00	0.00		0	0	0	0 0	0	10.00
200.00			1, 635, 147		728, 369		0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		OPERATING ROOM	0	0		-	0	1.00
2.00		EMERGENCY	0	, o			0	2.00
3.00		LABORATORY	0	0	-	° .	0	3.00
4.00	0.00		0	0		-	0	4.00
5.00	0.00		0	0	0	° .	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	(0	0	7.00
8.00	0.00		0	0	(0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	(°	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	18.00		
1.00		OPERATING ROOM	15.00	0				1.00
2.00		EMERGENCY						2.00
2.00		LABORATORY						2.00
3.00 4.00	0.00		0		-	°		3.00 4.00
4.00 5.00	0.00		0					
5.00 6.00	0.00			0	-	° .		5.00 6.00
	0.00		0	0				
7.00			0			-		7.00
8.00	0.00		0					8.00
9.00	0.00		0			-		9.00
10.00	0.00		0					10.00
200.00	I	I	0	1 U	(C	906, 778		200.00

	IFINANCIAL SYSTEMS COMM WABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	JUNI TY HOSPI TAL FURNI SHED BY		CCN: 151300 Pe Fi Te	eriod: rom 05/01/2015		-3 pared:
					-	1.00	
1 00	PART I - GENERAL INFORMATION						1 00
1.00 2.00	Total number of weeks worked (excluding aide: Line 1 multiplied by 15 hours per week	s) (see Instruc	tions)			2 30	1.00 2.00
3.00	Number of unduplicated days in which supervis	sor or therapis	t was on provi	der site (see i	instructions)	6	3.00
4.00	Number of unduplicated days in which therapy					0	4.00
F 00	nor therapist was on provider site (see inst			-+			F 00
5.00 6.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - there				therapy	0	5.00 6.00
0.00	assi stant and on which supervisor and/or the					0	0.00
	instructions)					5.05	
7.00 8.00	Standard travel expense rate Optional travel expense rate per mile					5.25 0.00	
0.00		Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	0.00
0.00	Tatal barren manland	1.00	2.00	3.00	4.00	5.00	0.00
9.00 10.00	Total hours worked AHSEA (see instructions)	0. 00 0. 00	9. 77 79. 65	0.00		0.00 0.00	
11.00	Standard travel allowance (columns 1 and 2,	39.83	39.83	0.00			11.00
	one-half of column 2, line 10; column 3,						
12.00	one-half of column 3, line 10) Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
14.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1	11 20 10				0	 14.00
14.00	Therapists (column 2, line 9 times column 2,					778	
16.00	Assistants (column 3, line 9 times column 3,					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and	nd 15 for respi	ratory therapy	or lines 14-10	6 for all	778	17.00
18.00	others) Aides (column 4, line 9 times column 4, line	10)				0	18.00
19.00	Trainees (column 5, line 9 times column 5, l					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for					778	20.00
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete	lines 21-23.					
21.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3,			m of columns 1	and 2, line 9	79.63	21.00
22.00	Weighted allowance excluding aides and train					2, 389	22.00
23.00	Total salary equivalency (see instructions)					2, 389	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	VANCE AND TRAVE	L EXPENSE COMPL	UTATION - PROVI	DER SITE		
24.00						239	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00 27.00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				and 4 for all	239 32	
27.00	others)	Tor respirator	y the apy of s			32	27.00
28.00	Total standard travel allowance and standard	travel expense	at the provide	er site (sum of	flines 26 and	271	28.00
	27) Optional Travel Allowance and Optional Travel	Evnense					
29.00	Therapists (column 2, line 10 times the sum		d 2, line 12)			0	29.00
30.00	Assistants (column 3, line 10 times column 3,	line 12)				0	30.00
31.00 32.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column:				or cum of	0 0	31.00 32.00
32.00	columns 1-3, line 13 for all others)	s i anu z, i i ne	13 IOI TESPIT	atory therapy (0	32.00
	Standard travel allowance and standard trave					271	33.00
33.00	Optional travel allowance and standard trave					32 0	34.00 35.00
34.00			or rines of dif	,			1 33.00
	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW		EXPENSE COMPUT	TATION - SERVIO	JES OUISIDE PRO	IVIDER SITE	
34. 00 35. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense		EXPENSE COMPUT	TATION - SERVIO	LES OUTSIDE PRO		
34. 00 35. 00 36. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11)		EXPENSE COMPU	TATION - SERVIO	LES OUTSIDE PRO	0	
34. 00 35. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense		EXPENSE COMPU	TATION - SERVIO			37.00
34. 0035. 0036. 0037. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	nce AND TRAVEL		TATION - SERVIO	LES OUTSIDE PRO	0 0	37.00 38.00
34.00 35.00 36.00 37.00 38.00 39.00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel	nce and TRAVEL m of lines 5 an Expense	d 6)	TATION - SERVI		0 0 0 0	37.00 38.00 39.00
34.00 35.00 36.00 37.00 38.00 39.00 40.00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	n of lines 5 an Expense D1 times column	d 6)	TATION - SERVI		0 0 0 0	37.00 38.00 39.00 40.00
34.00 35.00 36.00 37.00 38.00 39.00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel	n of lines 5 an Expense D1 times column	d 6)	TATION - SERVI		0 0 0 0	37.00 38.00 39.00 40.00 41.00
 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	n of lines 5 an Expense 1 times column 1 3, line 10) n of columns 1-	d 6) 2, line 10) 3, line 13.01)			0 0 0 0 0 0 0 0 0 0 0	37.00 38.00 39.00 40.00 41.00 42.00
 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12, 0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	n of lines 5 an Expense 1 times column 1 3, line 10) n of columns 1-	d 6) 2, line 10) 3, line 13.01)			0 0 0 0 0 0 0 0 0 0 0	37.00 38.00 39.00 40.00 41.00 42.00

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151300	Period: From 05/01/2015 To 04/30/2016	Worksheet A-8 Parts I-VI Date/Time Pre 9/28/2016 3:4	pared:
					Occupational Therapy	Cost	
						1.00	
45.00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	d 42 - see ir	nstructions)	0	45.00
46.00	Optional travel allowance and optional travel		of lines 42 an				46.00
		Therapi sts	Assistants	Aides	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0.0	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00				48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0. 00	0.00	0.0	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0. (0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.65	0.00				52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.00
56. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56.00
	respiratory therapy and columns 1 through 3 for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
57.00 58.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 22	24 or 25)			2, 389 271	
59.00	Travel allowance and expense - Offsite service	•)		0	
60.00	Overtime allowance (from column 5, line 56)					0	
61.00						0	
	Supplies (see instructions)						62.00
63.00 64.00		vour rocorde)					63.00 64.00
	Excess over limitation (line 64 minus line 63	J .	, enter zero)				65.00
100 00	LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	sum of lines ?	1 and 25 for a	11 othors		220	100. 00
100.01	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27				others	32	100.00 100.01 100.02
	LINE 34 CALCULATION						1
	Line 27 = line 7 times line 3 for respiratory				others		101.00
	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	sum of lines 2	9 and 30 for a	II others			101. 01 101. 02
102.00	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or	sum of lines ?	9 and 30 for a	others		0	102.00
	Line 32 = line 8 times columns 1 and 2, line 13 for all others				umns 1-3, line		102.00

	IABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151300	Period: From 05/01/2015 To 04/30/2016		pared:
					Speech Pathol ogy		
						1.00	
	PART I - GENERAL INFORMATION						
1.00 2.00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instruct	ions)			8 120	1.00 2.00
3.00	Number of unduplicated days in which supervis	sor or therapist	was on provi	der site (se	e instructions)	14	3.00
4.00	Number of unduplicated days in which therapy		n provider si	te but neith	er supervisor	0	4.00
5.00	nor therapist was on provider site (see instr Number of unduplicated offsite visits - super		nists (soo in	structions)		o	5.00
6.00	Number of unduplicated offsite visits - thera				by therapy	0	6.00
	assistant and on which supervisor and/or the	apist was not p	resent during	the visit(s)) (see		
7.00	instructions) Standard travel expense rate					5.25	7.00
8.00	Optional travel expense rate per mile					0.00	
		Supervi sors	Therapi sts	Assi stants	Ai des 4.00	Trai nees 5.00	
9.00	Total hours worked	1.00	2.00 18.31	3.00	4.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76. 57	0.	00 0.00		10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	38. 29	38. 29	0.	00		11.00
	one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.00
12.01 13.00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12.01 13.00
13.01	Number of miles driven (offsite)	0	0		0		13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00	Supervisors (column 1, line 9 times column 1,					-	14.00
15.00 16.00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					1, 402	15.00 16.00
17.00	Subtotal allowance amount (sum of lines 14 ar		atory therapy	or lines 14	-16 for all		17.00
	others)		5 15				
18.00 19.00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li					0	18.00 19.00
20.00	Total allowance amount (sum of lines 17-19 fo		herapy or lin	es 17 and 18	for all others)	-	20.00
	If the sum of columns 1 and 2 for respiratory						
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		o entries on i	Thes 21 and	22 and enter on	line 23	
21.00	Weighted average rate excluding aides and tra	ainees (line 17		m of columns	1 and 2, line 9	76.57	21.00
22.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained					9, 188	22.00
23.00	Total salary equivalency (see instructions)		3 1116 21)				23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMPL	JTATION - PR	OVIDER SITE		
24 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)						
						536	24 00
25.00	Assistants (line 4 times column 3, line 11)						24. 00 25. 00
25. 00 26. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or					0 536	25. 00 26. 00
25.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				3 and 4 for all	0	25. 00 26. 00
25. 00 26. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	for respiratory	therapy or s	um of lines		0 536 74	25. 00 26. 00
25. 00 26. 00 27. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27)	for respiratory travel expense	therapy or s	um of lines		0 536 74	25. 00 26. 00 27. 00
25. 00 26. 00 27. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	for respiratory travel expense Expense	therapy or so	um of lines		0 536 74	25. 00 26. 00 27. 00 28. 00
25.00 26.00 27.00 28.00 29.00 30.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,	for respiratory travel expense Expense of columns 1 and line 12)	therapy or si at the provide 2, line 12)	um of lines er site (sum		0 536 74 610 0 0	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
25.00 26.00 27.00 28.00 29.00 30.00 31.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29	therapy or so at the provide 2, line 12) and 30 for a	um of lines er site (sum	of lines 26 and	0 536 74 610 0 0 0 0	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00
25.00 26.00 27.00 28.00 29.00 30.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29	therapy or so at the provide 2, line 12) and 30 for a	um of lines er site (sum	of lines 26 and	0 536 74 610 0 0	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel	for respiratory travel expense f columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line 1	therapy or su at the provide 2, line 12) and 30 for a 13 for respire 28)	um of lines er site (sum ll others) atory therap	of lines 26 and	0 536 74 610 0 0 0 0 0 610	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o	therapy or si at the provide 2, line 12) and 30 for a 13 for respire 28) f lines 27 and	um of lines er site (sum li others) atory therap d 31)	of lines 26 and	0 536 74 610 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel	for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	therapy or si at the provide 2, line 12) and 30 for a 13 for respira 28) f lines 27 and f lines 31 and	um of lines er site (sum ll others) atory therap d 31) d 32)	of lines 26 and	0 536 74 610 0 0 0 0 0 610 74 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWF Standard Travel Expense	for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	therapy or si at the provide 2, line 12) and 30 for a 13 for respira 28) f lines 27 and f lines 31 and	um of lines er site (sum ll others) atory therap d 31) d 32)	of lines 26 and	0 536 74 610 0 0 0 0 0 0 610 74 0 VI DER_SI TE	25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWF	for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	therapy or si at the provide 2, line 12) and 30 for a 13 for respira 28) f lines 27 and f lines 31 and	um of lines er site (sum ll others) atory therap d 31) d 32)	of lines 26 and	0 536 74 610 0 0 0 0 0 0 610 74 0 VI DER_SI TE	25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NCE AND TRAVEL I	therapy or si at the provide 2, line 12) and 30 for a 13 for respire 28) f lines 27 and f lines 31 and EXPENSE COMPU	um of lines er site (sum ll others) atory therap d 31) d 32)	of lines 26 and	0 536 74 610 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NCE AND TRAVEL I	therapy or si at the provide 2, line 12) and 30 for a 13 for respire 28) f lines 27 and f lines 31 and EXPENSE COMPU	um of lines er site (sum ll others) atory therap d 31) d 32)	of lines 26 and	0 536 74 610 0 0 0 0 0 610 74 0 0VI DER_SI TE 0 0 0 0	25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NCE AND TRAVEL 1	therapy or si at the provide 2, line 12) and 30 for a 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPUT 6)	um of lines er site (sum ll others) atory therap d 31) d 32)	of lines 26 and	0 536 74 610 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWF Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times column	for respiratory travel expense f columns 1 and line 12) sum of lines 29 a 1 and 2, line expense (line expense (sum o expense (sum o NCE AND TRAVEL 1 n of lines 5 and Expense	therapy or si at the provide 2, line 12) and 30 for a 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPUT 6)	um of lines er site (sum ll others) atory therap d 31) d 32)	of lines 26 and	0 536 74 610 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.07 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	for respiratory travel expense f columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o expense (sum o NCE AND TRAVEL I n of lines 5 and Expense 1 times column in a, line 10)	therapy or si at the provide 2, line 12) and 30 for a 13 for respire 28) f lines 27 and f lines 31 and EXPENSE COMPU 6) 2, line 10)	um of lines er site (sum ll others) atory therap d 31) d 32)	of lines 26 and	0 536 74 610 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWF Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times column	for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o expense (sum o NCE AND TRAVEL I n of lines 5 and Expense 1 times column a, line 10) n of columns 1-3	therapy or si at the provide 2, line 12) and 30 for a 13 for respire 28) f lines 27 and f lines 31 and EXPENSE COMPU 6) 2, line 10) , line 13.01)	um of lines er site (sum ll others) atory therap d 31) d 32) FATION - SER	of lines 26 and y or sum of <u>VICES OUTSIDE PRC</u>	0 536 74 610 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur	for respiratory travel expense f columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o expense (sum o NCE AND TRAVEL 1 n of lines 5 and Expense 1 times column a 3, line 10) n of columns 1-3 offsite Services	therapy or si at the provide 2, line 12) and 30 for a 13 for respire 28) f lines 27 and f lines 31 and EXPENSE COMPU 6) 2, line 10 Complete one	um of lines er site (sum ll others) atory therap d 31) d 32) FATION - SER	of lines 26 and y or sum of <u>VICES OUTSIDE PRO</u>	0 536 74 610 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00

	E SUPPLIERS				From 05/01/2015 To 04/30/2016	Date/Time Pre 9/28/2016 3:4	
					Speech Pathology	Cost	
						1.00	
6.00	Optional travel allowance and optional travel						46.00
	-	Therapists 1.00	Assistants	Aides	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each	0.00	0.00	0. (0.00	0.00	47.00
8.00	column of line 56) Overtime rate (see instructions)	0.00	0.00	0.	0. 00		48.00
9.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00	0.0			49.00
	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0.00	0.00	0.	0.00	0.00	50.00
1.00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0. 00	0.	0. 00	0. 00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE					I	
	Adjusted hourly salary equivalency amount (see instructions) Overtime cost limitation (line 51 times line	76. 57	0.00	0.	0.00		52.0 53.0
	52) Maximum overtime cost (enter the lesser of	0	0		0 0		54.0
5. 00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply	О	0		0 0		55.0
6. 00	line 47 times line 52) Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	O		0 0	0	56.0
						1.00	<u> </u>
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			1.00	
3.00 9.00 0.00 1.00 2.00 3.00 4.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	your records)	44, 45, or 46)		0 0 0 9, 798 1, 062	58.0 59.0 60.0 61.0 62.0 63.0
00. 01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	sum of lines 24 therapy or sum	and 25 for a of lines 3 a	II others nd 4 for all	others	74	100. C 100. C 100. C
01. 01 01. 02	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 29	and 30 for a	II others	others	0 74	101. 0 101. 0 101. 0
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line 13 for all others				umns 1-3, line		102. 0 102. 0

In Lieu of Form CMS-2552-10 d: Worksheet B

0031 P	LLUCATION - GLINERAL SERVICE COSTS		FIOVIDEI	CCN. 151500		com 05/01/2015 0 04/30/2016	Part I Date/Time Pre 9/28/2016 3:4	pared: 8 pm
			CAPI TAL REL	ATED COSTS				
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	NEW BLDG & FIXT	NEW MVBLE EQUI P		EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		col. 7)						
	OFNEDAL CEDILLOS COCT CENTERS	0	1.00	2.00		4.00	4A	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	1, 317, 930	1, 317, 930					1.00
2.00	00200 NEW CAP REL COSTS-BEDG & FIXT	1, 317, 930	1, 317, 930		0			2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 085, 181	4, 928		0	2, 090, 109		4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL	2, 424, 972	109, 938		0	329,605	2, 864, 515	
7.00	00700 OPERATION OF PLANT	627, 880	237, 861		0	43, 622	2, 804, 515	
8.00	00800 LAUNDRY & LINEN SERVICE	130, 093	4, 694		0	43, 022	134, 787	8.00
9,00	00900 HOUSEKEEPING	168, 163	8,065		0	37, 356	213, 584	
10.00	01000 DI ETARY	88, 359	26, 946		0	11, 125	126, 430	
11.00	01100 CAFETERI A	205, 316	26, 796		0	43, 552	275, 664	•
13.00	01300 NURSI NG ADMI NI STRATI ON	156, 305	8, 513		0	37, 788	202,606	•
16.00	01600 MEDICAL RECORDS & LI BRARY	355, 534	14, 124		0	61, 775	431, 433	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		, .= .	1	-	.,		1
30.00	03000 ADULTS & PEDIATRICS	883, 909	260, 771		0	197, 281	1, 341, 961	30.00
43.00	04300 NURSERY	39, 799	6, 230		0	6, 435	52, 464	43.00
	ANCILLARY SERVICE COST CENTERS			•				1
50.00	05000 OPERATI NG ROOM	1, 059, 267	178, 337		0	252, 762	1, 490, 366	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	41, 517	0		0	6, 713	48, 230	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	813, 177	84, 976		0	119, 130	1, 017, 283	54.00
57.00	05700 CT SCAN	360, 710	0		0	13, 464	374, 174	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	359, 099	0		0	15, 203	374, 302	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60.00	06000 LABORATORY	1, 920, 350	51, 417		0	223, 463	2, 195, 230	
60. 01	06001 BLOOD LABORATORY	0	0		0	0	0	60.01
64.00	06400 I NTRAVENOUS THERAPY	40, 864	6, 400		0	797	48, 061	•
65.00	06500 RESPI RATORY THERAPY	19, 482	0		0	0	19, 482	
66.00	06600 PHYSI CAL THERAPY	276, 105	60, 079		0	67, 055	403, 239	
67.00	06700 OCCUPATIONAL THERAPY	0	0		0	0	0	•
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	0	
69.00	06900 ELECTROCARDI OLOGY	0	1, 536		0	0	1, 536	
69. 02	06902 SLEEP LAB	29, 210	9, 579		0	0	38, 789	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	450, 504	45, 358		0	27, 870	523, 732	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	222, 511	0		0	0	222, 511	
73.00	07300 DRUGS CHARGED TO PATIENTS	711, 637	17, 046		0	54, 254	782, 937	73.00
00.00	OUTPATIENT SERVICE COST CENTERS			1	0	0		
90.00 91.00		0	0		0	0	0	
91.00 92.00	09100 EMERGENCY	1, 223, 688	145, 375		0	394, 493	1, 763, 556	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						0	92.00
118.00		16, 011, 562	1, 308, 969		0	1, 943, 743	15, 856, 235	110 00
110.00	NONREI MBURSABLE COST CENTERS	10,011,302	1, 300, 909		0	1, 743, 743	15, 650, 255	1118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8, 961		0	0	Q 061	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	955, 180	0, 201		0	146, 366	1, 101, 546	
200.00		,33,100	0		3	140, 300		200.00
200.00	5		Ω		0	0		201.00
201.00		16, 966, 742	1, 317, 930		0	2, 090, 109		
			., , ,	1	-1	_, , 10 /		

Heal th	Financial Systems COM	IMUNI TY HOSPI TAL	OF BREMEN. IN	IC.	In Lie	u of Form CMS-	2552-10
	ALLOCATION - GENERAL SERVICE COSTS				Peri od:	Worksheet B	
					From 05/01/2015	Part I	
					To 04/30/2016	Date/Time Pre	
						9/28/2016 3:4	8 pm
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	- 1		T			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	2, 864, 515					5.00
7.00	00700 OPERATION OF PLANT	184, 714	1, 094, 077				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	27, 379	5, 320	167, 48	6		8.00
9.00	00900 HOUSEKEEPI NG	43, 384	9, 141				9.00
10.00	01000 DI ETARY	25, 681	30, 544			190, 983	10.00
11.00	01100 CAFETERI A	55, 994	30, 374			0	
13.00	01300 NURSI NG ADMI NI STRATI ON	41, 154	9, 649		0 2,494	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	87, 635	16,009		0 4, 138	0	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	07,033	10,007		4,130	0	10.00
30.00	03000 ADULTS & PEDI ATRI CS	272, 586	295, 594	47,63	5 76, 401	190, 983	30.00
43.00							
43.00	04300 NURSERY	10, 657	7,062	25	6 1, 825	0	43.00
F0 00	ANCI LLARY SERVI CE COST CENTERS	000 704	000.440	50.54	7 50 047	0	50.00
50.00	05000 OPERATING ROOM	302, 731	202, 148			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	9, 797	C			0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	206, 636	96, 322			0	
57.00	05700 CT SCAN	76, 004	0		0 0	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	76, 030	0		0 0	0	00.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	445, 906	58, 282		0 15, 063	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	60.01
64.00	06400 I NTRAVENOUS THERAPY	9, 762	7, 255	ò	0 1, 875	0	64.00
65.00	06500 RESPI RATORY THERAPY	3, 957	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	81, 908	68, 100	10, 22	7 17, 601	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	l c)	0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	l a		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	312	1, 741		-	0	69.00
69.02	06902 SLEEP LAB	7,879	10, 858			0	
70.00	07000 ELECTROENCEPHALOGRAPHY	,,,,,,	10,000		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	106, 383	51, 414		0 13, 288	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	45, 198	01,414		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	159, 034	19, 322		0 4.994	0	
73.00		159,034	19, 322	-	4,994	0	/3.00
~~~~~	OUTPATIENT SERVICE COST CENTERS			J		0	00.00
90.00	09000 CLINIC	0	0		0 0	0	
91.00	09100 EMERGENCY	358, 222	164, 785	25, 05	1 42, 590	0	/ / / 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	_			_		
118.00		2, 638, 943	1, 083, 920	165, 30	4 276, 412	190, 983	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1, 820	10, 157		0 2, 625		190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	223, 752	C	2, 18	2 0	0	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118-201)	2, 864, 515	1, 094, 077	167, 48	6 279, 037	190, 983	202.00
							•

Heal th	Financial Systems COM	/UNI TY HOSPI TAL	. OF BREMEN, IN	C.	In Lie	eu of Form CMS-:	2552-10
	ALLOCATION - GENERAL SERVICE COSTS			CCN: 151300	Period: From 05/01/2015 To 04/30/2016	Worksheet B Part I	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS	1	Γ	1		T	-
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	370, 379					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	6, 928	262, 831				13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	24, 146	0	563, 36	1		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	53, 546	92, 644	53, 16	6 2, 424, 516	0	30.00
43.00	04300 NURSERY	1, 839	3, 183	3, 08	80, 373	0	43.00
	ANCILLARY SERVICE COST CENTERS					-	
50.00	05000 OPERATING ROOM	47,096	81, 484	97, 22		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 917	3, 317	3, 30		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	30, 348	0			0	54.00
57.00	05700 CT SCAN	4, 103	0			0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	4,015	0	19, 67		0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	94, 398	0	166, 35	2, 975, 234	0	60.00 60.01
64.00	06400 I NTRAVENOUS THERAPY	260	0	3, 05	8 70, 271	0	64.00
65.00	06500 RESPIRATORY THERAPY	200	0			0	65.00
66,00	06600 PHYSI CAL THERAPY	14, 349		19, 72		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 010, 144	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	6,66	8 11, 311	0	69.00
69.02	06902 SLEEP LAB	0	0	2, 10		0	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 994	0	14, 35	6 720, 167	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	9, 30	3 277, 012	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 079	12, 248	28, 16	6 1, 013, 780	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	•
91.00	09100 EMERGENCY	40, 432	69, 955	34, 97	2, 499, 564	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS					-	
118.00	· · · · · · · · · · · · · · · · · · ·	341, 450	262, 831	563, 36	1 15, 586, 770	0	118.00
100.00	NONREI MBURSABLE COST CENTERS	0	0	1	0 00 5/0		100.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 23, 563		190.00 192.00
200.00	19200 PHYSICIANS' PRIVATE OFFICES Cross Foot Adjustments	28, 929	0		0 1, 356, 409		200.00
200.00	5	0	_		0		200.00
201.00	5	370, 379	262, 831	563, 36	1 16, 966, 742		201.00
202.00		1 570, 379	202,031	1 505, 50	10, 700, 742	1 0	1202.00

	LLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 151300	Period: From 05/01/2015 To 04/30/2016	Worksheet B Part I Date/Time Prepared: 9/28/2016 3:48 pm
	Cost Center Description	Total		<u> </u>	772072010 3.40 pm
		26.00			
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPING				9.00
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERI A				11.00
	01300 NURSI NG ADMI NI STRATI ON				13.00
16.00					16.00
16.00	01600 MEDICAL RECORDS & LIBRARY				18.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 404 514			20, 00
30.00	03000 ADULTS & PEDI ATRI CS	2, 424, 516			30.00
43.00	04300 NURSERY	80, 373			43.00
	ANCI LLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	2, 323, 861			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	66, 898			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 437, 672			54.00
57.00	05700 CT SCAN	510, 292			57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	474,019			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0			59.00
60.00	06000 LABORATORY	2, 975, 234			60.00
60. 01	06001 BLOOD LABORATORY	0			60.01
64.00	06400 I NTRAVENOUS THERAPY	70, 271			64.00
65.00	06500 RESPI RATORY THERAPY	23, 851			65.00
66.00	06600 PHYSI CAL THERAPY	615, 144			66.00
67.00	06700 OCCUPATIONAL THERAPY	0			67.00
68.00	06800 SPEECH PATHOLOGY	0			68.00
69.00	06900 ELECTROCARDI OLOGY	11, 311			69.00
69.02	06902 SLEEP LAB	62, 805			69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	720, 167			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	277, 012			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,013,780			73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0			90.00
91.00	09100 EMERGENCY	2, 499, 564			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	SPECIAL PURPOSE COST CENTERS				
118.00		15, 586, 770			118.00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	23, 563			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 356, 409			192.00
200.00		0			200.00
201.00	5	Ō			201.00
202.00		16, 966, 742			202.00
50					1 00

Heal th Financial		Systems					
		OF C		PELATED	C		

Health Financial Systems		MMUNITY HOSPITAL OF BREMEN, INC.			In Lieu of Form CMS-2552-10			
	OF CAPITAL RELATED COSTS		Provi der	CCN: 151300	Peri od:	Worksheet B		
					From 05/01/2015	Part II		
					To 04/30/2016	Date/Time Pre	pared:	
				ATER ADOTO		9/28/2016 3:4	8 pm	
			CAPITAL REI	LATED COSTS				
	Cost Costos Docosistica	Discontinu			C			
	Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE		
		Assigned New	FLXT	EQUI P		BENEFITS		
		Capital				DEPARTMENT		
		Related Costs	1 00	2.00	24	4.00		
CEN	ERAL SERVICE COST CENTERS	0	1.00	2.00	2A	4.00		
	DO NEW CAP REL COSTS-BLDG & FIXT			1			1 1 00	
							1.00	
	DO NEW CAP REL COSTS-MVBLE EQUIP		1 000			1 000	2.00	
	DO EMPLOYEE BENEFITS DEPARTMENT	0	4, 928		0 4, 928	4, 928	4.00	
	DO ADMI NI STRATI VE & GENERAL	0	109, 938		0 109, 938	777	5.00	
	DO OPERATION OF PLANT	0	237, 861		0 237, 861	103	•	
	DO LAUNDRY & LINEN SERVICE	0	4, 694		0 4, 694	0	8.00	
	DO HOUSEKEEPI NG	0	8, 065		0 8, 065	88		
	DO DI ETARY	0	26, 946		0 26, 946	26		
	DO CAFETERI A	0	26, 796		0 26, 796	103		
13.00 0130	DO NURSI NG ADMI NI STRATI ON	0	8, 513		0 8, 513	89	13.00	
16.00 0160	DO MEDICAL RECORDS & LIBRARY	0	14, 124		0 14, 124	146	16.00	
I NPA	ATIENT ROUTINE SERVICE COST CENTERS							
30.00 0300	DO ADULTS & PEDIATRICS	0	260, 771		0 260, 771	465	30.00	
43.00 0430	DO NURSERY	0	6, 230		0 6, 230	15	43.00	
ANCI	LLARY SERVICE COST CENTERS						1	
	DO OPERATING ROOM	0	178, 337		0 178, 337	596	50.00	
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	0	0		0 0	16	52.00	
54.00 0540	DO RADI OLOGY-DI AGNOSTI C	0	84, 976		0 84, 976	281	54.00	
57.00 0570	DO CT SCAN	0	0		0 0	32	57.00	
	DO MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	36	•	
59.00 0590	DO CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00	
	DO LABORATORY	0	51, 417		0 51, 417	527	60.00	
	D1 BLOOD LABORATORY	0	01,11		0 0	00	60.01	
	DO I NTRAVENOUS THERAPY	0	6, 400		0 6,400	2	64.00	
	DO RESPIRATORY THERAPY	0	0, 100		0 0	0	65.00	
	DO PHYSI CAL THERAPY	0	60, 079		0 60, 079	158	•	
	DO OCCUPATI ONAL THERAPY	0	00,0,7		0 0	0	67.00	
	DO SPEECH PATHOLOGY	0	0		0 0	0	68.00	
	DO ELECTROCARDI OLOGY	0	1, 536		0 1, 536	0	69.00	
	DELECTROCARDIOLOGI DE SLEEP LAB	0				0	69.00	
		-	9, 579		0 9,579 0 0		•	
	DO ELECTROENCEPHALOGRAPHY	0	0			0	70.00	
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	45, 358		0 45, 358	66	71.00	
	DO I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00	
	DO DRUGS CHARGED TO PATIENTS	0	17, 046		0 17, 046	128	73.00	
	PATIENT SERVICE COST CENTERS			1				
	DO CLINIC	0	0		0 0	0	90.00	
	DO EMERGENCY	0	145, 375		0 145, 375	929		
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00	
SPEC	CLAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1, 308, 969		0 1, 308, 969	4, 583	118.00	
NONF	REIMBURSABLE COST CENTERS							
190.001900	DO GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8, 961		0 8, 961	0	190. 00	
192.00 1920	DO PHYSICIANS' PRIVATE OFFICES	0	0		0 0	345	192.00	
200.00	Cross Foot Adjustments				0		200.00	
201.00	Negative Cost Centers		0		0 0	0	201.00	
202.00	TOTAL (sum lines 118-201)	0	1, 317, 930		0 1, 317, 930	4, 928	202.00	

	Financial Systems CON TION OF CAPITAL RELATED COSTS		Provi der		Period: From 05/01/2015 To 04/30/2016	u of Form CMS- Worksheet B Part II Date/Time Pre 9/28/2016 3:4	pared.
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE		10.00	
		5.00	7.00	8.00	9.00	10.00	
4 00	GENERAL SERVICE COST CENTERS			1			1 4 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	110, 715					5.00
7.00	00700 OPERATION OF PLANT	7, 139	245, 103				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 058	1, 192				8.00
9.00	00900 HOUSEKEEPI NG	1, 677	2, 048	53	6 12, 414		9.00
10.00	01000 DI ETARY	993	6, 843	1	8 351	35, 177	10.00
11.00	01100 CAFETERI A	2, 164	6, 805	2	1 349	0	11.00
13.00	01300 NURSING ADMINISTRATION	1, 591	2, 162		0 111	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 387	3, 587		0 184	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDIATRICS	10, 536	66, 219	1, 97	5 3, 400	35, 177	30.00
	04300 NURSERY	412	1, 582			0	1
	ANCI LLARY SERVICE COST CENTERS		.,		.,		
50.00	05000 OPERATING ROOM	11, 701	45, 287	2,09	6 2, 324	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	379	10, 20,	1		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 987	21, 579			0	
57.00	05700 CT SCAN	2, 938	0		0 1,100	0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 930	0		0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 737	0		0 0	0	
	06000 LABORATORY	17 221	-			0	•
60. 00 60. 01	06001 BLOOD LABORATORY	17, 231	13, 057		-		
		0	0			0	
64.00	06400 I NTRAVENOUS THERAPY	377	1, 625		0 83	0	
65.00	06500 RESPI RATORY THERAPY	153	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	3, 166	15, 256			0	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	12	390			0	
69. 02	06902 SLEEP LAB	305	2, 433	1	5 125	0	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 112	11, 518		0 591	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 747	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 147	4, 329		0 222	0	73.00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	13, 846	36, 916	1, 03	9 1, 895	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS			1			
118.00		101, 997	242, 828	6, 85	4 12, 297	35, 177	118.00
5. 50	NONREI MBURSABLE COST CENTERS		2.2, 320	6,00	,_,,	00,111	1
190 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	70	2, 275		0 117	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	8, 648			-		192.00
200.00		0,040				0	200.00
200.00	,	0	_		0 0	0	200.00
		110 715	0 245 102		-		201.00
202.00	TOTAL (sum lines 118-201)	110, 715	245, 103	6, 94	4 12, 414	35, 177	1202.0

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411004			

Heal th	Financial Systems COMM	UNI TY HOSPI TAL	OF BREMEN, IN	C.	In Li€	eu of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS		Provi der	CCN: 151300	Peri od:	Worksheet B	
				1	From 05/01/2015		
				-	To 04/30/2016	Date/Time Pre	epared:
		0.0557551.0				9/28/2016 3:4	18 pm
	Cost Center Description	CAFETERI A	NURSI NG	MEDICAL	Subtotal	Intern &	
			ADMI NI STRATI ON			Residents Cost	
				LI BRARY		& Post	
						Stepdown	
						Adjustments	
		11.00	13.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS			1		1	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	36, 238					11.00
13.00	01300 NURSING ADMINISTRATION	678					13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	2, 362			n		16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	2,002	<u> </u>	20,77	<u> </u>	1	10.00
30, 00	03000 ADULTS & PEDI ATRI CS	5, 239	4, 633	2, 24	4 390, 659	0	30,00
43.00	04300 NURSERY	180					
+0.00	ANCI LLARY SERVICE COST CENTERS	100	107	130	0,000		43.00
50.00	05000 OPERATING ROOM	4, 608	4,075	4, 104	4 253, 128	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	188					
54.00	05400 RADI OLOGY-DI AGNOSTI C	2,969					1
57.00	05700 CT SCAN						
		401					
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	393			-		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	-		0 0	0	
60.00	06000 LABORATORY	9, 236		.,			
60. 01	06001 BLOOD LABORATORY	0			0 0		
64.00	06400 I NTRAVENOUS THERAPY	25					
65.00	06500 RESPI RATORY THERAPY	0	-				
66.00	06600 PHYSI CAL THERAPY	1, 404					
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(	0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	28	1 2, 264	. 0	69.00
69.02	06902 SLEEP LAB	0	0	80	9 12, 546	0	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 076	0	600	6 63, 327	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	393			72.00
	07300 DRUGS CHARGED TO PATIENTS	693	613				1
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	3, 956			-		1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,,00	0,170	., .,	200,700	0	
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		33, 408	13, 144	23, 790	0 1, 294, 594	0	118.00
118.00	NONREI MBURSABLE COST CENTERS	33,400	13,144	23, 790	J 1, 274, 374	0	118.00
100.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 11, 423		190.00
	19000 GFFT, FLOWER, COFFEE SHOP, & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	0					
		2, 830	0		0 11, 913		192.00
200.00	,	-	-		0		200.00
201.00	5	0	0		0 0		201.00
202.00	TOTAL (sum lines 118-201)	36, 238	13, 144	23, 790	0 1, 317, 930	0	202.00

In Lieu of Form CMS-2552-10

	Financial Systems	COMMUNITY HOSPITAL O	F DREMEN, TNC.		of Form CMS-2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der CCN: 151300	Period: From 05/01/2015 To 04/30/2016	Worksheet B Part II Date/Time Prepared: 9/28/2016 3:48 pm
	Cost Center Description	Total			
		26.00			
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINI STRATI VE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY				16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	390, 659			30.00
30.00 43.00		390, 859 8, 800			
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	8,800			43.00
50.00	05000 OPERATING ROOM	253, 128			50.00
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	902			52.00
52.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	121, 513			54.00
57.00	05700 CT SCAN	5, 736			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 198			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	4,170			59.00
60.00	06000 LABORATORY	99, 171			60.00
60.01	06001 BLOOD LABORATORY				60.01
64.00	06400 I NTRAVENOUS THERAPY	8, 641			64.00
65.00	06500 RESPI RATORY THERAPY	170			65.00
66.00	06600 PHYSI CAL THERAPY	82, 102			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0			67.00
68.00	06800 SPEECH PATHOLOGY	0			68.00
69.00	06900 ELECTROCARDI OLOGY	2, 264			69.00
	06902 SLEEP LAB	12, 546			69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	S 63, 327			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 140			72.00
	07300 DRUGS CHARGED TO PATIENTS	30, 367			73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0			90.00
91.00	09100 EMERGENCY	208, 930			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
	SPECIAL PURPOSE COST CENTERS	· · · · ·			
118.00	SUBTOTALS (SUM OF LINES 1-117)	1, 294, 594			118.00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEE	N 11, 423			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	11, 913			192.00
200.00	Cross Foot Adjustments	0			200.00
		0			
201.00 202.00	5	1, 317, 930			201.00 202.00

Heal th	Financial Systems COM	MUNI TY HOSPI TAL	OF BREMEN, IN	C.	In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eriod:	Worksheet B-1	
					rom 05/01/2015 o 04/30/2016	Date/Time Pre	pared.
						9/28/2016 3:4	
		CAPITAL RELA	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Poconciliation	ADMI NI STRATI VE	
	cost center bescription	FIXT	EQUI P	BENEFITS	Reconciliation	& GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FOOTAGE)	FOOTAGE)	(GROSS		COST)	
				SALARI ES)			
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	5A	5.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	61, 774					1.00
2.00	00200 NEW CAP REL COSTS-BEDG & TTXT	01,774	61, 774				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	231	231	8, 280, 303			4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	5, 153	5, 153			14, 102, 227	5.00
7.00	00700 OPERATION OF PLANT	11, 149	11, 149	172, 816		909, 363	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	220	220	0	0	134, 787	8.00
9.00	00900 HOUSEKEEPI NG	378	378	147, 994	0	213, 584	9.00
10.00	01000 DI ETARY	1, 263	1, 263	44, 075	0	126, 430	10.00
11.00	01100 CAFETERI A	1, 256	1, 256	172, 540		275, 664	
13.00	01300 NURSING ADMINISTRATION	399	399	149, 703		202, 606	
16.00	01600 MEDI CAL RECORDS & LI BRARY	662	662	244, 730	0	431, 433	16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10,000	10,000	781, 561	0	1 241 0/1	1 20 00
	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	12, 223 292	12, 223 292	25, 494	0	1, 341, 961 52, 464	•
43.00	ANCI LLARY SERVICE COST CENTERS	292	292	25, 494	0	32,404	43.00
50, 00	05000 OPERATING ROOM	8, 359	8, 359	1, 001, 358	0	1, 490, 366	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	26, 594		48, 230	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 983	3, 983	471, 955	0	1, 017, 283	•
57.00	05700 CT SCAN	0	0	53, 341	0	374, 174	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	60, 229	0	374, 302	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	2, 410	2, 410	885, 286	0	2, 195, 230	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	300	300	3, 159		48, 061	•
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	19, 482	•
66.00	06600 PHYSI CAL THERAPY	2, 816	2, 816	265, 648		403, 239	•
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	
68.00 69.00		0 72	0 72	0	0	0	68.00
69.00 69.02	06900 ELECTROCARDI OLOGY 06902 SLEEP LAB	449	449	0	0	1, 536 38, 789	
70.02	07000 ELECTROENCEPHALOGRAPHY	449	449		0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 126	2, 126	110, 411	0	523, 732	•
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	2, 120	0	0	222, 511	•
	07300 DRUGS CHARGED TO PATIENTS	799	799	214, 935			
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	6, 814	6, 814	1, 562, 834	0	1, 763, 556	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	(1.054	(1.05)	7 700 450	0.044.545	10 001 700	
118.00		61, 354	61, 354	7, 700, 450	-2, 864, 515	12, 991, 720	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	420	420	0	0	0.061	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	420	420				
200.00		Ŭ	0	577,000	0	1, 101, 340	200.00
200.00							201.00
201.00		1, 317, 930	0	2, 090, 109		2, 864, 515	•
	Part I)	., 5, 750	0	_, ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;		_,,	
203.00		21. 334704	0. 000000	0. 252419		0. 203125	203.00
204.00	Cost to be allocated (per Wkst. B,			4, 928		110, 715	
	Part II)						
205.00				0. 000595		0. 007851	205.00
	11)	I I		l	I	l	I

Heal th	Financial Systems COM	MUNI TY HOSPI TAL	_ OF BREMEN. IN	IC.	In Lie	eu of Form CMS-	2552-10
	LLOCATION - STATISTICAL BASIS			CCN: 151300	Period:	Worksheet B-1	
					From 05/01/2015		norod.
					To 04/30/2016	Date/Time Pre 9/28/2016 3:4	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPIN	G DI ETARY	CAFETERI A	
	·	PLANT	LINEN SERVICE	(SQUARE	(MEALS	(FTE HRS)	
		(SQUARE	(POUNDS	FOOTAGE)	SERVED)		
		F00TAGE)	OF LAUNDRY)				
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS		1	1			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	45 241					5.00
8.00	00800 LAUNDRY & LINEN SERVICE	45, 241					8.00
9.00	00900 HOUSEKEEPING	378		1	13		9.00
10.00	01000 DI ETARY	1, 263		1			10.00
11.00	01100 CAFETERI A	1, 256				180, 818	
13.00	01300 NURSI NG ADMI NI STRATI ON	399				3, 382	
16.00	01600 MEDICAL RECORDS & LIBRARY	662					
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	12, 223	22, 487	12, 22	23 4, 463	26, 141	30.00
43.00	04300 NURSERY	292					
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	8, 359	23, 871	8, 35	59 0	22, 992	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C	157	7	0 0	936	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 983	7, 746	3, 98	33 0	14, 816	54.00
57.00	05700 CT SCAN	C	0		0 0	2,003	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	C	0 0	)	0 0	1, 960	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	C	0 0		0 0	0	59.00
60.00	06000 LABORATORY	2,410	0 0	2,41	10 0	46, 085	60.00
60.01	06001 BLOOD LABORATORY	C	-		0 0	0	
64.00	06400 I NTRAVENOUS THERAPY	300	0	30	0 0	127	
65.00	06500 RESPI RATORY THERAPY	C	C	D	0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	2, 816				7,005	
67.00	06700 OCCUPATI ONAL THERAPY	C	-		0 0	0	
68.00	06800 SPEECH PATHOLOGY	C			0 0	0	
69.00	06900 ELECTROCARDI OLOGY	72			72 0	0	
69.02		449			19 0	0	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 126	-		0	0 5, 367	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,120				0 0	
	07300 DRUGS CHARGED TO PATIENTS	799			-	-	
75.00	OUTPATIENT SERVICE COST CENTERS	177		/	0	5,430	/ 3.00
90.00	09000 CLINIC	C			0 0	0	90.00
91.00	09100 EMERGENCY	6, 814				-	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,011	, 020				92.00
	SPECIAL PURPOSE COST CENTERS	1	1	1			
118.00		44, 821	78, 035	44, 22	4, 463	166, 695	1118.00
	NONREI MBURSABLE COST CENTERS				.,		
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	420	0	) 42	20 0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	C	1, 030		0 0	14, 123	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	1, 094, 077	167, 486	279, 03	37 190, 983	370, 379	202.00
	Part I)						
203.00		24. 183307					
204.00		245, 103	6, 944	12, 41	14 35, 177	36, 238	204.00
	Part II)	_					
205.00		5. 417718	0. 087826	0. 2780	73 7. 881918	0. 200411	205.00
	11)	1	I	1	I	I	I

	Health Financial Systems	COMMUNI TY HOSPI TAL	OF BREMEN, INC.		In Lieu	u of Form CMS-	·2552-10
To         04/30/2016         Date/Time Prove           Cost Center Description         ADMINISTRATION (DIRECT)         RECORDS 4 (DIRECT)         RECORDS 4 (DIRECT)           EXPERAL SERVICE COST CENTERS         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         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	COST ALLOCATION - STATISTICAL BASIS		Provider CC	CN: 151300	Peri od:	Worksheet B-1	1
Cost Center Description         NURSI NG ADM IN STRATURAL         MEDICAL RCORRS & CHARGES & CORRS & CHARGES & CHAR							
Cost Center Description         DNRESI NO BUINT STRATO (DIRECT MSINGE INS) (DIRECT MSINGE INS)					To 04/30/2016		
ADMI NI STRATI ON         RECORDS & UIRCT (0) RECT (0) RECT (		NUDCLNO				9/28/2016 3:4	18 pm
Understand         UD RECT (RS) (KG (RS) CHARGES) 13.00         LBRARY (GROSS CHARGES) 13.00           CENERAL SERVICE COST CENTERS         10.00           1.0         GC100 NEW CAP REL COSTS-BLD.6 & FLXT CHARGES)         10.00           0.00         D0200 NEW CAP REL COSTS-BLD.6 & FLXT CHARGES)         10.00           0.00         D0200 NEW CAP REL COSTS-BLD.6 & FLXT CHARGES)         10.00           0.00         D0200 NEW CAP REL COSTS-BLD.6 & FLXT CHARGES)         10.00           0.00         D0200 NEW CAP REL COSTS-BLD.6 & FLXT CHARGES)         10.00           0.00         D0200 NEW CAP REL COSTS-BLD.6 & FLXT CHARGES)         10.00           0.000 D000 DUTAPS NET NEW CE CONTRACT         0.00           0.00         D100 CAFETERI A 13.00         11.00           10.00         NERS NE ADMI NISTRATI ON 10.00         74.162           0.00         D1000 AULTS & PEDI ATRIC CS         20.141           11.00         D1000 CAFETERI A 13.00         13.00           10.00         NURSENG ADMI NISTRATI ON 03000 ADULTS & PEDI ATRIC CS         22.992           10.00         D5200 DEL VERY ROUA & LABOR ROM 22.737.326         27.73.36           10.00         D500 DEL VERY ROUA & LABOR ROM 27.73.36         27.73.36           10.00 STOD CARDIT RESONANCE I MAGI NE (MRI)         0         1.176.103	LOST CENTER DESCRIPTION						
CONCENT         CORRACS           1: 00         CHARCES           0: 01         CHARCES           0: 02		ADMINI STRATION					
INS.         CHARGES         CHARGES           13.00         13.00         16.00           100         OCIONEW CAP REL COSTS-BLOG & FLXT							
ENERAL SERVICE COST CENTERS         13.00         16.00           1.00         OTIOD NEW CAP REL COSTS-BLUG & FLXT         20.0         00200 NEW CAP REL COSTS-BLUG & FLXT           2.00         OTIOD NEW CAP REL COSTS-MULE EQUIP         10.00         10.00           3.00         OTIOD NEW CAP REL COSTS-MULE EQUIP         10.00           3.00         OTIOD OPERATION OF PLANT         80.00           3.00         00000 DETARY         80.00           3.00         11.00         Status         33.666.255           3.00         10.00 MERSI KA AUMINI STRATION         74.162         31.79.036           3.00         00000 MERSI KA AUMINI STRATION         74.73.736         99.619.75.44           5.00         05000 DELIVERY MOROM		(DI RECT	(GROSS				
ERBERAL SERVICE COST CENTERS           1.00         OUTON RW CAP REL COSTS-HUBCE EQUIP           4.00         OCAD (APL OCAP REL COSTS-HUBCE EQUIP)           6.00         OCAD (APL OCAP REL COSTS-HUBCE EQUIP)           7.00         OTOD OPERATION OF PLANT           8.00         OCAD (AUX) NISTRATIVE & GENERAL           7.00         OTOD OPERATION OF PLANT           8.00         OCADO (AUX) NISTRATIVE & GENERAL           7.00         OTOD OPERATION OF PLANT           8.00         OCADO (AUX) NISTRATION           11.00         OTIOC DETARY           11.00         OTIOC DETARY           11.00         OTIOC APLICE COST CENTERS           00.000000 ADULTS & FEDITARICS         26.141           3.100         OSGOO OPERATING ROOM           22.00         DSGOO DELLVERY KOROM           22.00         DSGOO OPERATING ROOM           00 AGOO CARDALCS*/ DELARTRY         0           2.00         DSGOO DELLVERY KOROM & LABOR ROOM           05.00         DSGOO CARDIA CENTERER LINGING (MRI)           60.00         DSGOO CARDIA CENTERER LINGING (MRI)           70.00         DSGOO CARDIA CENTERER LINGING (MRI)           70.00         DSGOO CARDIA CENTERER LINGING (MRI)           70.00         DSGOO CARDIA CENTERER LINGIN		NRSING HRS)	CHARGES)				
1. 00 00100 NEW CAP REL COSTS-BLOG & FLXT 2. 00 00200 OEW CAP REL COSTS-BLOG & FLXT 0. 00200 OWE CAP REL COSTS-WUELE COULP 0. 00200 OPERATION OF PLANT 0. 00200 OPERATION OF PLANT 0. 00200 OPERATION OF PLANT 10. 00 1000 OFFARTING NEWSTEEPING 10. 00 1000 DI FLARY 11. 00 0100 CAFETERIA 13. 00 10300 AURISING ADMINI STRATION 13. 00 40300 AURISING ADMINI STRATION 14. 00 4000 OPERATING SERVICE COST CENTERS 15. 00 05000 OPERATING ROM 15. 00 5000 CARDIAC CATHETERI ZATION 0 0500 CARDIAC CATHETERI ZATION 0 0 00 0000 CARDIAC CATHETERI ZATION 0 0 00 0000 CARDIAC CATHETERI ZATION 0 0 00 000 CARDIAC CATHETERI ZATION 0 0 00 0000 CARDIAC CATHETERI ZATION 0 0 00 000 CARDIAC CATHETERI ZATION 0 0 00 0000 CARDIAC CATHETERI ZATION 0 0 00 0000 CARDIAC CATHETERI ZATION 0 0 00000 CARDIAC CATHETERI ZATION 0 0 0000 CARDIAC CATHETERI ZATION 0 0 00000 CARDIAC CATHETERI ZATION 0 0 00000 CARDIAC CATHETERI		13.00	16.00				
1. 00 00100 NEW CAP REL COSTS-BLOG & FLXT 2. 00 00200 OEW CAP REL COSTS-BLOG & FLXT 0. 00200 OWE CAP REL COSTS-WUELE COULP 0. 00200 OPERATION OF PLANT 0. 00200 OPERATION OF PLANT 0. 00200 OPERATION OF PLANT 10. 00 1000 OFFARTING NEWSTEEPING 10. 00 1000 DI FLARY 11. 00 0100 CAFETERIA 13. 00 10300 AURISING ADMINI STRATION 13. 00 40300 AURISING ADMINI STRATION 14. 00 4000 OPERATING SERVICE COST CENTERS 15. 00 05000 OPERATING ROM 15. 00 5000 CARDIAC CATHETERI ZATION 0 0500 CARDIAC CATHETERI ZATION 0 0 00 0000 CARDIAC CATHETERI ZATION 0 0 00 0000 CARDIAC CATHETERI ZATION 0 0 00 000 CARDIAC CATHETERI ZATION 0 0 00 0000 CARDIAC CATHETERI ZATION 0 0 00 000 CARDIAC CATHETERI ZATION 0 0 00 0000 CARDIAC CATHETERI ZATION 0 0 00 0000 CARDIAC CATHETERI ZATION 0 0 00000 CARDIAC CATHETERI ZATION 0 0 0000 CARDIAC CATHETERI ZATION 0 0 00000 CARDIAC CATHETERI ZATION 0 0 00000 CARDIAC CATHETERI	GENERAL SERVICE COST CENTERS		· · ·				
2.00         002200 KEV CAP REL COSTS_NVELE EQUIP           4.00         004500 KEVICYSE DEVENT IS DEPARTIMENT           5.00         005500 ADM IN STRATIVE & GENERAL           7.00         00700 OPERATION OF PLANT           8.00         008500 LAUNDRY & LINEN SERVICE           9.00         00900 MUSEKEEPI NG           11.00         01100 OFECATION OF CROSS & LIBRARY           0.01         0100 MUELCAL RECORDS & LIBRARY           0.00         0300 AULTS & PEDIATRICS           0.01         04300 MUESTARY           ANDI CLARY SERVICE COST CENTERS           3.00         04300 DELIVERY ROUM & LABOR ROOM           926         197, 544           5.00         05600 DELIVERY ROUM & LABOR ROOM           936         05600 DELIVERY ROUM & LABOR ROOM           936         05600 MARDIT & RESONANCE I MAGING (MRI)           0         1, 176, 303           930         05600 DELIVERY ROUM & LABORATORY           0         0, 4000 CLABORATORY           0         0, 4000 CLABORATORY           0         0, 4000 CLABORATORY           0         0, 42, 317, 336           0         05600 MARDIT I C RESONANCE I MAGING (MRI)           1, 176, 303         0           0         0 <td></td> <td>т</td> <td></td> <td></td> <td></td> <td></td> <td>1.00</td>		т					1.00
4. 00         00400 [MM INSTRATIVE & GENEFITS DEPARTMENT           7. 00         00700 OPERATION OF PLANT           8. 00         00800 (ANDI NISTRATION OF PLANT           8. 00         00800 (ANDI NISTRATION OF PLANT           10. 00         00700 OPERATION OF PLANT           11. 00         0100 (ANDI NISTRATION           11. 00         01100 (AFETERIA           13. 00         01300 MURSI NA SAMINI STRATION           11. 00         01400 MURSI NA SAMINI STRATION           11. 00         11000 CAFETERIA           11. 00         01400 MURSI NA SAMINI STRATICS           11. 00         03000 ADULTS & PEDI ATRICS           11. 00         000 OS000 MURSERY           11. 00         0500 OFERATI NE ROOM           11. 00         0500 OFERATI NE ROOM           11. 00         0500 OC ABDI ACCATHETERI ZATION           11. 00         0500 OC ABDIA CCATHETERI ZATION           11. 00         0500 OC ABDIA CCATHETERI ZATION           11. 00         0500 OC ABDIA CCATHETERI ZATION           11.							2.00
5. 00         000500 APM IN STRATTIVE & GENERAL							4.00
7.00       00700       OPERATION OF PLANT         8.00       00800       LANDRY & LINEN SERVICE         9.00       00900       HOUSEKEEPING         11.00       01100       CAFTERIA         13.00       01300       MUSING ADMINISTRATION       74, 162         11.00       OH600       HEDICAL RECORDS & LIBBARY       0       33, 686, 255         10.00       01000       NUSING RADIALISTS & LIBBARY       0       33, 686, 255         10.01       CASTERIA       SPEDIATRICE       0       33, 686, 255         10.00       MICLLARY SERVICE COST CENTERS       690       184, 613         ANCLLARY SERVICE COST CENTERS       0       22, 992       5, 813, 295         50.00       05000 OPELIVERY ROMA & LABOR ROOM       92, 6177, 544         51.00       05000 INCUST RESONANCE IMAGING (MRI)       0       1, 176, 303         50.00       05000 ARADIC CATHETERIZATION       0       0       0         50.00       05000 ARADIC CATHETERIZATION       0       1, 176, 303         50.00       05000 ARADIC NETHETERIZATION       0       1, 176, 303         50.00       05000 ARADIC NESPI RATORY       0       1, 29, 20         60.00       066000 INSDUCAL ABORATORY       0							5.00
8. 00         00000         LAUNRY & LINEN SERVICE            9.00         00700         POUSEKEEPING            13. 00         01300         NUESING ADMINISTRATION         74, 162           16. 00         16000         MEDICAL RECORDS & LIBRARY         0         33, 66, 255           10. 00         OBJOO NUESICAL RECORDS & LIBRARY         0         33, 66, 255           10. 00         ODUEDICAL RECORDS & LIBRARY         0         33, 66, 255           10. 00         ODUEDICAL RECORDS & LIBRARY         0         33, 66, 255           10. 00         ODUEDICAL RECORDS & LIBRARY         0         33, 66, 255           10. 00         ODUEDICEPT ROUTINE SERVICE COST CENTERS         26, 141         3, 179, 036           10. 00         ODUEDICEPT ROUM & LABOR ROOM         22, 992         5, 613, 295           50. 00         OSECOL DELIVERY ROUM & LABOR ROOM         3, 349, 165         57.00           51.00         OSECOL DELIVERY ROUM & LABOR ROOM         22, 992         5, 613, 295           50.00         DESIDERT RESONAUCE IMAGING (MRI)         0         1, 176, 303           57.00         OSECOL DALAC CATHETERIZATION         0         0           60.00         LABORATORY         0         0         2, 727							
9 0.00 00000 HOUSEKEEPING 10 00 1010 OLETARY 11 0.0 01100 CAFETERIA 13 00 01300 NURSING ADMINISTRATION 14 00 01500 NURSING ADMINISTRATION 15 0.0 01500 NURSING ADMINISTRATION 15 0.0 01500 NURSING ADMINISTRATION 15 0.0 01500 NURSING ADMINISTRATION 16 01100 NURSERY 17 0.0 01500 NURSING SERVICE COST CENTERS 17 00 05000 OPERATING ROOM 22.992 5.813.295 20 05200 DELIVERY ROOM & LABOR ROOM 22.992 5.813.295 20 05200 DELIVERY ROOM & LABOR ROOM 22.992 5.813.295 20 05200 DELIVERY ROOM & LABOR ROOM 22.992 5.813.295 20 05200 DELIVERY ROOM & LABOR ROOM 22.992 5.813.295 20 05200 DELIVERY ROOM & LABOR ROOM 22.992 5.813.295 20 05200 DELIVERY ROOM & LABOR ROOM 23.00 05400 RADIA CATHETRI ZATION 0 0, 2, 727.336 5.00 0500 CARDIA CATHETRI ZATION 0 0, 3 0 05000 LABORATORY 0 0, 9, 947.566 0 05600 LABORATORY 0 0, 9, 947.566 0 05600 RESPIRATORY DI CATHETRI ZATION 0 0, 0 0 0000 LBLOOD LABORATORY 0 126.0ESD 0 0500 CERSPIRATORY DI CALSPRAY 0 126.822 0 05200 DELIVERY RADARTORY 0 126.0ESD 0 0500 CERSPIRATORY DI CALSPRAY 0 126.0ESD 0 0500 DELIVERY RADARTORY 0 126.0ESD 0 0500 CERSPIRATORY DI CALSPRAY 0 126.0ESD 0 0500 DELIVERY RADARTORY 0 126.0ESD 0 0500 DELIVERY RADARTORY 0 126.0ESD 0 0500 DELEVING THERAPY 0 126.0ESD 0 0500 DELEVING THERAPY 0 126.0ESD 0 0500 DELEVING 0 0700 DELIVERY RADARTORY 0 0 0 0 0000 CLECTROCATAL THERAPY 0 126.0ESD 0 0500 DELEVING 0 0500 DELEVING 0 0 000 0 0000 CLECTROCATAL THERAPY 0 126.0E3 0 0500 DELEVING 0 0 000 0 0000 CLECTROCATAL THERAPY 0 126.0E3 0 0500 DELEVING 0 0 000 0 0000 CLECTROCATAL ORGAPHY 0 126.0E4 0 0 0 0000 CLECTROCATAL ORGAPHY 0 0 0 00							7.00
10:00       01000       DITARY       74, 162         13:00       01300       NURSING ADMINISTRATION       74, 162         16:00       01500       NURSING ADMINISTRATION       74, 162         16:00       01500       NURSING ADMINISTRATION       74, 162         10:00       NURSIEN       01300       NURSIEN         10:00       NURSIEN       01300       NURSIEN         10:00       OUDOR (ADULTS & PEDIATRICS       20, 141       3, 179, 036         30:00       02000       ADMINISTRATION       22, 992       5, 813, 295         50:00       05000       DEDIADR ROM       22, 992       5, 813, 295         50:00       05000       ROM ROMO       22, 992       5, 813, 295         50:00       05000       RADIO RADUCORY - DI AGNOSTIC       0       2, 737, 336         50:00       05000       ALBOR ADORY       0       1, 176, 303         59:00       05900       ADORIAC CATHETERIZATION       0       1, 176, 303         60:00       06000       INDERVISHERADRY       0       14, 637         60:00       06000       INTEAVENDUS THERAPY       0       14, 637         60:00       060000       INTEAVENDUS THERAPY       0							8.00
11.00       01100       CAFETERIA       74, 162         16.00       01600       MEDICAL       RECORDS & LIBRARY       0       33, 686, 255         10.00       MARTIENT ROUTINE SERVICE COST CENTERS       30, 179, 036       33, 686, 255         30.00       03000       AURLTS & PEDIATRICS       20, 141       3, 179, 036         30.00       03000       AURLTS & PEDIATRICS       20, 141       3, 179, 036         30.00       05000       PERATING ROOM       22, 992       5, 813, 295         50.00       05000       DELIVERY ROOM & LABOR ROOM       936       197, 544         50.00       05000       DELIVERY ROOM & LABOR ROOM       936       197, 544         58.00       05000       CARDACTHETERIZATION       0       3, 349, 165         59.00       05000       CARDACTHETERIZATION       0       1, 176, 303         60.00       06000       LABORATORY       0       0       0         60.00       06000       LABORATORY       0       12, 822       0         61.00       06000       LABORATORY       0       0       24, 637         66.00       06000       DENATORY THERAPY       0       126, 084       0         67.00							9.00
13.00       01300 NURSI NG ADMI NI STRATI ON       74, 162         10.00       1600 OLGOM MEDI CAL RECORDS & LI BRARY       0         00       02000 ADULTS & FCIDATRI CS       26, 141         04.300       NURSERY       898         04.300       NURSERY       998         0500       05000       PEDIATRI CS COST CENTERS       998         04.000       NUCLIARY SERVICE COST CENTERS       996         0500       05200       DELIVERY ROOM & LABOR ROOM       936         0510       CR SCOLO RADI USERY FUCOL A LABOR ROOM       936         0500       ORDON RADUET C RESONANCE I MAGI NG (MRI )       0       1, 176, 303         0500       OS900       LABOR ROTY       0       9, 947, 566         060       06000       LABORATORY       0       9, 947, 566         000       0       0       0       0         0100       LECTROCARDI ULOGY       0       1, 179, 129         0200       LECTROCARDI ULOGY       0       1, 179, 129         0400       OR000       LECTROCARDI ULOGY       0       0         05000       LECTROCARDI ULOGY       0       0       0         06000       SPECH PATHOLOGY       0       0							10.00
16. 00         OTGOO MEDICAL RECORDS & LIBRARY         0         33, 686, 255           30. 00         03000 ADULTS & PEDIATRICS         26, 141         3, 179, 036           43. 00         04300 NURSERY         098         184, 0.13           AKCILLARY SERVICE COST CENTERS         098         184, 0.13           AKCILLARY SERVICE COST CENTERS         0         50.00         05000 DELIVERY NOM & LABOR ROM         23, 295           50. 00         05000 DELIVERY NOM & LABOR ROM         936         197, 584           51. 00         05000 CT SCAN         0         3, 349, 165           58. 00         05800 MARETIC RESONANCE IMAGING (MRI)         0         1, 176, 303           59. 00         05900 CARDIA CATHETERIZATI ON         0         0         0           60. 01         06000 LABORATORY         0         1, 176, 303         0           59. 00         05900 OKAPATIAC CATHETERIZATI ON         0         0         0           60. 01         06000 LABORATORY         0         1, 172, 132         0           60. 01         06000 LABORATORY         0         1, 172, 129         0         1, 172, 129           61. 00 GAODO OCLAPATIONAL THERAPY         0         1, 172, 129         0         0         0      <	11. 00 01100 CAFETERI A						11.00
16. 00         Ordeol MEDI CAL RECORDS & LIBRARY         0         33, 686, 255           30. 00         OULTS & PEDI ATRI CS         26, 141         3, 179, 036           43. 00         O3000 ADULTS & PEDI ATRI CS         26, 141         3, 179, 036           ARCILLARY SERVICE COST CENTERS         898         184, 613           ARCILLARY SERVICE COST CENTERS         0         50. 00         05000 DELI VERY NOM & LABOR ROM         926           50. 00         05000 DELI VERY NOM & LABOR ROM         936         197, 544           54. 00         05400 RADI OLOGY-DI AGNOSTI C         0         2, 73, 336           57. 00         05700 CT SCAN         0         3, 349, 165           58. 00         05600 CARDI AC CATHETER IZATI ON         0         0         0           59. 00         05600 CARDI AC CATHETER IZATI ON         0         0         0           64. 00         06400 INTRAVENDUS THERAPY         0         12, 75, 832         0           65. 00         06500 OPHYSI CAL THERAPY         0         1, 179, 129         0         0           66. 00         06000 PHYSI CAL THERAPY         0         1, 179, 129         0         0         0           67. 00         05900 ELECTROCARDI OLOCY         0         0	13.00 01300 NURSING ADMINISTRATION	74, 162					13.00
INPATIENT ROUTINE SERVICE COST CENTERS           30.00         COMO ADULTS & PEDIATRICS         26, 14, 1         3, 179, 036           43.00         CASOO (PERATING ROM         22, 992         5, 813, 295           50.00         CSOO (OPERATING ROM         22, 992         5, 813, 295           50.00         CSOO OPERATING ROM         22, 992         5, 813, 295           50.00         CSOO OPERATING ROM         2, 737, 336           57.00         CSOO CADUTC S & CAN         0         3, 349, 165           58.00         CSOO CADUTC C & CATHETERIZATION         0         1, 176, 303           59.00         CARDIA CORTATORY         0         0         0           66.00         DEGOO CRESPIR ATORY THERAPY         0         24, 637         0           66.00         OBCOO RESPIRATORY THERAPY         0         24, 637         0           66.00         OBCOO RESPIRATORY THERAPY         0         1, 179, 129         0           67.00         CARDIO LAGORATORY         0         0         0           68.00         OBCOO CREADINAL THERAPY         0         1, 179, 129         0           69.00         CARDIA CORTACRY         0         0         0           69.00         OBCOO CREADINAL							16.00
30.00       0000       AULTS & PEDIATRICS       26, 141       3, 179, 036         43.00       04300       NURSERY       898       184, 613         ANCILLARY SERVICE COST CENTERS       5.813, 295         50.00       DSCOOL DELIVERY ROOM & LABOR ROOM       92, 992       5.813, 295         51.00       DSCOOL DELIVERY ROOM & LABOR ROOM       936       197, 544         50.00       DSCOOL CASCAN       0       3, 349, 165         50.00       DSGOOL CARDIAC CATHETERIZATION       0       1, 176, 303         59.00       DSGOOL CARDIAC CATHETERIZATION       0       9, 947, 556         60.01       DGOOL LABORATORY       0       9, 947, 556         60.00       OSGOOL CARDIAC CATHERAPY       0       182, 822         65.00       OSGOO PERSICAL THERAPY       0       182, 822         66.00       OSGOOL ELECTROCARDIOLOGY       0       398, 707         67.00       OCTOOCUPATI ONAL THERAPY       0       126, 084         67.00       OCOOL ELECTROCARDIOLOGRAPHY       0       0         68.00       OBGOOD ELECTROCARDIOLOGRAPHY       0       0         71.00       OTOON ELECTROCARDIOLOGRAPHY       0       0       0         72.00       DOCOOL ELECTROCARDIOLO			00,000,200				-
43.00         Q4300         QUSERY         898         184.613           ANCILLARY SERVICE COST CENTERS         50.00         DSC000         OPERATING ROOM         926.992         5.813.295           52.00         DSC000 CPERATING ROOM         936         177.544         50.00           54.00         DSC000 RADICIOCOT-DIAGNOSTIC         0         2.737.336           57.00         DSC000 MACNETIC RESONANCE I MAGING (MRI)         0         1.776.303           59.00         DSC000 LABORATORY         0         9.947.566           60.01         GOOD LABORATORY         0         9.947.566           60.00         DSC00 OCLEDERTRY THERAPY         0         182.822           65.00         DSC00 ORESPI RATORY THERAPY         0         1.179, 129           67.00         DSC00 ORESPI RATORY THERAPY         0         1.179, 129           67.00         DSC00 ORESPI RATORY THERAPY         0         1.179, 129           67.00         DSC00 ORESPI RATORY THERAPY         0         1.00           68.00         DBEDCI CARDIOLOGY         0         0         0           69.00         G9000         CLECTROENCEPHALLOGRAPHY         0         1.68, 414         0           70.00         DSCORDELCTROENCEPHALLOGRAPHY </td <td></td> <td></td> <td>2 170 026</td> <td></td> <td></td> <td></td> <td>30.00</td>			2 170 026				30.00
ANCI LLARY SERVICE COST CENTERS           50.00         05000 OPERATING ROOM         22,992         5,813,295           52.00         05200 DELLVERY ROOM & LABOR ROOM         936         197,544           54.00         05200 DELLVERY ROOM & LABOR TIC         0         2,737,336           57.00         05700 CT SCAN         0         3,349,165           58.00         05800 MAGNETIC CENDANCE IMAGING (MRI )         0         1,176,303           59.00         05900 CARDIA CATHERIZATION         0         0           60.00         06000 LABORATORY         0         9,947,566           60.01         06000 INTRAVENUOS THERAPY         0         182,822           65.00         06500 RESPI RATORY THERAPY         0         1,179,129           67.00         06700 OCCUPATI ONAL THERAPY         0         1,179,129           67.00         06700 OCCUPATI ONAL THERAPY         0         1,179,129           67.00         06700 OCCUPATI ONAL THERAPY         0         0           68.00         06800 SPEECH PATHOLOGY         0         0           69.00         06900 ELECT ROCARDI OLOGY         0         398,707           69.00         06900 ELECT NOCEPHALOGRAPHY         0         0           70.00							
50.00     05000     0PERATING ROOM     22,992     5,813,295       52.00     05200     DELIVERY ROOM & LABOR ROOM     936     197,544       54.00     05400     RADIOLOGY-DIAGNOSTIC     0     2,737,336       57.00     05700     CT SCAN     0     3,349,165       58.00     05800     MARDIAC CATHETERIZATION     0     1,176,303       59.00     05900     CARDIAC CATHETERIZATION     0     0       60.01     06001     BLOOD LABORATORY     0     0       64.00     06400     INTRAVENUS THERAPY     0     182,822       65.00     06500 RESPI RATORY THERAPY     0     1,179,129       67.00     06600     PHYSICAL THERAPY     0     1,179,129       67.00     06600 SPEECH PATHOLOGY     0     0       68.00     06600 SPEECH PATHOLOGY     0     0       69.00     06600 SPEECH PATHOLOGY     0     0       69.00     06900     ELECTROCARDIALORAPHY     0     126,084       70.00     07200 IMPL. DEV. CHARGED TO PATIENTS     3,456     1,684,152       0017HOU MEDICAL SUPPLIES CHARGED TO PATIENTS     0     556,279       73.00     07300 DRUGS CHARGED TO PATIENTS     3,456     1,684,152       0017000 EMERGENCY     19,739		898	184, 613				43.00
52.00     05200     DELIVERY ROOM & LABOR ROOM     936     197, 544       54.00     05400     RADIOLOGY-DIAGNOSTIC     0     2, 737, 336       57.00     05700     CT SCAN     0     3, 349, 165       58.00     05800     MAGNETIC RESONANCE IMAGING (MRI)     0     1, 176, 303       59.00     05900     CARDIAC CATHETERI ZATION     0     0       60.01     06400     INTRAVENOUS THERAPY     0     182, 822       65.00     06500     RESPI RATORY THERAPY     0     14, 637       66.00     06600     INTRAVENOUS THERAPY     0     1, 179, 129       67.00     06700     0     0     0       68.00     06600     SPECIAL THERAPY     0     1, 179, 129       67.00     06700     0     0     0       69.00     06900     ELECTROCARDI OLOGY     0     0       69.00     06900     ELECTROCARDI OLOGY     0     0       71.00     07100     MEDI CAL SUPPLIES CHARGED TO PATIENTS     0     888, 414       72.00     07200     INPL     EV <charged patients<="" td="" to="">     0     2, 091, 173       7300     DRUGS CHARGED TO PATIENTS     0     2, 091, 173     2, 091, 173       79200     09200     DESCHARTION B</charged>			1 1				4
54.00     05400     RADI OLOGY - DI AGNOSTI C     0     2, 737, 336       57.00     05700     CT SCAN     0     3, 349, 165       58.00     05800     MAGNETI C RESONANCE I MAGI NG (MRI )     0     1, 176, 303       59.00     05900     CARDI AC CATHETERI ZATI ON     0     0       60.00     06000     LBOOR LABORATORY     0     9, 947, 566       60.01     06001     BLOOD LABORATORY     0     1, 179, 129       66.00     06500     RSPI RATORY THERAPY     0     182, 822       66.00     06600     PHYSI CAL THERAPY     0     1, 179, 129       67.00     06700     OCCUPATI ONAL THERAPY     0     1, 179, 129       67.00     06700     OCCUPATI ONAL THERAPY     0     1, 179, 129       67.00     06700     OCCUPATI ONAL THERAPY     0     0       68.00     06600     SPECH PATHOLOGY     0     0       69.00     06900     ELECTROCARDI OLOGY     0     0       69.00     06900     ELECTROCARDI OLOGY     0     0       71.00     07100     MEDI CAL SUPPLIES CHARGED TO PATI ENTS     0     56, 279       72.00     07200     IMPL. DEV. CHARGED TO PATI ENTS     0     56, 279       73.00     07300		22, 992	5, 813, 295				50.00
57.00       05700       CT SCAN       0       3, 349, 165         58.00       05800       MAGNETIC RESONANCE I MAGING (MRI)       0       1, 176, 303         59.00       05900       CARDIAC CATHETRIZATION       0       0         60.00       DABORATORY       0       9, 947, 566         60.01       D6600       INTRAVENOUS THERAPY       0       182, 822         65.00       O6500       RSPI RATORY THERAPY       0       24, 637         66.00       O6600       PHSI CAL THERAPY       0       24, 637         67.00       06600       DECETROCARDI LOGY       0       0         68.00       O6600       SPECH PATHOLOGY       0       0         69.00       O6900       ELECTROCARDI LOGY       0       0         69.00       O6900       ELECTROCARDI LOGY       0       0         71.00       O7100       IML       DECTRORADERCERDI TO PATIENTS       0       556, 279         73.00       O7300       RU30       GAMAGE COST CENTERS       0       0         72.00       OP300       ELETRORENCY       19, 739       2, 091, 173         79.00       O9100       ELETRORENCY       19, 739       2, 091, 173	52.00 05200 DELIVERY ROOM & LABOR ROOM	936	197, 544				52.00
58.00       05800       MAGNETIC RESONANCE HANGING (MRI)       0       1, 176, 303         59.00       05900       CARDI AC CATHETERI ZATION       0       0         60.01       06000       LABORATORY       0       9, 947, 566         60.01       06000       LABORATORY       0       9, 947, 566         61.01       06400       INTRAVENUS THERAPY       0       182, 822         65.00       06500       RESPIRATORY THERAPY       0       1, 179, 129         66.00       06600       PHYSI CAL THERAPY       0       1, 179, 129         67.00       06700       000       0       0         68.00       06800       SPEECH PATHOLOGY       0       0       0         69.00       06900       ELECTROEADIOLOGY       0       398, 707         69.00       07000       ELECTROEADIOLOGRAPHY       0       0         70.00       07100       MDIGS CHARGED TO PATIENTS       0       556, 279         73.00       07300       DRUGS CHARGED TO PATIENTS       3, 456       1, 684, 152         001700       DRUGS CHARGED TO PATIENTS       3, 456       1, 684, 152         01.00       09000       ELECTROENCENTERS       9       0	54.00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 737, 336				54.00
58.00       05800       MAGNETIC RESONANCE IMAGING (MRI)       0       1,176,303         59.00       05900       CARDIAC CATHETERIZATION       0       0         60.01       06000       LABORATORY       0       9,947,566         60.01       06400       INTRAVENUS THERAPY       0       182,822         65.00       06500       RESPIRATORY THERAPY       0       1,179,129         66.00       06600       PHYSI CAL THERAPY       0       1,179,129         67.00       06700       00       0       0         68.00       06800       SPECH PATHOLOGY       0       0         69.00       06900       ELECTROCARDIOLOGY       0       0         69.00       06900       ELECTROENCEPHALOGRAPHY       0       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0         71.00       07100       MPL DEV. CHARGED TO PATIENTS       0       556,279         73.00       07200       IMPL. DEV. CHARGED TO PATIENTS       3,456       1,684,152         001900       ELEGTROENCE COST CENTERS       9       0       0         90.00       09000       ELEGTROENCENTORS       0       0         90	57.00 05700 CT SCAN	0	3, 349, 165				57.00
59.00       05900       CARDIAC CATHETERIZATION       0       0         60.00       06000       LABORATORY       0       9,947,566         60.01       06001       BLODD LABORATORY       0       182,822         65.00       06500       RESPIRATORY THERAPY       0       182,822         65.00       06500       PHYSI CAL THERAPY       0       1,179,129         67.00       06600       PHYSI CAL THERAPY       0       0         68.00       06600       SPEECH PATHOLOGY       0       0         69.00       06900       ELECTROCARDIOLOGY       0       0         69.00       06900       ELECTROCARDIOLOGY       0       0         70.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       126,084         71.00       07100 MEDICAL SUPPLIES CHARGED TO PATIENTS       0       556,279         73.00       07300       PRUSCIALCOST CENTERS       0       0         90.00       09100       ELNISC (NON-DISTINCT PART)       9       0       0         91.00       09100       ELNISC (NON-DISTINCT PART)       74,162       33,686,255       0         118.00       SUBTOTALS (SUM OF LINES 1-117)       74,162       33		MRL) 0					58.00
60.00       06000       LABORATORY       0       9,947,566         60.01       06001       BLOOD LABORATORY       0       0         64.00       06400       INTRAVENOUS THERAPY       0       182,822         65.00       06500       RESPIRATORY THERAPY       0       1,179,129         67.00       06700       0CCUPATIONAL THERAPY       0       1,179,129         67.00       06700       0CCUPATIONAL THERAPY       0       0         68.00       06800       SPEECH PATHOLOGY       0       0         69.00       06900       ELECTROCACEPHALOGRAPHY       0       398,707         69.02       06902       SLEEP LAB       0       126,084         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0         70.00       07200 IMPL       DEV. CHARGED TO PATIENTS       0       858,414         72.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0         04000       CLINIC       0       0       0       0         04100       EMERGENCY       19,739       2,091,173       0         92.00       DSECVALINIC COST CENTERS       1100       0       0 <t< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td>59.00</td></t<>		0					59.00
60.01       06001       BLOOD LABORATORY       0       0         64.00       06400       INTRAVENUUS THERAPY       0       182,822         65.00       06500       RESPIRATORY THERAPY       0       1,179,129         67.00       06500       PRESPIRATORY THERAPY       0       1,179,129         67.00       06500       PRESPIRATORY THERAPY       0       0         68.00       06600       PHECH PATHOLOGY       0       0         69.00       06900       ELECTROCARDIOLOGY       0       398,707         69.00       069002       SLEEP LAB       0       126,084         70.00       07000       ELECTROCARDIOLOGY       0       0         70.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       858,414         72.00       07200       INPL. DEV. CHARGED TO PATIENTS       0       556,279         73.00       07000       CLARGED TO PATIENTS       3,456       1,684,152         0UTPATIENT SERVICE COST CENTERS       0       0       0         90.00       09000       CLINIC       19,739       2,091,173         92.00       09200       DSERVATION BEDS (NON-DISTINCT PART)       33,686,255         90		0					60.00
64.00       06400       INTRAVENUUS THERAPY       0       182,822         65.00       06500       RESPI RATORY THERAPY       0       24,637         60.00       06600       PHYSI CAL THERAPY       0       1,179,129         67.00       06700       0CCUPATI ONAL THERAPY       0       0         68.00       06800       SPEECH PATHOLOGY       0       0         69.00       06900       ELECTROCARDIOLOGY       0       398,707         69.01       06900       ELECTROENCEPHALOGRAPHY       0       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       858,414         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       556,279         73.00       07300       DRUGS CHARGED TO PATI ENTS       3,456       1,684,152         001741       ENT EEWI CE COST CENTERS       0       0         90.00       09000       CLINIC       0       0         91.00       09100       EMEREMACHY       19,739       2,091,173         92.00       0SEVANTION BEDS (NON-DI STI NCT PART)       33,686,255       0		0	9, 947, 500				
65.00       06500       RESPI RATORY THERAPY       0       24,637         66.00       06600       PHYSI CAL THERAPY       0       1,179,129         67.00       06700       0CUPATI ONAL THERAPY       0       0         68.00       06800       SPEECH PATHOLOGY       0       0         69.00       06902       SLEEP LAB       0       126,084         0.00       07000       ELECTROCARDI OLOGY       0       0         0.01       07000       ELECTROCARDI OLOGY       0       0         0.02       06902       SLEEP LAB       0       126,084         0.00       07000       ELECTROCARDI OLOGY       0       0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       858,414         72.00       07300       PRUGS CHARGED TO PATI ENTS       3,456       1,684,152         001704       IMPL.       DEV. CHARGENCY       19,739       2,091,173         90.00       O9000       CLINIC       0       0       0         90.00       O9100       EMERGENCY       19,739       2,091,173       92,091,173         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       NONREI MBURSABLE		0	100,000				60.01
66.00       06600       PHYSICAL THERAPY       0       1, 179, 129         67.00       06700       OCCUPATIONAL THERAPY       0       0         68.00       SPEECH PATHOLOGY       0       0         69.00       06900       ELECTROCARDIOLOGY       0       398, 707         69.02       SEEP LAB       0       126, 084       0         70.00       07000       ELCTROCARDIOLAL SUPPLIES CHARGED TO PATIENTS       0       0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       556, 279         73.00       07300       DRUGS CHARGED TO PATIENTS       0       556, 279         73.00       09000       CLI NIC       0       0         90.00       O9000       EMERGENCY       19, 739       2, 091, 173         92.00       092000       OBSERVATION BEDS (NON-DI STINCT PART)       33, 686, 255       5         NONREI MBURSABLE COST CENTERS         18.00       SUBTOTALS (SUM OF LINES 1-117)       74, 162       33, 686, 255         NONREI MBURSABLE COST CENTERS         190.00       FIV ATE OFFICES       0       0         192.00       PHYSI CLANS' PRI VATE OFFICES       0       0		0					64.00
67.00       06700       OCCUPATIONAL THERAPY       0       0         68.00       06800       SPEECH PATHOLOGY       0       0         69.00       06900       ELECTROCARDIOLOGY       0       398,707         69.02       06902       SLEEP LAB       0       126,084         70.00       07000       ELECTROCRPHALOGRAPHY       0       0         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       858,414         72.00       07200 I MPL.       DEV. CHARGED TO PATIENTS       0       556,279         73.00       07300       DRUGS CHARGED TO PATIENTS       3,456       1,684,152         OUTPATIENT SERVICE COST CENTERS       0       0       0         90.00       O9000       CLINIC       19,739       2,091,173         92.00       OSERVATION BEDS (NON-DISTINCT PART)       59ECIAL PURPOSE COST CENTERS       50         118.00       SPECIAL PURPOSE COST CENTERS       0       0       0         192.00       19200       GREAT, FLOWER, COFFEE SHOP, & CANTEEN       0       0         192.00       19200       GHYSI CLANS' PRI VATE OFFICES       0       0         201.00       Negative Cost Centers       0       0       0 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td>65.00</td>		0					65.00
68.00       06800       SPEECH PATHOLOGY       0       0         69.00       06900       ELECTROCARDIOLOGY       0       398,707         69.02       06902       SLEEP LAB       0       126,084         70.00       OTOOD       ELECTROCKCPHALOGRAPHY       0       0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       858,414         72.00       07200       INPL. DEV. CHARGED TO PATIENTS       0       556,279         73.00       DRUGS CHARGED TO PATIENTS       3,456       1,684,152         OUTPATIENT SERVICE COST CENTERS       0       0         90.00       09000       CLINIC       0       0         91.00       D9100       EMERGENCY       19,739       2,091,173         92.00       09200       0BSERVATION BEDS (NON-DISTINCT PART)       5         SPECIAL PURPOSE COST CENTERS       190.00       SUBTOTALS (SUM OF LINES 1-117)       74,162       33,686,255         190.00       GIPCON GIFT, FLOWER, COFFEE SHOP, & CANTEEN       0       0       0         192.00       PHYSI CLANS' PRI VATE OFFICES       0       0       0         200.00       Cross Foot Adj ustments       262,831       563,361	66. 00 06600 PHYSI CAL THERAPY	0	1, 179, 129				66.00
69.00       06900       ELECTROCARDIOLOGY       0       398,707         69.00       06902       SLEEP LAB       0       126,084         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       858,414         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       556,279         73.00       07300       DRUGS CHARGED TO PATIENTS       0       556,279         70.00       09000       CLINIC       0       0         90.00       09000       ELERGENCY       19,739       2,091,173         92.00       092000       DESERVATION BEDS (NON-DI STINCT PART)       19,739       2,091,173         92.00       OSUBTOTALS (SUM OF LINES 1-117)       74,162       33,686,255         NONREL MBURSABLE COST CENTERS       0       0         18.00       SUBTOTALS (SUM OF LINES 1-117)       74,162       33,686,255         NONREL MBURSABLE COST CENTERS       0       0       0         192.00       PHYSI CLANS' PRIVATE OFFICES       0       0         200.00       Cross Foot Adj ustments       20       0       0         201.00       Negative Cost	67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
69.02       06902       SLEEP LAB       0       126,084         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       858,414         72.00       07200 IMPL. DEV. CHARGED TO PATI ENTS       0       556,279         73.00       07300 DRUGS CHARGED TO PATI ENTS       3,456       1,684,152         OUTPATI ENT SERVICE COST CENTERS         90.00       090000       CLINIC       0       0         91.00       09000 OLINIC       0       0       0         92.00       09200 IDSERVATI ON BEDS (NON-DI STI NCT PART)       19,739       2,091,173         SPECIAL PURPOSE COST CENTERS         118.00       SUBTOTALS (SUM OF LINES 1-117)       74,162       33,686,255         NONREI MBURSABLE COST CENTERS         190.00       GI FT, FLOWER, COFFEE SHOP, & CANTEEN       0       0         192.00       PHYSI CLANS' PRI VATE OFFI CES       0       0         200.00       Cross Foot Adj ustments       0       0         201.00       Negati ve Cost Centers       0       0         202.00       Cost to be al I ocated (per Wkst. B, Part I)       3.544012       0.	68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69.02       06902       SLEEP LAB       0       126,084         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       858,414         72.00       07200 IMPL. DEV. CHARGED TO PATI ENTS       0       556,279         73.00       07300 DRUGS CHARGED TO PATI ENTS       3,456       1,684,152         OUTPATI ENT SERVICE COST CENTERS         90.00       090000       CLINIC       0       0         91.00       09000 OLINIC       0       0       0         92.00       09200 IDSERVATI ON BEDS (NON-DI STI NCT PART)       19,739       2,091,173         SPECIAL PURPOSE COST CENTERS         118.00       SUBTOTALS (SUM OF LINES 1-117)       74,162       33,686,255         NONREI MBURSABLE COST CENTERS         190.00       GI FT, FLOWER, COFFEE SHOP, & CANTEEN       0       0         192.00       PHYSI CLANS' PRI VATE OFFI CES       0       0         200.00       Cross Foot Adj ustments       0       0         201.00       Negati ve Cost Centers       0       0         202.00       Cost to be al I ocated (per Wkst. B, Part I)       3.544012       0.	69.00 06900 ELECTROCARDI OLOGY	0	398, 707				69.00
70. 00       07000       ELECTROENCEPHALOGRAPHY       0       0         71. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       858, 414         72. 00       07200   MPL. DEV. CHARGED TO PATIENTS       0       556, 279         73. 00       07300 DRUGS CHARGED TO PATIENTS       3, 456       1, 684, 152         00UTPATIENT SERVICE COST CENTERS       0       0       0         90. 00       09000       CLINIC       0       0         91. 00       09100       EMERGENCY       19, 739       2, 091, 173         92. 00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       92, 091, 173         SPECIAL PURPOSE COST CENTERS         1800         NONRE! MBURSABLE COST CENTERS         190. 00       19000       GIFT, FLOWER, COFFEE SHOP, & CANTEEN       0       0         192. 00       19200       PHYSICIANS' PRIVATE OFFICES       0       0         192. 00       19200       PHYSICIANS' PRIVATE OFFICES       0       0         201. 00       Cross Foot Adjustments       0       0       0         202. 00       Cost to be al located (per Wkst. B, Part I)       3. 544012       0. 016724		0					69.02
71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       858, 414         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       556, 279         73.00       OTOOD RUGS CHARGED TO PATIENTS       0       1, 684, 152         0UTPATIENT SERVICE COST CENTERS       0       0         90.00       09000       CLINIC       0         91.00       09100       EMERGENCY       19, 739       2, 091, 173         92.00       0BSERVATION BEDS (NON-DISTINCT PART)       SPECIAL PURPOSE COST CENTERS       19, 739       2, 091, 173         92.00       OBSERVATION SEDS (SUM OF LINES 1-117)       74, 162       33, 686, 255       190, 00         190.00       IFT, FLOWER, COFFEE SHOP, & CANTEEN       0       0       0         192.00       19200       PHYSICIANS' PRIVATE OFFICES       0       0         201.00       Regative Cost Centers       0       0       0         2020.00       Cross Foot Adjustments       0       0       0         2021.00       Negative Cost Centers       0       0       0         2020.00       Cost to be al located (per Wkst. B, Part I)       3.544012       0.016724		0					70.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       556, 279         73.00       07300       DRUGS CHARGED TO PATIENTS       3, 456       1, 684, 152         0UTPATIENT SERVICE COST CENTERS       0       0       0         90.00       O9100       CLINIC       0       0         91.00       09200       DSERVATION BEDS (NON-DI STINCT PART)       19, 739       2, 091, 173         92.00       09200       DSERVATION BEDS (NON-DI STINCT PART)       SPECIAL PURPOSE COST CENTERS         118.00       SUBTOTALS (SUM OF LINES 1-117)       74, 162       33, 686, 255         NONREI MBURSABLE COST CENTERS       0       0         190.00       19000       GI FT, FLOWER, COFFEE SHOP, & CANTEEN       0       0         192.00       19200       PHYSI CLANS' PRI VATE OFFICES       0       0         201.00       Cross Foot Adj ustments       0       0       0         202.00       Cost to be al located (per Wkst. B, 262, 831       563, 361       262, 831       563, 361         203.00       Unit cost multiplier (Wkst. B, Part I)       3. 544012       0. 016724       0.016724		DATIENTS 0					71.00
73.00       07300       DRUGS CHARGED TO PATIENTS       3,456       1,684,152         90.00       09000       CLINIC       0       0         91.00       09100       EMERGENCY       19,739       2,091,173         92.00       09200       DBSERVATION BEDS (NON-DISTINCT PART)       SPECIAL PURPOSE COST CENTERS         118.00       SUBTOTALS (SUM OF LINES 1-117)       74,162       33,686,255         NONREI MBURSABLE COST CENTERS       0       0         190.00       I 9000       GI FT, FLOWER, COFFEE SHOP, & CANTEEN       0       0         192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       0       0         201.00       Cross Foot Adj ustments       0       0       0         202.00       Cost to be al located (per Wkst. B, 262,831       563,361       263,361         203.00       Unit cost multiplier (Wkst. B, Part I)       3.544012       0.016724							
OUTPATI ENT SERVICE COST CENTERS           90.00         09000 CLI NI C         0           91.00         09100 EMERGENCY         19,739           92.00         0BSERVATI ON BEDS (NON-DI STINCT PART)         19,739           92.00         0BSERVATI ON BEDS (NON-DI STINCT PART)         SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1-117)         74,162         33,686,255           NONREI MBURSABLE COST CENTERS         19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN         0         0           192.00         19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN         0         0         0           192.00         19200 PHYSI CI ANS' PRI VATE OFFICES         0         0         0           201.00         Cross Foot Adj ustments         0         0         0           202.00         Cost to be al located (per Wkst. B, 262,831         563,361         262,831         563,361           203.00         Unit cost multiplier (Wkst. B, Part I)         3.544012         0.016724         0.016724							72.00
90.00       09000       CLINIC       0       0         91.00       09100       EMERGENCY       19,739       2,091,173         92.00       09200       0BSERVATION BEDS (NON-DISTINCT PART)       19,739       2,091,173         SPECIAL PURPOSE COST CENTERS         118.00         SUBTOTALS (SUM OF LINES 1-117)       74,162       33,686,255         NONREI MBURSABLE COST CENTERS         190.00       19000       GIFT, FLOWER, COFFEE SHOP, & CANTEEN       0       0         192.00       19200       PHYSI CLANS' PRI VATE OFFICES       0       0         200.00       Cross Foot Adj ustments       0       0       0         201.00       Negati ve Cost Centers       0       0       0         202.00       Cost to be allocated (per Wkst. B, 262,831       563,361       263,361         203.00       Unit cost multiplier (Wkst. B, Part I)       3.544012       0.016724			1, 684, 152				73.00
91.00       09100       EMERGENCY       19,739       2,091,173         92.00       OBSERVATION BEDS (NON-DISTINCT PART)       19,739       2,091,173         SPECIAL PURPOSE COST CENTERS         118.00       SUBTOTALS (SUM OF LINES 1-117)       74,162       33,686,255         NONREI MBURSABLE COST CENTERS         190.00       19000       GIFT, FLOWER, COFFEE SHOP, & CANTEEN       0       0         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       0         200.00       Cross Foot Adj ustments       0       0       0         201.00       Negative Cost Centers       262,831       563,361         2023.00       Unit cost multiplier (Wkst. B, Part I)       3.544012       0.016724							4
92.00       09200       0BSERVATION BEDS (NON-DISTINCT PART)         SPECIAL PURPOSE COST CENTERS         118.00       SUBTOTALS (SUM OF LINES 1-117)       74, 162       33, 686, 255         NONREI MBURSABLE COST CENTERS         190.00       19000       GIFT, FLOWER, COFFEE SHOP, & CANTEEN       0       0         192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       0       0         201.00       Cross Foot Adj ustments       0       0       0         201.00       Cost to be allocated (per Wkst. B, 262, 831       563, 361       262, 831       563, 361         203.00       Unit cost multiplier (Wkst. B, Part I)       3. 544012       0. 016724       0.016724		0	0				90.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1-117)         74,162         33,686,255           NONREI MBURSABLE COST CENTERS         0         0           190.00         19200         GIFT, FLOWER, COFFEE SHOP, & CANTEEN         0         0           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         0         0           200.00         Cross Foot Adj ustments         0         0         0           201.00         Negati ve Cost Centers         202.00         Cost to be allocated (per Wkst. B, 262, 831         563, 361           203.00         Unit cost multiplier (Wkst. B, Part I)         3.544012         0.016724	91. 00 09100 EMERGENCY	19, 739	2, 091, 173				91.00
SUBTOTALS (SUM OF LINES 1-117)         74,162         33,686,255           NONREI MBURSABLE COST CENTERS         0         0           190.00         19000         GIFT, FLOWER, COFFEE SHOP, & CANTEEN         0         0           192.00         19200         PHYSI CLANS' PRI VATE OFFICES         0         0           200.00         Cross Foot Adjustments         0         0         0           201.00         Negative Cost Centers         262,831         563,361           202.00         Cost to be allocated (per Wkst. B, Part I)         3.544012         0.016724	92.00 09200 OBSERVATION BEDS (NON-DISTIN	CT PART)					92.00
SUBTOTALS (SUM OF LINES 1-117)         74,162         33,686,255           NONREI MBURSABLE COST CENTERS         0         0           190.00         19000         GIFT, FLOWER, COFFEE SHOP, & CANTEEN         0         0           192.00         19200         PHYSI CLANS' PRI VATE OFFICES         0         0           200.00         Cross Foot Adjustments         0         0         0           201.00         Negative Cost Centers         262,831         563,361           202.00         Cost to be allocated (per Wkst. B, Part I)         3.544012         0.016724	SPECIAL PURPOSE COST CENTERS		I				
NONREI         MBURSABLE         COST         CENTERS           190.00         19000         GIFT, FLOWER, COFFEE         SHOP, & CANTEEN         0         0           192.00         19200         PHYSICLANS'         PRI VATE         OFFICES         0         0           200.00         Cross         Foot Adjustments         0         0         0           201.00         Negative         Cost Centers         0         0         0           202.00         Cost to be allocated (per Wkst. B, 262, 831         563, 361		7) 74 162	33 686 255				118.00
190.00       GIFT, FLOWER, COFFEE SHOP, & CANTEEN       0       0         192.00       19200       PHYSICLANS' PRIVATE OFFICES       0       0         200.00       Cross Foot Adjustments       0       0         201.00       Negative Cost Centers       0       0         202.00       Cost to be allocated (per Wkst. B, Part I)       262,831       563,361         203.00       Unit cost multiplier (Wkst. B, Part I)       3.544012       0.016724		7) 74,102	33,000,233				
192.00       19200       PHYSICLANS' PRIVATE OFFICES       0       0         200.00       Cross Foot Adjustments       0       0         201.00       Negative Cost Centers       0       0         202.00       Cost to be allocated (per Wkst. B, Part I)       262,831       563,361         203.00       Unit cost multiplier (Wkst. B, Part I)       3.544012       0.016724		CANTEEN					100.00
200.00Cross Foot Adjustments201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B, Part I)203.00Unit cost multiplier (Wkst. B, Part I)3.5440120.016724		CANTEEN U	0				190.00
201.00         Negative Cost Centers           202.00         Cost to be allocated (per Wkst. B, Part I)         262,831         563,361           203.00         Unit cost multiplier (Wkst. B, Part I)         3.544012         0.016724		0	0				192.00
202.00         Cost to be allocated (per Wkst. B, Part I)         262,831         563,361           203.00         Unit cost multiplier (Wkst. B, Part I)         3.544012         0.016724							200.00
Part I)            203.00         Unit cost multiplier (Wkst. B, Part I)         3.544012         0.016724	201.00 Negative Cost Centers						201.00
203.00 Unit cost multiplier (Wkst. B, Part I) 3.544012 0.016724	202.00 Cost to be allocated (per Wk	.st. B, 262,831	563, 361				202.00
203.00 Unit cost multiplier (Wkst. B, Part I) 3.544012 0.016724	Part I)						
		B, Part I) 3.544012	0. 016724				203.00
							204.00
Part II)			20, , , 0				
205.00 Unit cost multiplier (Wkst. B, Part 0.177234 0.000706		B Part 0 177004	0 000704				205.00
		D, FAIL U. 177234	0.000706				203.00
		I	I				1

Health Financial Systems	COMMUNI TY HOSPI TAL	OF BREMEN, IN	IC.	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			CCN: 151300	Period: From 05/01/2015 To 04/30/2016	Worksheet C Part I Date/Time Pre 9/28/2016 3:4	pared: 8 pm
		Titl	e XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)			Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		i				
30. 00 03000 ADULTS & PEDIATRICS	2, 424, 516		2, 424, 5		0	
43. 00 04300 NURSERY	80, 373		80, 3	73 0	0	43.00
ANCI LLARY SERVI CE COST CENTERS		1	T			
50.00 05000 OPERATING ROOM	2, 323, 861		2, 323, 8		0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	66, 898		66, 8		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 437, 672		1, 437, 6		0	
57.00 05700 CT SCAN	510, 292		510, 2		0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	474, 019		474, 0	19 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0.075.0	0 0	0	59.00
60. 00 06000 LABORATORY	2, 975, 234		2, 975, 2	34 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0		70.0	0 0	0	60.01
64.00 06400 I NTRAVENOUS THERAPY	70, 271		70, 2		0	64.00
65. 00 06500 RESPI RATORY THERAPY	23, 851		23,8		0	65.00
66. 00 06600 PHYSI CAL THERAPY	615, 144		615, 1	44 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0			0 0	0	67.00 68.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	11 211		11.0	11 0	0	69.00
69. 02 06900 ELECTROCARDIOLOGY 69. 02 06902 SLEEP LAB	11, 311 62, 805		11, 3 62, 8		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	02,805		02, 0	0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	-		720, 1	-	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATTER	277, 012		277, 0		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 013, 780		1, 013, 7		0	
OUTPATIENT SERVICE COST CENTERS	1,013,780	1	1,013,7	50 0	0	1 73.00
90. 00 09000 CLINIC	0		1	0 0	0	90.00
91. 00 09100 EMERGENCY	2, 499, 564		2, 499, 5		0	•
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR			667, 0		0	•
200.00 Subtotal (see instructions)	16, 253, 777					200.00
201.00 Less Observation Beds	667,007		667, 0			201.00
	557,007	1	1 007,0	- 1	0	

COMPUTATION OF RATIO OF COSTS TO CHARGES			CCN: 151300	Period: From 05/01/2015 To 04/30/2016	9/28/2016 3:4	
			e XVIII	Hospi tal	Cost	
Cost Center Description	Inpatient	Charges Outpatient	Total (col	6 Cost or Other	TEFRA	
	inputront	outputront	+ col . 7)	Ratio	I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2,043,672		2, 043, 6			30.00
43. 00 04300 NURSERY	184, 613		184, 61	3	L	43.00
ANCI LLARY SERVI CE COST CENTERS	,		1			
50.00 OPERATING ROOM	1, 414, 661	4, 398, 634				
52.00 05200 DELIVERY ROOM & LABOR ROOM	197, 544	0	, -		0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	82, 047	2, 655, 289			0. 000000	
57.00 05700 CT SCAN	105, 801	3, 243, 364			0. 000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	31, 311	1, 144, 992	1, 176, 30		0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.00000	
60. 00 06000 LABORATORY	428, 116	9, 519, 450	9, 947, 50		0.00000	
60. 01 06001 BLOOD LABORATORY	0	0	100.01	0 0.00000	0.00000	
64. 00 06400 I NTRAVENOUS THERAPY	0	182, 822			0.00000	
65. 00 06500 RESPIRATORY THERAPY	2, 872	21, 765			0.00000	
66. 00 06600 PHYSI CAL THERAPY	249, 491	929, 638			0.00000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0.000000	0.00000	
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0.00000	0.00000	
69. 00 06900 ELECTROCARDI OLOGY	35, 417	363, 290			0.00000	
69. 02 06902 SLEEP LAB	0	126, 084			0.00000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0.000000	0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	270, 850	587, 564			0.00000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	476, 286	79, 993			0.00000	
OUTPATIENT SERVICE COST CENTERS	481, 568	1, 202, 584	1, 684, 1	0. 601953	0. 000000	/3.00
90. 00 09000 CLINIC	0	0		0 0.000000	0. 000000	90.00
91. 00 09100 EMERGENCY	34, 892	2, 056, 281				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 470	1, 125, 894				
200.00 Subtotal (see instructions)	9, 470 6, 048, 611	27, 637, 644			0.00000	200.00
· · · · · · · · · · · · · · · · · · ·	0, 040, 011	21,031,044	33, 000, 23	00	1	200.00
201.00 Less Observation Beds						

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 151300	Period: From 05/01/2015 To 04/30/2016	Worksheet C Part I Date/Time Pr 9/28/2016 3:	
	_	Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDIATRICS					30. (
3. 00 04300 NURSERY					43.
ANCI LLARY SERVI CE COST CENTERS					
0.00 05000 OPERATING ROOM	0. 000000				50.
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.
7.00 05700 CT SCAN	0. 000000				57.
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.
9. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.
0. 00 06000 LABORATORY	0. 000000				60.
0. 01 06001 BLOOD LABORATORY	0. 000000				60.
4.00 06400 INTRAVENOUS THERAPY	0. 000000				64.
5. 00 06500 RESPI RATORY THERAPY	0. 000000				65.
6. 00 06600 PHYSI CAL THERAPY	0. 000000				66.
7.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.
8.00 06800 SPEECH PATHOLOGY	0. 000000				68.
9. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.
9. 02 06902 SLEEP LAB	0. 000000				69.
0. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLINIC	0. 000000				90.
1.00 09100 EMERGENCY	0. 000000				91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.
00.00 Subtotal (see instructions)					200.
01.00 Less Observation Beds					201.
02.00 Total (see instructions)					202.

	ancial Systems CO N OF RATIO OF COSTS TO CHARGES	MMUNI TY HOSPI TAL		<u>C.</u> CCN: 151300	In Lie Period: From 05/01/2015 To 04/30/2016	u of Form CMS-: Worksheet C Part I Date/Time Pre	pared:
				le XIX	Hospi tal	9/28/2016 3:4 Cost	8 pm
			1 11		Costs	COST	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs		Total Costs	
		1.00	2.00	3.00	4.00	5.00	
I NPA	ATIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	DO ADULTS & PEDIATRICS	2, 424, 516		2, 424, 5	16 0	2, 424, 516	30.00
	DO NURSERY	80, 373	6	80, 3	73 0	80, 373	43.00
	LLARY SERVICE COST CENTERS		-				
	DO OPERATING ROOM	2, 323, 861		2, 323, 8		2, 323, 861	
	DO DELIVERY ROOM & LABOR ROOM	66, 898		66, 8		66, 898	
	DO RADI OLOGY-DI AGNOSTI C	1, 437, 672		1, 437, 6		1, 437, 672	
	DO CT SCAN	510, 292		510, 2		510, 292	
	DO MAGNETIC RESONANCE IMAGING (MRI)	474, 019		474, 0		474, 019	
	DO CARDIAC CATHETERIZATION	0			0 0	0	
	DO LABORATORY	2, 975, 234		2, 975, 2	34 0	2, 975, 234	
	D1 BLOOD LABORATORY	0			0 0	0	
	DO I NTRAVENOUS THERAPY	70, 271		70, 2		70, 271	64.00
	DO RESPIRATORY THERAPY	23, 851		20,0		23, 851	
	DO PHYSI CAL THERAPY	615, 144		615, 1	44 0	615, 144	
	DO OCCUPATIONAL THERAPY	0			0 0	0	
		11 011		11.0	0 0	0	68.00
		11, 311		11, 3		11, 311	
	D2 SLEEP LAB D0 ELECTROENCEPHALOGRAPHY	62, 805		62, 8	0 0	62, 805	
		0		700 1	0	0	
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS DO IMPL. DEV. CHARGED TO PATIENTS	720, 167 277, 012		720, 1 277, 0		720, 167	
	DO DRUGS CHARGED TO PATIENTS	1, 013, 780		1, 013, 7		277, 012 1, 013, 780	
	PATIENT SERVICE COST CENTERS	1,013,780	/	1,013,7	80 0	1,013,780	/3.00
	DO CLINIC	0		1	0 0	0	90.00
	DO EMERGENCY	2, 499, 564		2, 499, 5	0	2, 499, 564	
	DO OBSERVATION BEDS (NON-DISTINCT PART)	667,007		667, 0		667,007	
200.00	Subtotal (see instructions)	16, 253, 777				16, 253, 777	
200.00	Less Observation Beds	667,007		667, 0		667,007	
202.00	Total (see instructions)	15, 586, 770					

Health Financial Systems         COM           COMPUTATION OF RATIO OF COSTS TO CHARGES	MUNI TY HOSPI TAL	Provi der	CCN: 151300	Period: From 05/01/2015 To 04/30/2016	9/28/2016 3:4	epared:
			le XIX	Hospi tal	Cost	
	· · · · ·	Charges			TEEDA	
Cost Center Description	I npati ent	Outpati ent	+ col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 043, 672		2, 043, 6	72		30.00
43. 00 04300 NURSERY	184, 613		184, 61	13		43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 414, 661	4, 398, 634				
52.00 05200 DELIVERY ROOM & LABOR ROOM	197, 544	0	, -		0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	82, 047	2, 655, 289			0.00000	
57.00 05700 CT SCAN	105, 801	3, 243, 364			0.00000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	31, 311	1, 144, 992	1, 176, 30		0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.00000	
60. 00 06000 LABORATORY	428, 116	9, 519, 450	9, 947, 50		0.00000	
60. 01 06001 BLOOD LABORATORY	0	0		0 0.000000	0.00000	
64.00 06400 INTRAVENOUS THERAPY	0	182, 822			0.00000	
65.00 06500 RESPI RATORY THERAPY	2, 872	21, 765			0.00000	
66.00 06600 PHYSI CAL THERAPY	249, 491	929, 638			0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0.000000	0.00000	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0.00000	
69.00 06900 ELECTROCARDI OLOGY	35, 417	363, 290			0.00000	
69.02 06902 SLEEP LAB	0	126, 084			0.00000	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0.000000	0.00000	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	270, 850	587, 564			0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	476, 286	79, 993			0.00000	
73.00 O7300 DRUGS CHARGED TO PATIENTS	481, 568	1, 202, 584	1, 684, 1	0. 601953	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS				0 000000	0.00000	00.00
90. 00 09000 CLINIC	0	0		0 0.00000		
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	34, 892	2,056,281				
	9,470	1, 125, 894			0.00000	
200.00 Subtotal (see instructions)	6, 048, 611	27, 637, 644	33, 686, 25	00		200.00
201.00 Less Observation Beds	6 040 (11		22 (0/ 2)			201.00
202.00  Total (see instructions)	6, 048, 611	27, 637, 644	33, 686, 25	00		202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151300	Period: From 05/01/2015 To 04/30/2016	Worksheet C Part I Date/Time Pro 9/28/2016 3:	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	- <b>-</b>				
0. 00 03000 ADULTS & PEDIATRICS					30.
3. 00 04300 NURSERY					43.
ANCILLARY SERVICE COST CENTERS					
0. 00 05000 OPERATI NG ROOM	0. 000000				50.
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.
7.00 05700 CT SCAN	0. 000000				57.
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.
9. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.
0. 00 06000 LABORATORY	0. 000000				60.
0.01 06001 BLOOD LABORATORY	0. 000000				60.
4.00 06400 INTRAVENOUS THERAPY	0. 000000				64.
5. 00 06500 RESPI RATORY THERAPY	0. 000000				65.
6. 00 06600 PHYSI CAL THERAPY	0. 000000				66.
7.00 06700 OCCUPATIONAL THERAPY	0. 000000				67
8.00 06800 SPEECH PATHOLOGY	0. 000000				68.
9. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.
9.02 06902 SLEEP LAB	0. 000000				69.
0. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLINIC	0. 000000				90.
1.00 09100 EMERGENCY	0. 000000				91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.
00.00 Subtotal (see instructions)					200.
01.00 Less Observation Beds					201.
02.00 Total (see instructions)					202.

Health Financial Systems COM	MUNI TY HOSPI TAL	OF BREMEN, IN	C.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS			Period: From 05/01/2015 To 04/30/2016	9/28/2016 3:4	
			e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	253, 128				17, 897	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	902	197, 544	0. 00456	6 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	121, 513	2, 737, 336	0. 04439	41, 290	1, 833	54.00
57. 00 05700 CT SCAN	5, 736	3, 349, 165	0. 00171	3 44, 635	76	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 198	1, 176, 303	0. 00356	9 19, 799	71	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0 0	0	59.00
60. 00 06000 LABORATORY	99, 171	9, 947, 566	0. 00996	9 146, 764	1, 463	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0 0	0	60. 01
64.00 06400 INTRAVENOUS THERAPY	8, 641	182, 822	0. 04726	5 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	170	24, 637	0. 00690	0 1, 232	9	65.00
66. 00 06600 PHYSI CAL THERAPY	82, 102	1, 179, 129	0. 06962	9 83, 875	5, 840	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0. 00000	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0. 00000	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	2,264	398, 707	0. 00567	8 4, 900	28	69.00
69. 02 06902 SLEEP LAB	12, 546	126, 084	0. 09950	5 0	0	69.02
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	63, 327	858, 414	0. 07377	2 49, 057	3, 619	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2,140	556, 279	0. 00384	7 234, 427	902	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	30, 367	1, 684, 152	0. 01803	1 219, 790	3, 963	73.00
OUTPATIENT SERVICE COST CENTERS			•			
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
91.00 09100 EMERGENCY	208, 930	2, 091, 173	0. 09991	0 2, 333	233	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	107, 474	1, 135, 364	0. 09466	0 0	0	92.00
200.00   Total (lines 50-199)	1,002,609		1	1, 259, 115	35, 934	200. 00

Health Financial Systems COM	MUNI TY HOSPI TAL	OF BREMEN, IN	C.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	S Provi der	CCN: 151300	Period: From 05/01/2015 To 04/30/2016		
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anestheti st	-		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	- 1					
50.00 05000 OPERATING ROOM	0	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0	C		0 0	0	60. 01
64.00 06400 INTRAVENOUS THERAPY	0	C	)	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	C	)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C	)	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C	)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 02 06902 SLEEP LAB	0	C	)	0 0	0	69.02
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	)	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	C		0 0	0	90.00
91.00 09100 EMERGENCY	0	C		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0 0	0	92.00
200.00 Total (lines 50-199)	0	C		0 0	0	200.00
						•

Health Financial Systems COW	MUNI TY HOSPI TAL	OF BREMEN, IN	C.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 05/01/2015		
				Го 04/30/2016	Date/Time Pre 9/28/2016 3:4	
		Titl	e XVIII	Hospi tal	Cost	o piii
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	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	1	1	1			
50.00 O5000 OPERATI NG ROOM	0					
52.00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 737, 336				
57.00 05700 CT SCAN	0	3, 349, 165				
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 176, 303				
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59.00
60. 00 06000 LABORATORY	0	9, 947, 566	0.00000	0. 000000	146, 764	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0. 000000	0	60. 01
64.00 06400 I NTRAVENOUS THERAPY	0	182, 822	0.00000	0. 000000	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	24, 637	0.00000	0. 000000	1, 232	65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 179, 129	0.00000	0. 000000	83, 875	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0. 000000	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.00000	0. 000000	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	398, 707	0.00000	0. 000000	4, 900	69.00
69. 02 06902 SLEEP LAB	0	126, 084	0.00000	0. 000000	0	69.02
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0. 000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	858, 414	0.00000	0. 000000	49, 057	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	556, 279	0.00000	0. 000000	234, 427	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 684, 152	0.00000	0. 000000	219, 790	73.00
OUTPATIENT SERVICE COST CENTERS		•	•			1
90. 00 09000 CLINIC	0	0	0.00000	0. 000000	0	90.00
91.00 09100 EMERGENCY	0	2, 091, 173	0.00000	0. 000000	2, 333	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 135, 364	0. 000000	0. 000000	0	92.00
200.00 Total (lines 50-199)	0	31, 457, 970	1		1, 259, 115	200. 00

Health Financial Systems 0	OMMUNI TY HOSPI TAL	OF BREMEN, IN	IC.	In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER PASS		CCN: 151300	Period: From 05/01/2015 To 04/30/2016	9/28/2016 3:	
			e XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent Program Pass-Through Costs (col. 8 <u>x col. 10</u> ) 11.00	Outpatient Program Charges 12.00	Outpatient Program Pass-Throug Costs (col. <u>x col. 12)</u> 13.00			
ANCILLADY SEDVICE COST CENTERS	11.00	12.00	13.00			-
ANCI LLARY         SERVI CE         COST         CENTERS           50.00         05000         OPERATI NG         ROOM           52.00         05200         DELI VERY         ROOM         & LABOR         ROOM           54.00         05400         RADI OLOGY-DI AGNOSTI C               57.00         05700         CT         SCAN	0					$  \begin{array}{c} 50.\ 00\\ 52.\ 00\\ 54.\ 00\\ 57.\ 00\\ 59.\ 00\\ 60.\ 01\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 02\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ \end{array} $
90.00         09000         CLINIC           91.00         09100         EMERGENCY           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)           200.00         Total (lines 50-199)	0 0 0 0			0 0 0 0		90. 00 91. 00 92. 00 200. 00

	MUNI TY HOSPI TAL			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
				From 05/01/2015 To 04/30/2016		narad
				10 04/30/2010	9/28/2016 3:4	pareu. 8 pm
		Titl	e XVIII	Hospi tal	Cost	-
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	. ,	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			-			
50.00 05000 OPERATING ROOM	0. 399749		992, 64	9 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 338649	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 525208	0	624, 17	9 0	0	54.00
57.00 05700 CT SCAN	0. 152364	0	946, 99	8 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 402974	0	296, 80	5 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 299092	0	4, 810, 46	4 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0. 384368	0	70, 89	3 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 968097	0	10, 03	2 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 521694	0	313, 34	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 028369	0	76, 88	2 0	0	69.00
69. 02 06902 SLEEP LAB	0. 498120	0		0 0	0	69.02
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 838951	0	96,00	03 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 497973	0	39, 38	7 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 601953	0	626, 47	8 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	1. 195293		480, 97	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 587483	0	543, 81	6 0	0	92.00
200.00 Subtotal (see instructions)		0	9, 928, 89		0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	1	0	9, 928, 89	6 0	0	202.00
	•				-	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST         Provider CCN: 151300         Period: From 05/01/2015 To 04/30/2016         Worksheet D Part V Date/Time Prepared: 97.00           Cost Center Description         Cost Services Subject To Ded. & Coins.         Title XVIII         Hospital         Cost           ANCILLARY SERVICE COST CENTERS         Soubject To Ded. & Coins.         Cost         Cost         Soubject To Ded. & Coins.         Soubject To Ded. & Coins.           ANCILLARY SERVICE COST CENTERS         6.00         7.00         Soubject To Ded. & Coins.         Soubject To Ded. & Coins.         Soubject To Ded. & Coins.         Soubject To Ded. & Coins.           Soudo DELIVERY ROWA & LABOR ROOM         396,810         0         Soubject To Ded. & Coins.         Soubject To Ded. & Coins.         Soubject To Ded. & Coins.         Soubject To Ded. & Coins.           Soudo DELIVERY ROWA & LABOR ROOM         396,810         0         Soubject To Ded. & Coins.         Soubject To Ded. & Coins.         Soubject To Ded. & Coins.         Soubject To Ded. & Coins.           Soudo DELIVERY ROWA & LABOR ROOM         396,810         0         Soubject To Ded. & Coins.         Soubject To Ded. & Coins.         Soubject To Ded. & Coins.         Soubject To Ded. & Coins.           Soudo DELIVERY ROWA & LABOR ROOM         396,810         0         Soubject To Ded. & Coins.         Soubject To Ded. & Coins.         Soubject To Ded.	Health Financial Systems COM	MUNI TY HOSPI TAL	. OF BREMEN, IN	C.	In Lie	u of Form CMS-	2552-10
Cost Center Description         Cost Reimbursed Services         Cost Reimbursed Services         Cost Reimbursed Services           ANCILLARY SERVICE COST CENTERS         Subject To Ded. & Coins. (see inst.)         Subject To Ded. & Coins. (see inst.)         Subject To Ded. & Coins. (see inst.)           50.00         05000 (PERATING ROOM 0 05000 (DERATING ROOM 52.00         396,810 0 0         0 0 0         50.00 0 0         50.00 52.00           50.00         05000 (ADUCGY-DIAGNOSTIC 05400 (RADIOLOGY-DIAGNOSTIC 50.00         327,824 0         0 54.00         50.00 55.00           50.00         05000 (ABORTIC RESPIANCE IMAGING (MRI)         119,605 0         0 0 0 0         59.00 0 0 0 0         59.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151300	From 05/01/2015	Part V Date/Time Pre	epared: 8 pm
Cost Center Description         Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)         Cost Reimbursed Subject To Ded. & Coins. (see inst.)           ANCILLARY SERVICE COST CENTERS         0         0         0         0           50.00         05000 DPERATING ROM         396, 810         0         0         50.00           50.00         05000 ARAID LYERY ROM & LABOR ROM         307, 824         0         52.00         52.00           51.00         05700 CT SCAN         144, 228         0         57.00         58.00         58.00           59.00         05900 CARDIA CATHETERI ZATION         0         0         0         59.00         60.00         59.00           60.01         05000 LABORATORY         1,438,771         0         0         60.01         60.01           60.01         05000 RESPIRATORY THERAPY         27.249         0         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66			Ti tl	e XVIII	Hospi tal	Cost	
Reimbursed Services         Reimbursed Services Not Subject To Ded. & Coins.         Services Not Subject To Ded. & Coins.           ANCI LLARY SERVICE COST CENTERS         (see inst.)         (see inst.)         (see inst.)           6.00         7.00         7.00         50.00           50.00         05000 (DELVERY ROM & LABOR ROM 0         396, 810         0         50.00           52.00         05200 (DELVERY ROM & LABOR ROM 0         327, 824         0         54.00           57.00         05300 (MaGNETI C RESONANCE IMAGI NG (MRI )         119, 605         0         58.00           59.00         05900 (LABORATORY         14.43, 87, 771         0         60.01         60.01           60.00         06000 (LABORATORY         1, 438, 771         0         60.01         60.01           61.00         NGOOI LABORATORY         1, 438, 771         0         66.00         66.00           65.00         06500 RESPI RATORY THERAPY         27, 249         0         66.00         66.00           66.00         06500 RESPI RATORY THERAPY         163, 468         0         67.00         67.00           67.00         0         0         0         0         67.00         67.00           68.00         06600 PHYSI CAL THERAPY         <		Cos	sts				
Services Subject To Ded. & Coins. (see inst.)         Services (see inst.)         Other (see inst.)           ANCILLARY SERVICE COST CENTERS	Cost Center Description	Cost					
ANCI LLARY SERVICE COST CENTERS         Subject To Ded. & Coins. (see inst.)         Ded. & Coins. (see inst.)         Obd. & Coins. (see inst.)           50.00         05000         OPERATING ROOM         396,810         0           50.00         05000         DEPERATING ROOM         50.00           50.00         05000         DEPERATING ROOM         50.00           51.00         05000         DEVERY ROM & LABOR ROOM         0           52.00         05300         CI SCAN         327,824         0           57.00         05300         MARTIC RESONANCE IMAGING (MRI )         1144,288         0           50.00         05000 LABORATORY         0         0         0           60.00         06000 LABORATORY         1,438,771         0         60.00           61.00         IBLODD LABORATORY         163,468         0         66.00           65.00         06500 RESPI RATORY THERAPY         9,712         0         66.00           66.00         00         0         0         0         66.00           67.00         00         0         0         0         67.00           68.00         06600 RESPI RATORY THERAPY         163,468         0         66.00           69.0							
Image: Instant Service Cost centers         Ded. & Coins. (see inst.)         Ded. & Coins. (see inst.)         Ded. & Coins. (see inst.)           ANCILLARY SERVICE COST CENTERS							
ANCI LLARY SERVICE COST CENTERS         (see inst.)         (see inst.)         7.00           50.00         05000         0PERATI NG ROOM         396, 810         0           52.00         05200         DEL VERY ROOM & LABOR ROOM         0         0           54.00         05400         RADI OLOGY-DI AGNOSTI C         327, 824         0         54.00           57.00         05700         CT SCAN         144, 288         0         55.00           58.00         05800         AABORANCE I MAGI NG (MRI )         119, 605         0         59.00           60.00         LABORATORY         0         0         0         60.00           60.01         BLOON LABORATORY         1, 438, 771         0         60.00           61.00         D6400         INTRAVENUS THERAPY         27, 249         0         66.00           65.00         06500 RESPI RATORY THERAPY         9, 712         0         66.00           66.00         OF00 OCUPATI ONAL THERAPY         9, 712         0         66.00           66.00         OF00 OCUPATI ONAL THERAPY         0         0         67.00           67.00         OCUPATI ONAL THERAPY         0         0         67.00           67.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
ANCI LLARY SERVICE COST CENTERS           50.00         05000         0PERATI NG ROOM         396, 810         0         50.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         59.00         50.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         66.00         65.00         66.00         67.00         66.00         67.00         66.00         67.00         68.00         69.00         69.00							
ANCI LLARY SERVICE COST CENTERS         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         50         60         50         65         50         65         50         65         50         65         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60			(see inst.)				
50.00       05000       0PERATING R00M       396,810       0       50.00         52.00       05200       DELIVERY R00M & LABOR R00M       0       0       0         54.00       05200       DELIVERY R00M & LABOR R00M       0       0       52.00         54.00       05400 RADI LOGY-DI AGNOSTI C       327,824       0       57.00       57.00         57.00       05700 CT SCAN       144,288       0       57.00       58.00         59.00       05900 CARDI AC CATHETRIZATION       0       0       0       59.00       59.00       59.00       59.00       59.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.0		6.00	7.00				
52.00       05200       DELI VERY ROOM & LABOR ROOM       52.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       327,824       0         57.00       05700       CT SCAN       144,288       0         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       119,605       0       58.00         59.00       05900       CATHETERI ZATI ON       0       0       0         60.00       06000       LABORATORY       0       0       60.00         60.01       06000       LABORATORY       0       0       60.00         60.00       06000       LABORATORY       0       0       60.00         61.00       064001       NTRAVENOUS THERAPY       27,249       0       64.00         65.00       06500       RESPI RATORY THERAPY       9,712       0       65.00         65.00       06600       PHYSI CAL THERAPY       163,468       0       67.00       67.00         69.00       069002       LECTROCARDI OLOGY       2,181       0       69.00       69.00         69.00       069002       LECTROCARDI OLOGY       2,181       0       71.00       72.00       70.00       70.00       70.00 <td< td=""><td></td><td></td><td>-</td><td>1</td><td></td><td></td><td></td></td<>			-	1			
54.00       05400       RADI OLOGY-DI AGNOSTI C       327,824       0       54.00         57.00       05700       CT SCAN       144,288       0       57.00         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       119,605       0       59.00         60.00       06000       LABORATORY       1,438,771       0       60.00         60.01       BLOOD LABORATORY       0       0       60.00       60.00         64.00       64.00       INTRAVENOUS THERAPY       27,249       0       64.00         65.00       06500       RESPI RATORY THERAPY       9,712       0       65.00         66.00       0000       CAUPATI CAL THERAPY       163,468       0       66.00         67.00       06000       ELECTROCARDI OLOGY       0       0       68.00       69.00         69.00       00000       ELECTROCARDI OLOGY       2,181       0       69.00       69.02         70.00       0000       ELECTROENCEPHALOGRAPHY       0       0       71.00       71.00         71.00       00       00       0       0       71.00       71.00       71.00         71.00       00       00       0       0<				1			
57.00       05700       CT SCAN       144,288       0       57.00         58.00       05800       MAGNETIC RESONANCE I MAGING (MRI)       119,605       0       58.00         59.00       05900       CARDI AC CATHETERIZATION       0       0       59.00       60.00       59.00       60.00       59.00       60.00       59.00       60.00       59.00       60.00       59.00       60.00       59.00       60.00       59.00       60.00       59.00       60.00       59.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       65.00       65.00       65.00       66.00       65.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00 <td></td> <td>-</td> <td>-</td> <td></td> <td></td> <td></td> <td></td>		-	-				
58.00       05800       MAGNETIC RESONANCE IMAGING (MRI)       119,605       0         59.00       05900       CARDIAC CATHETERIZATION       0       0         60.00       LABORATORY       1,438,771       0       60.00         60.01       BLOOD LABORATORY       0       0       60.01         64.00       06400       INTRAVENOUS THERAPY       27,249       0       64.00         65.00       06500       RESPIRATORY THERAPY       9,712       0       65.00         66.00       06000       CQUPATIONAL THERAPY       9,712       0       66.00         66.00       06000       PCOLUPATIONAL THERAPY       0       0       67.00         68.00       064000       SPEECH PATHOLOGY       0       0       68.00         69.00       OEGO2       SEEEP LAB       0       0       69.00         69.02       OGO2       SEEEP LAB       0       0       69.00         70.00       OTO0       ELECTROENCEPHALOGRAPHY       0       0       70.00         71.00       OTO0       ELECTROENCEPHALOGRAPHY       0       71.00       72.00         72.00       OT200       IMPL. DEV. CHARGED TO PATI ENTS       80,542       0							
59.00       05900       CARDI AC CATHETERI ZATI ON       0       0         60.00       06000       LABORATORY       1, 438, 771       0         61.00       06001       BLOOD LABORATORY       0       0         62.00       06400       INTRAVENOUS THERAPY       27, 249       0         64.00       06500       RESPI RATORY THERAPY       9, 712       0         65.00       06600       PHYSI CAL THERAPY       163, 468       0       66, 00         67.00       06700       OCUPATI ONAL THERAPY       0       0       67, 00         68.00       06800       SPECH PATHOLOGY       0       0       68, 00         69.02       06902       SLEECT ROCARDI OLOGY       2, 181       0       69, 00         69.02       07000       ELCTROCARDI OLOGY       2, 181       0       69, 02         70.00       07000       ELCTROCARDI OLOGY       2, 181       0       71.00         71.00       07000       ELCTROCARDI OLOGY       2, 181       0       72.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       80, 542       0       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       377, 110							
60.00       06000       LABORATORY       1,438,771       0       60.00       60.00         60.01       06001       BLOOD LABORATORY       0       0       60.01         64.00       06400       INTRAVENOUS THERAPY       27,249       0       66.00         65.00       06500       RESPIRATORY THERAPY       9,712       0       65.00         66.00       06600       PHYSI CAL THERAPY       9,712       0       66.00         67.00       06700       0CCUPATI IONAL THERAPY       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       69.00         69.00       06900       ELECTROCARDI OLOGY       2,181       0       69.02         69.02       06902       SLEEP LAB       0       0       69.02         70.00       07000       ELECTROCARDI OLOGY       2,181       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       80,542       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       377,110       0       73.00         0.00       09000       CLINIC       0       0       90.00       91.00 <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>		-					
60.01       06001       BLOOD LABORATORY       0       0       60.01         64.00       06400       INTRAVENOUS THERAPY       27,249       0       64.00         65.00       06500       RESPI RATORY THERAPY       9,712       0       65.00         66.00       06600       PHYSI CAL THERAPY       163,468       0       66.00         67.00       0C700       0CCUPATI ONAL THERAPY       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       2,181       0       69.00         69.02       06902       SLEECT LAB       0       0       69.00         70.00       07000       ELECTROCEPHALOGRAPHY       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       80,542       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       377,110       0       72.00         73.00       07300       DUTPATI ENT SERVICE COST CENTERS       90.00       91.00       91.00         90.00       09000       CLI NI C       0       0       92.00       200.00		-	C				
64.00       06400       INTRAVENOUS THERAPY       27,249       0       64.00         65.00       06500       RESPI RATORY THERAPY       9,712       0       65.00         66.00       06600       PHYSI CAL THERAPY       163,468       0       66.00         67.00       06700       0CUPATI ONAL THERAPY       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       69.00         69.02       06900       ELECTROCARDI OLOGY       0       0       69.02         70.00       07000       ELECTROCARDI OLOGARPHY       0       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       80,542       0       71.00         71.00       07100       IMPL. DEV. CHARGED TO PATI ENTS       19,614       0       72.00         73.00       070000       CLI NI C       0       0       90.00       91.00         90.00       09000       EMERGENCY       574,900       0       91.00       91.00         92.00       09200       OSERVATI ON BEDS (NON-DI STI NCT PART)       319,483       0<			C				
65.00       06500       RESPIRATORY THERAPY       9,712       0       65.00         66.00       06600       PHYSI CAL THERAPY       163,468       0       66.00         67.00       0CCUPATIONAL THERAPY       0       0       67.00       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       68.00       68.00         69.00       06900       ELECTROCARDI OLOGY       2,181       0       69.02         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       69.02         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       80,542       0       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       19,614       0       72.00         73.00       OPO00       CLI NI C       0       0       90.00       91.00       91.00       91.00         91.00       09000       CLI NI C       0       0       91.00       91.00       92.00         92.00       0826VATI ON BEDS (NON-DI STI NCT PART)       319,483       0       92.00       200.00       201.00 <t< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></t<>		0					
66.00       06600       PHYSI CAL THERAPY       163,468       0       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       2,181       0       69.02         69.02       06902       SLEEP LAB       0       0       69.02         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       80,542       0       71.00         72.00       07300       DRUGS CHARGED TO PATI ENTS       19,614       0       72.00         000TPATI ENT SERVICE COST CENTERS       377,110       0       73.00       73.00         90.00       09000       CLI NI C       0       0       90.00       91.00         91.00       09100       EMERGENCY       574,900       0       91.00       92.00         92.00       09200       DSERVATI ON BEDS (NON-DI STI NCT PART)       319,483       0       92.00       200.00       200.00       200.00       201.00       200.00       201.00       201							
67.00       06700       0CCUPATIONAL THERAPY       0       0       67.00       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       68.00         69.00       06900       ELECTROCARDIOLOGY       2,181       0       69.00         69.02       06902       SLEEP LAB       0       0       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       80,542       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       19,614       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       377,110       0       73.00         0171.00       90000       CLINIC       0       0       73.00       73.00         0171.00       BESERVATION BEDS (NON-DISTINCT PART)       319,483       0       90.00       91.00       92.00       92.00       92.00       200.00       200.00       200.00       200.00       200.00       201.00       200.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00							
68.00       06800       SPEECH PATHOLOGY       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       2,181       0       69.00         69.02       06902       SLEEP LAB       0       0       0         70.00       07000       ELECTROCKEPHALOGRAPHY       0       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       80,542       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       19,614       0       72.00       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       377,110       0       73.00       73.00         0017PATI ENT SERVICE COST CENTERS       90.00       0       90.00       91.00       90000       CLI NI C       90.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       319,483       0       92.00         200.00       200.00       Subtotal (see instructions)       4,001,557       0       200.00       200.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201							
69.00       06900       ELECTROCARDI OLOGY       2, 181       0       69.00       69.00         69.02       06902       SLEEP LAB       0       0       69.02       69.02         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       70.00       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       80,542       0       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       19,614       0       72.00         73.00       07000       CLINIC       0       0       0       73.00       73.00         001741       ENT SERVICE COST CENTERS       377,110       0       73.00       73.00         01700       EMERGENCY       574,900       0       90.00       91.00       92.00       9200       0BSERVATI ON BEDS (NON-DI STINCT PART)       319,483       0       92.00       92.00       92.00       200.00       200.00       200.00       200.00       201.00       200.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00		0	C				
69.02       06902       SLEEP LAB       0       0       69.02         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       70.00         71.00       07100       MEDI CAL       SUPPLI ES       CHARGED TO PATI ENTS       80,542       0       71.00         72.00       07200       IMPL.       DEV.       CHARGED TO PATI ENTS       19,614       0       72.00       73.00         00       07300       DRUGS       CHARGED TO PATI ENTS       377,110       0       73.00       73.00         00       09000       CLI NI C       0       0       90.00       90.00       91.00       90.00       91.00       90.00       91.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       0SERVATI ON BEDS (NON-DI STI NCT PART)       319, 483       0       92.00       92.00       200.00       200.00       200.00       201.00       200.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00 <t< td=""><td></td><td>0</td><td>C</td><td></td><td></td><td></td><td></td></t<>		0	C				
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         70.00         70.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         80,542         0         71.00         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         19,614         0         72.00         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         377,110         0         73.00           00TPATIENT SERVICE COST CENTERS         0         0         0         73.00         73.00           90.00         09100         EMERGENCY         574,900         0         90.00         91.00         91.00         92.00         92000         0BSERVATION BEDS (NON-DISTINCT PART)         319,483         0         92.00         92.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         201.00         0         200.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00 <td></td> <td></td> <td>C</td> <td></td> <td></td> <td></td> <td></td>			C				
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       80, 542       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       19, 614       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       377, 110       0       73.00         00TPATI ENT SERVICE COST CENTERS       0       0       0       90.00       91.00         90.00       09100       EMERGENCY       574, 900       0       91.00       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       319, 483       0       92.00       92.00         200.00       Subtotal (see instructions)       4, 001, 557       0       200.00       200.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00 <td></td> <td>0</td> <td>C</td> <td></td> <td></td> <td></td> <td></td>		0	C				
72.00         07200         IMPL.         DEV.         CHARGED TO PATIENTS         19, 614         0         72.00         73.00           73.00         DRUGS CHARGED TO PATIENTS         377, 110         0         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00		0	C				
73.00         07300         DRUGS CHARGED TO PATIENTS         377,110         0         73.00           0UTPATIENT SERVICE COST CENTERS         0         0         0         90.00         09000         CLINIC         90.00         90.00         90.00         91.00         91.00         92.00         92.00         085ERVATION BEDS (NON-DISTINCT PART)         319,483         0         92.00         92.00         92.00         200.00         200.00         200.00         201.00         Less PBP Clinic Lab. Services-Program         0         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
OUTPATIENT SERVICE COST CENTERS           90.00         09000         CLINIC         0         0           91.00         09100         EMERGENCY         574,900         0           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         319,483         0         92.00           200.00         Subtotal (see instructions)         4,001,557         0         200.00         200.00           201.00         Less PBP Clinic Lab. Services-Program         0         201.00         201.00         201.00							
90.00         09000         CLINIC         0         0         90.00         91.00         91.00         91.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00<		377, 110	C				73.00
91.00         09100         EMERGENCY         574,900         0           92.00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART)         319,483         0           200.00         Subtotal (see instructions)         4,001,557         0         200.00           201.00         Less PBP Clinic Lab. Services-Program Only Charges         0         201.00         201.00							
92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         319,483         0         92.00           200.00         Subtotal (see instructions)         4,001,557         0         200.00           201.00         Less PBP Clinic Lab. Services-Program 0         0         201.00         201.00		-	-	1			
200.00         Subtotal (see instructions)         4,001,557         0         200.00           201.00         Less PBP Clinic Lab. Services-Program         0         0         201.00							
201.00     Less PBP Clinic Lab. Services-Program     0     201.00       Only Charges     0     0				1			
Only Charges							
		0					201.00
202.00   Net charges (The 200 +/- The 201)   4,001,55/  0   202.00		4 001 557					000 00
	202.00  Net charges (line 200 +/- line 201)	4,001,557	1 0	1			J202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST         Provider CCK: 151300         Period: From 04/30/2016         Worksheet D Part V           Cost Center Description         Cost to Charge Ratio From Services (see inst.)         Swing Beds - SNF         Cost         PS Reimbursed Services (see inst.)         Provider CCK: 151300         Provider CCK: 151300           MACILLARY SERVICE COST CENTERS         Cost Cost Center Description         Cost to Charge Ratio From Services (see inst.)         Cost Cost         PS Services Subject To Ded. & Coins.         PS Services Services (see inst.)         PS Services Subject To Ded. & Coins.           50:	Heal th	Financial Systems COM	MUNI TY HOSPI TAL	OF BREMEN, IN	C.	In Lie	u of Form CMS-:	2552-10
ANCILLARY SERVICE COST CENTERS         Cost to Charge	APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151300			
ANCI LLARY SERVICE COST CENTERS         Cost         Cost         Cost         Cost         Cost         Cost         Cost           05000 DELLIVERY NOM & LABOR ROOM         0.399749         0         0         0         0         0         50.00           50.00 DELLIVERY NOM & LABOR ROOM         0.399749         0         0         0         0         0         50.00           50.00 DELLIVERY NOM & LABOR ROOM         0.338649         0         0         0         0         0         51.00           50.00 OSCOO DELLIVERY NOM & LABOR ROOM         0.338649         0         0         0         0         0         52.00           50.00 OSCOO DELLIVERY NOM & LABOR ROOM         0.338649         0         0         0         0         0         51.00           51.00 OSCOO OC CATHETER INFORMAL LLARY SERVICE COST CENTERS         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				Component	- CON- 157200			narodi
Cost Center Description         Cost to Charges         Cost Cost Relimbursed Ratio From Worksheet C, Part I, col. 9         Cost to Charges         Cost Relimbursed Relimbursed Services Not Subject To Ded. & Coins.         PSS Services (see inst.)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50:00 DED(PERATING ROOM 52:00 DED(VERY ROOM & LABOR ROOM 52:00 DEC) VERY ROOM & LABOR ROOM 53:00 DS000 RADILOGY-DIAGNOSTIC         0.399749         0         0         0         0         52:00           50:00 DEC COST CENTERS         0         0         0         0         0         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00         52:00				component	. CCN. 152500	10 04/30/2010		
Cost Center Description         Cost to Charge Ratio From Worksheet C, Part I, col. 9         Cost Center Description         Cost Cost Ratio From Worksheet C, Part I, col. 9         Cost Center Description         Cost Center Description         Cost Center Description           ANCILLARY SERVICE COST CENTERS         Part I, col. 9         Pirt I, col. 9         Services Services Services Services Inst.)         Servi				Ti tl	e XVIII	Swing Beds - SNF		<u>o p</u>
Ratio From Part I, col. 9         Retimbursed inst.)         Retimbursed subject To Ded. & Col ns. (see inst.)         Retimbursed Subject To Subject T								
Ratio From Part I, col. 9         Retimbursed inst.)         Retimbursed subject To Ded. & Col ns. (see inst.)         Retimbursed Subject To Subject T		Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
ANCILLARY SERVICE COST CENTERS         Subject To         Ded. & Coins.           1.00         2.00         3.00         4.00         5.00           50.00         05000         0PERATING ROOM         0.399749         0         0         0         0         5.00           52.00         52.00         0.3000         0PENATING ROOM         0.399749         0         0         0         0         52.00           52.00         05200         DELIVERY ROOM & LABOR ROOM         0.338649         0         0         0         57.00         57.00           57.00         D5300         DES00         CARDIAC CATHETERIZATION         0.152364         0         0         0         0         57.00           59.00         D5800         MARINETI C RESONANCE I MAGI NG (MRI )         0.402974         0         0         0         0         0         58.00           60.00         06000         LABORATORY         0.299092         0         0         0         0         60.00         60.00         60.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         6				Services (see	Reimbursed		(see inst.)	
Ded. & Coins.         Ded. & Coins.         (see inst.)         (see inst.)         (see inst.)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           S0.00         05000 0PERATING ROM         0.399749         0         0         0         0           52.00         05200 0FLIVERY ROM & LABOR ROM         0.338649         0         0         0         52.00           54.00         54.00         57.00         0         0         0         52.00         0         52.00         0         0         0         52.00         0         0         0         52.00         0         0         0         0         0         52.00         0         0         0         0         52.00         0         0         0         0         52.00         0         0         0         0         52.00         0         0         0         0         0         0         52.00         0         0         0         0         0         0         0         0         0         0         58.00         0         0         0         0         0         0         0         0         0         0								
ANCI LLARY SERVICE COST CENTERS         (see inst.)         (see inst.)         (see inst.)           ANCI LLARY SERVICE COST CENTERS         0.300         4.00         5.00           50.00         05000         0PERATI NG ROOM         0.399749         0         0         0         0         0         50.00           52.00         05200         DEL VERY ROOM & LABOR ROOM         0.338649         0         0         0         52.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0.525208         0         0         0         0         54.00           57.00         05700 CT SCAN         0.152364         0         0         0         0         58.00           59.00         05800         LABORATORY         0.299092         0         0         0         0         59.00           60.01         GOOD LABORATORY         0.299092         0         0         0         0         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00			Part I, col. 9					
ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 [PERATING ROM         0.399749         0         0         0         50.00           52.00         05200 [DEL IVERY ROM & LABOR ROM         0.338649         0         0         0         52.00           54.00         05400 [RADI LOGY-DI AGNOSTI C         0.525208         0         0         0         57.00           57.00         05700 [CT SCAN         0.152364         0         0         0         58.00           59.00         05900 [ARADIAC CATHETERI ZATI ON         0.000000         0         0         58.00           60.01         16001 LABORATORY         0.299092         0         0         0         60.00           64.00         06400 INTRAVENUOS THERAPY         0.384368         0         0         0         64.00           65.00         06500 RESPI RATORY THERAPY         0.984368         0         0         0         65.00           66.00         06700 OCUPATI INAL THERAPY         0.968097         0         0         0         66.00           67.00         06700 OCUPATI INAL THERAPY         0.928369         0         0         0         67								
ANCILLARY SERVICE COST CENTERS         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         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 <th< td=""><td></td><td></td><td>1.00</td><td></td><td></td><td></td><td>5.00</td><td></td></th<>			1.00				5.00	
50.00       05000       0PERATINC ROOM       0.39749       0       0       0       0       50.00         52.00       05200       DELIVERY ROOM & LABOR ROOM       0.336649       0       0       0       0       52.00         54.00       05400       ADIOLOGY-DI AGNOSTIC       0.525208       0       0       0       0       52.00         57.00       05700       CT SCAN       0.152364       0       0       0       0       58.00         58.00       05800       CARDIAC CATHETERI ZATION       0.000000       0       0       0       59.00         05900       CARDIAC CATHETERI ZATION       0.000000       0       0       0       59.00         05400       DESONC CARDIAC CATHETERI ZATION       0.000000       0       0       0       60.00         64.00       D6400       LABORATORY       0.299092       0       0       0       64.00       0       64.00       0       64.00       0       0       64.00       64.00       64.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66			1.00	2.00	3.00	4.00	5.00	
52.00       05200       DELIVERY ROOM & LABOR ROOM       0.338649       0       0       0       52.00         54.00       O5400       RADI OLOGY-DI AGNOSTI C       0.525208       0       0       0       57.00         57.00       OTSCAN       0.152364       0       0       0       0       57.00         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0.402974       0       0       0       58.00         59.00       05900       CARDI AC CATHETERI ZATI ON       0.000000       0       0       0       59.00         60.01       06001       BLORD LABORATORY       0.299092       0       0       0       0       60.01         64.00       06400       INTRAVENOUS THERAPY       0.383458       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0.384368       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.384368       0       0       0       66.00         66.00       06500       CELPATHOLOGY       0.521694       0       0       0       67.00         67.00       CENTROCARADI OLOGY       0.0028369	F0 00		0.200740	0		0 0	0	1 50 00
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.525208       0       0       0       54.00         57.00       05700       CT SCAN       0.152364       0       0       0       57.00         58.00       05900       CARDI AC CATHETERI ZATI ON       0.402974       0       0       0       58.00         59.00       05900       CARDI AC CATHETERI ZATI ON       0.000000       0       0       0       60.00         60.01       BLOGO LABORATORY       0.299992       0       0       0       60.00         60.01       BLOGO LABORATORY       0.000000       0       0       60.01         64.00       D6400       INTRAVENOUS THERAPY       0.384368       0       0       0       65.00         65.00       065000       RESPI RATORY THERAPY       0.968097       0       0       0       65.00         64.00       06400       INTRAVENOUS THERAPY       0.928697       0       0       0       66.00         65.00       065000       RESPI RATORY THERAPY       0.900000       0       0       0       67.00         64.00       65.00       06600       PESPI RATORY       0.0000000       0       0						0 0	-	
57.00       05700       CT SCAN       0.152364       0       0       0       57.00         58.00       05800       MAGNETI C RESONANCE IMAGING (MRI)       0.402974       0       0       0       58.00         59.00       05900       CARDIAC CATHETERIZATION       0.000000       0       0       0       58.00         59.00       06000       LABORATORY       0.299092       0       0       0       60.00         60.01       06001       BLODD LABORATORY       0.299092       0       0       0       60.01         64.00       06400       INTRAVENOUS THERAPY       0.384368       0       0       0       66.00         65.00       06500       RESPI RATORY THERAPY       0.521694       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.521694       0       0       0       67.00         68.00       06800 SPEECH PATHOLOGY       0.000000       0       0       0       68.00       69.00       69.00       69.00       69.00       69.00       69.00       69.02       70.00       69.02       70.00       69.02       70.00       69.02       70.00       70.00       69.02						0 0	-	
58.00       05800       MAGNETIC RESONANCE IMAGING (MRI)       0.402974       0       0       0       58.00         59.00       05900       CARDIAC CATHETERIZATION       0.000000       0       0       0       0       59.00         60.00       LABORATORY       0.299092       0       0       0       0       60.00         60.01       BLOOD LABORATORY       0.000000       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       0       0       0       0       0       0       0       0       0       0       0       0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>0 0</td><td>-</td><td></td></t<>						0 0	-	
59.00       05900       CARDI AC CATHETERI ZATI 0N       0.000000       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       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 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>0 0</td> <td>-</td> <td></td>						0 0	-	
60.00       LABORATORY       0.299092       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       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		
60.01       06001       BLOOD LABORATORY       0.00000       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       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	-	
64.00       06400       INTRAVENOUS THERAPY       0.384368       0       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0.968097       0       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.521694       0       0       0       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.0028369       0       0       0       69.02         69.02       06902       SLEEP LAB       0.498120       0       0       0       0       70.00         70.00       OT000       ELECTROCREPHALOGRAPHY       0.000000       0       0       0       71.00       71.00         71.00       OT100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.838951       0       0       0       72.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.601953       0       0       0       72.00						0 0	-	
65.00       06500       RESPIRATORY THERAPY       0.968097       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.521694       0       0       0       66.00         67.00       0C0UPATI ONAL THERAPY       0.000000       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       0       0       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0.28369       0       0       0       0       69.02         69.02       06902       SLEEP LAB       0.498120       0       0       0       0       69.02         70.00       07000       ELECTROCARDIOLOGY       0.383951       0       0       0       70.00         71.00       MDID CAL SUPPLI ES CHARGED TO PATI ENTS       0.838951       0       0       0       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.497973       0       0       0       72.00         73.00       09000       CLI NI C       0.000000       0       0       0       91.00         90.00       09000       CLI NI C       0.000000       0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>0 0</td><td>-</td><td></td></t<>						0 0	-	
66.00       06600       PHYSI CAL THERAPY       0.521694       0       0       0       0       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.000000       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.028369       0       0       0       69.02         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       0       69.02         70.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.838951       0       0       0       70.00         71.00       07300       DRUGS CHARGED TO PATI ENTS       0.601953       0       0       0       72.00         73.00       09000       CLI NI C       0.000000       0       0       0       0       73.00         90.00       09000       CLI NI C       0.000000       0       0       0       90.00       91.00         91.00       09100       EMERGENCY       1.195293       0       0       0       91.00         92.00       09200       OBSE							-	•
67.00       06700       0CCUPATIONAL THERAPY       0.000000       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       0       0       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0.028369       0       0       0       69.00         69.02       06902       SLEEP LAB       0.498120       0       0       0       69.02         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.838951       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.497973       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.601953       0       0       0       73.00         017100       EMERGENCY       1.195293       0       0       0       0       90.00       91.00         90.00       O9200       OBSERVATION BEDS (NON-DI STINCT PART)       0.587483       0       0       0       92.00         90.00       Subtotal (see instru							-	
68.00       06800       SPEECH PATHOLOGY       0.000000       0       0       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0.028369       0       0       0       69.00         69.02       06902       SLEEP LAB       0.498120       0       0       0       0       69.02         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.838951       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.497973       0       0       0       72.00         07300       DRUGS CHARGED TO PATIENTS       0.601953       0       0       0       73.00         001720       IMPL. DEV. CLINIC       0.000000       0       0       0       0       73.00         011.00       90900       CLINIC       0.000000       0       0       0       90.00       91.00         90.00       09200       0BSERVATION BEDS (NON-DISTINCT PART)       0.587483       0       0       0       92.00         90.00       Subtotal (see instructions)						0 0	e e	•
69.00       06900       ELECTROCARDIOLOGY       0.028369       0       0       0       69.00         69.02       06902       SLEEP LAB       0.498120       0       0       0       0       69.02         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       0       0       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.838951       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.497973       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.601953       0       0       0       73.00         00000       01700       CLINIC       0.000000       0       0       0       0       73.00         90.00       09000       CLINIC       0.000000       0       0       0       90.00       91.00       92.00       90.00       91.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>0 0</td> <td>-</td> <td></td>						0 0	-	
69.02       06902       SLEEP LAB       0.498120       0       0       0       69.02         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.838951       0       0       0       0       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.497973       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.601953       0       0       0       73.00         0UTPATI ENT SERVICE COST CENTERS       0.000000       0       0       0       0       0       90.00         90.00       09000       CLINIC       0.000000       0       0       0       90.00       91.00         91.00       09100       EMERGENCY       1.195293       0       0       0       92.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       0.587483       0       0       0       92.00         200.00       Subtotal (see instructions)       0       0       0       0       200.00       200.00       201.00<						0 0	-	•
70.00         07000         ELECTROENCEPHALOGRAPHY         0.000000         0         0         0         70.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0.838951         0         0         0         0         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0.497973         0         0         0         72.00           73.00         DRUGS CHARGED TO PATIENTS         0.601953         0         0         0         0         73.00           001001         DRUGS CHARGED TO PATIENTS         0.601953         0         0         0         0         73.00           001001         DRUGS CHARGED TO PATIENTS         0.000000         0         0         0         0         73.00           001001         DRUGS CHARGED TO PATIENTS         0.601953         0         0         0         0         73.00           011001         BERGENCY         0.195293         0         0         0         0         91.00         92.00         92.00         0         92.00         92.00         0         92.00         92.00         92.00         92.00         92.00         0         0         92.00         92.00         0						0 0	-	
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.838951       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.497973       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.601953       0       0       0       73.00         000       09000       CLINIC       0.000000       0       0       0       90.00         90.00       09100       EMERGENCY       0.000000       0       0       0       90.00         91.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       0.587483       0       0       0       92.00         200.00       Subtotal (see instructions)       0       0       0       0       200.00       200.00       0       0       0       200.00         201.00       Less PBP Clinic Lab. Services-Program       0       0       0       201.00       201.00       201.00       201.00       201.00       201.00       201.00       0       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00						0 0	0	
72.00         07200         IMPL.         DEV.         CHARGED TO PATIENTS         0.497973         0         0         0         0         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0.601953         0         0         0         0         73.00           0UTPATIENT SERVICE COST CENTERS         0.000000         0         0         0         0         0         90.00           90.00         09100         EMERGENCY         0.000000         0         0         0         91.00         92.00         085ERVATION BEDS (NON-DISTINCT PART)         0.587483         0         0         0         92.00         200.00         200.00         200.00         200.00         200.00         200.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>0 0</td> <td>0</td> <td></td>						0 0	0	
73.00         07300         DRUGS CHARGED TO PATIENTS         0.601953         0         0         0         0         73.00           OUTPATIENT SERVICE COST CENTERS         0.00000         0         0         0         0         90.00         90.00         90.00         0         0         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         91.00         90.00         91.00         92.00         9200         0BSERVATION BEDS (NON-DISTINCT PART)         0.587483         0         0         0         92.00         92.00         92.00         92.00         0         0         0         0         200.00         200.00         200.00         200.00         200.00         200.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00						0 0	0	•
90.00         09000         CLINIC         0.00000         0         0         0         0         0         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00						0 0	0	
91.00         09100         EMERGENCY         1.195293         0         0         0         91.00           92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         0.587483         0         0         0         0         92.00           200.00         Subtotal (see instructions)         0         0         0         0         200.00           201.00         Less PBP Clinic Lab. Services-Program Only Charges         0         0         0         201.00		OUTPATIENT SERVICE COST CENTERS	4					1
92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         0.587483         0         0         0         92.00           200.00         Subtotal (see instructions)         0         0         0         0         200.00           201.00         Less PBP Clinic Lab. Services-Program Only Charges         0         0         0         201.00	90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
200.00Subtotal (see instructions)0000200.00201.00Less PBP Clinic Lab. Services-Program000201.00Only Charges00201.0000	91.00	09100 EMERGENCY	1. 195293	0	1	0 0	0	91.00
201.00     Less PBP Clinic Lab. Services-Program     0     0     201.00       Only Charges     0     0     201.00			0. 587483	0		0 0	0	
Only Charges				0		0 0	0	
	201.00					0 0		201.00
202.00         Net Charges (line 200 +/- line 201)         0         0         0         0         0         202.00								
	202.00	Net Charges (line 200 +/- line 201)		0		0 0	0	202.00

Health Financial Systems COM	MUNI TY HOSPI TAL	OF BREMEN, IN	IC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	VACCINE COST	Provi der	CCN: 151300	Period:	Worksheet D
		Componen	t CCN: 15Z300	From 05/01/2015 To 04/30/2016	Part V Date/Time Prepared:
		componen	L CON. 152500	10 047 307 2010	9/28/2016 3:48 pm
		Ti tl	e XVIII	Swing Beds - SNF	Cost
	Cos	sts			
Cost Center Description	Cost	Cost			
	Reimbursed	Reimbursed			
	Servi ces	Services Not			
	Subject To Ded. & Coins.	Subject To Ded. & Coins.			
	(see inst.)	(see inst.)			
	6.00	7.00	-		
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	1		
50. 00 05000 OPERATI NG ROOM	0	0			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54.00
57.00 05700 CT SCAN	0	0			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	D		59.00
60. 00 06000 LABORATORY	0	0	D		60.00
60.01 06001 BLOOD LABORATORY	0	0	D		60.01
64.00 06400 I NTRAVENOUS THERAPY	0	0	D		64.00
65. 00 06500 RESPI RATORY THERAPY	0	0			65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	D		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	(	0		67.00
68. 00 06800 SPEECH PATHOLOGY	0				68.00
69. 00 06900 ELECTROCARDI OLOGY 69. 02 06902 SLEEP LAB	0				69.00 69.02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0				73.00
OUTPATIENT SERVICE COST CENTERS			2		, 0. 00
90. 00 09000 CLINIC	0	(			90.00
91.00 09100 EMERGENCY	0	C			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	o		92.00
200.00 Subtotal (see instructions)	0	0			200.00
201.00 Less PBP Clinic Lab. Services-Program	0				201.00
Only Charges					
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

Health Financial Systems

COMMUNI TY	HOSPI TAL	0F	BREMEN,	INC.	

In Lieu of Form CMS-2552-10

Heal th	Financial Systems COMMUNITY HOSPITAL OF	BREMEN, INC.	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 151300	Peri od:	Worksheet D-1	
			From 05/01/2015 To 04/30/2016	Date/Time Pre	nared
			10 01/00/2010	9/28/2016 3:4	
		Title XVIII	Hospi tal	Cost	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATI ENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		1, 552	1.00
2.00	Inpatient days (including private room days, excluding swing-l			1, 267	2.00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3.00
	do not complete this line.		· · · · · · · · · · · · · · · · · · ·		
l. 00	Semi-private room days (excluding swing-bed and observation be	ed days)		862	4.0
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	132	5.0
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	66	6.0
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	58	7.0
/.00	reporting period	in days) thi ough becchiber	ST OF the cost	50	/.0
3.00	Total swing-bed NF type inpatient days (including private roor	m davs) after December 3	1 of the cost	29	8.00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	396	9.00
	newborn days)				
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	126	10.0
11 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		and days) after	4.2	11.0
11.00	December 31 of the cost reporting period (if calendar year, er		uoni uays) arter	03	11.0
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.0
	through December 31 of the cost reporting period	5 ( 5 )			
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.0
	after December 31 of the cost reporting period (if calendar ye				
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.0
	Total nursery days (title V or XIX only)			0	
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 service	es through December 31 o	f the cost		17.0
17.00	reporting period	es through becember 51 0	T the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18.0
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	134.09	19.00
~~ ~~	reporting period			407.00	
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	137.30	20.0
21 00	reporting period Total general inpatient routine service cost (see instructions	e)		2, 424, 516	21.0
	Swing-bed cost applicable to SNF type services through December		ing period (line	2, 424, 310	22.0
22.00	5 x line 17)		ing poir ou (iriio	0	
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23.0
	x line 18)				
24.00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	7, 777	24.0
25 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	21 of the cost reporting	pariod (line 9	3, 982	25 0
23.00	x line 20)	si ol the cost reporting	perrou (rine o	3, 902	25.0
26.00	Total swing-bed cost (see instructions)			337, 851	26.0
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 086, 665	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	\$/			1
28.00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28.0
	Private room charges (excluding swing-bed charges)			0	29.0
	Semi-private room charges (excluding swing-bed charges)			0	30.0
	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus lino 22)(soo instruc	tions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x lin		(10115)	0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36.0
	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	2, 086, 665	
	27 minus line 36)			_, 000, 000	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
	Adjusted general inpatient routine service cost per diem (see			1, 646. 93	
	Program general inpatient routine service cost (line 9 x line			652, 184	
	Medically necessary private room cost applicable to the Progra			0	40.0
41 (1()	Total Program general inpatient routine service cost (line 39	+ ITTHE 40)		652, 184	41.0

Heal th	Financial Systems COM	MUNITY HOSPITAL	OF BREMEN, IN	С.	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 05/01/2015 To 04/30/2016	Worksheet D-1 Date/Time Pre	pared:
						9/28/2016 3:4	
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	Cost Program Cost	
	cost center bescription	Inpatient Costli				(col. 3 x col. 4)	
10.00		1.00	2.00	3.00	4.00	5.00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.00
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.00 47.00
47.00	Cost Center Description						47.00
						1.00	
	Program inpatient ancillary service cost (Wks					582, 738	48.00
49.00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	ee instructio	ns)		1, 234, 922	49.00
50.00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D. sum	of Parts L and	0	50.00
51.00	Pass through costs applicable to Program inpa					0	51.00
	and IV)						
52.00	Total Program excludable cost (sum of lines !		atad non nhu	ololon onooth	ation and	0	52.00
53.00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 9		ated, non-phy	si ci an anestri	etist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
	Program discharges					0	54.00
55.00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55.00 56.00
56.00 57.00	Difference between adjusted inpatient operati	ing cost and tar	get amount (l	ine 56 minus	ine 53)		57.00
	Bonus payment (see instructions)		g			0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost rep	porting period e	ndi ng 1996, u	pdated and co	mpounded by the	0.00	59.00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report und	ated by the m	arkat baskat		0.00	60.00
	If line 53/54 is less than the lower of lines				the amount by	0.00	61.00
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% of	the target		
42 00	amount (line 56), otherwise enter zero (see i	instructions)				0	62.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)				62.00 63.00
00100	PROGRAM INPATIENT ROUTINE SWING BED COST		(1 0110)				00100
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reporti	ng period (See	207, 513	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reporting	neriod (See	103, 757	65.00
00.00	instructions) (title XVIII only)			ost reporting		103,737	00.00
66.00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line 6	4 plus line 6	5)(title XVII	only). For	311, 270	66. 00
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 o	f the cost re	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after De	cember 31 of	the cost repo	rting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient ( 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	ost per diem (li	ne 70 ÷ line	2)			71.00
72.00	Program routine service cost (line 9 x line		(1) - 14 - 11	25)			72.00
73.00 74.00	Medically necessary private room cost applica Total Program general inpatient routine servi	U	•	ne 35)			73.00 74.00
75.00	Capital -related cost allocated to inpatient ( 26, line 45)	•		orksheet B, P	art II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line						77.00
78.00 79.00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess	,	ovidor record	c)			78.00 79.00
80.00	Total Program routine service costs for compa			· · · · · · · · · · · · · · · · · · ·	us line 79)		80.00
81.00	Inpatient routine service cost per diem limit				,		81.00
82.00	Inpatient routine service cost limitation (I						82.00
83.00 84.00	Reasonable inpatient routine service costs (see in		)				83.00 84.00
84.00 85.00	Program inpatient ancillary services (see ins Utilization review - physician compensation		s)				84.00 85.00
	Total Program inpatient operating costs (sum	of lines 83 thr				<u> </u>	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 o		line 2)			405 1, 646. 93	87.00 88.00
	Observation bed cost (line 87 x line 88) (see					667, 007	
		-					-

Health Financial Systems COM	MUNI TY HOSPI TAL	OF BREMEN, IN	C.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 05/01/2015	Worksheet D-1	
				To 04/30/2016	Date/Time Pre 9/28/2016 3:4	
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	390, 659	2, 424, 516	0. 16112	9 667,007	107, 474	90.00
91.00 Nursing School cost	0	2, 424, 516	0.00000	0 667,007	0	91.00
92.00 Allied health cost	0	2, 424, 516	0.00000	667,007	0	92.00
93.00 All other Medical Education	0	2, 424, 516	0.00000	667, 007	0	93.00

COMMUNI TY	HOSPI TAL	0F	BREMEN,	INC.

In Lieu of Form CMS-2552-10

		Title XIX	From 05/01/2015 To 04/30/2016 Hospi tal	Date/Time Prep 9/28/2016 3:48 Cost	pared: 8 pm
	Cost Center Description			COST	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	NPATLENT DAYS Inpatient days (including private room days and swing-bed days	a avaluding nawbarn)		1, 552	1.0
	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			1, 552	2.0
	Private room days (excluding swing-bed and observation bed day		rivate room davs.	1, 207	
	do not complete this line.	5 5			
	Semi-private room days (excluding swing-bed and observation be	5 7		862	4.0
	Total swing-bed SNF type inpatient days (including private roc	om days) through Decembe	er 31 of the cost	0	5.0
	reporting period Total swing-bed SNF type inpatient days (including private roc	om davs) after December	31 of the cost	198	6. C
	reporting period (if calendar year, enter 0 on this line)				
	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	58	7.0
	reporting period		1 -6	20	
	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	I OF THE COST	29	8.0
	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	15	9.0
	newborn days)		, C		
	Swing-bed SNF type inpatient days applicable to title XVIII on		room days)	0	10. C
	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		and dave) often	0	11.0
	December 31 of the cost reporting period (if calendar year, en		oom days) arter	0	11.0
	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.0
	through December 31 of the cost reporting period		•		
	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.0
	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. (
	Total nursery days (title V or XIX only)	in (excluding swing-bed	uays)	186	
	Nursery days (title V or XIX only)			8	
	SWING BED ADJUSTMENT				]
	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost		17. (
	reporting period Medicare rate for swing-bed SNF services applicable to service	as after December 31 of	the cost		18.0
	reporting period				10.0
9.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19.0
	reporting period			0.00	
	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	ne cost	0.00	20.0
	Total general inpatient routine service cost (see instructions	5)		2, 424, 516	21. (
	Swing-bed cost applicable to SNF type services through Decembe		ing period (line	0	
	5 x line 17)				
	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23.0
	Swing-bed cost applicable to NF type services through December	- 31 of the cost reporti	na period (line	0	24.0
	7 x line 19)			-	
	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25.0
	x line 20) Total swing-bed cost (see instructions)			327, 682	26.0
	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		2, 096, 834	
-	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
1	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	11110 20)		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 min	, ,	tions)	0.00	
	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 2, 096, 834	
	27 minus line 36)	and private room cost di		2, 070, 034	37.0
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
		1		1, 654. 96	38. (
8.00	Adjusted general inpatient routine service cost per diem (see				
8.00 9.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	38)		24, 824	39. (

Heal th	Financial Systems COM	MUNITY HOSPITAL	OF BREMEN,	INC.	In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi de	er CCN: 151300	Period: From 05/01/2015	Worksheet D-1	
					To 04/30/2016	Date/Time Pre	
			т	itle XIX	Hospi tal	9/28/2016 3:44 Cost	8 pm
	Cost Center Description	Total	Total	Average Per		Program Cost	
	'	Inpatient Cost	Inpatient Day	ysDiem (col. 1		(col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
42.00	NURSERY (title V & XIX only)	80, 373		86 432.			42.00
	Intensive Care Type Inpatient Hospital Units	; 					
	INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.00 45.00
	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (W	(st D-3 col 3	Line 200)			1.00	48.00
	Total Program inpatient costs (sum of lines			i ons)		50, 370	49.00
	PASS THROUGH COST ADJUSTMENTS	¥ ; ;		•		1	
50.00	Pass through costs applicable to Program inp	patient routine	services (fr	om Wkst. D, sur	n of Parts I and	0	50.00
51.00	<pre>III) Pass through costs applicable to Program ing and IV)</pre>	batient ancillar	y services (	from Wkst. D, s	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
	Total Program inpatient operating cost exclu		lated, non-p	hysi ci an anestł	netist, and	0	53.00
	medical education costs (line 49 minus line	52)					
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	55.00
	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operat	ting cost and ta	rget amount	(line 56 minus	line 53)	0	57.00
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting poriod	onding 1004	undated and c	mounded by the	0.00	58.00 59.00
59.00	market basket	eportring perrou	ending 1990,	upuateu anu cu	inpounded by the	0.00	59.00
	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
61.00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (Tines 54	x 60), or 1% of	the target		
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive paym	nent (see instru	ictions)			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doco	mbor 21 of t	ho cost roporti	na pari od (Soo	0	64.00
04.00	instructions) (title XVIII only)	sts through bece		ne cost reporti	ng period (see	0	04.00
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	er 31 of the	cost reportino	g period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routir	ne costs through	December 31	of the cost re	eporting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routir	ne costs after D	ecember 31 o	f the cost rep	orting period	0	68.00
	(line 13 x line 20)				a chug por rou		
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil				1		70.00
	Adjusted general inpatient routine service of		ine 70 ÷ lin	e 2)			71.00
72.00 73.00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v	line 35)			72.00 73.00
74.00	Total Program general inpatient routine serv	-					74.00
75.00	Capital-related cost allocated to inpatient	•			Part II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
	Program capital -related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minu	,					78.00
79.00	Aggregate charges to beneficiaries for exces			· · · ·	Nuc Line 70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost rimitati		103 IIIC /7)		80.00 81.00
82.00	Inpatient routine service cost limitation (I		)				82.00
	Reasonable inpatient routine service costs (	•	s)				83.00
	Program inpatient ancillary services (see in						84.00
	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85.00 86.00
55.00	PART IV - COMPUTATION OF OBSERVATION BED PAS						00.00
	Total observation bed days (see instructions	5)				405	87.00
88.00 89.00	Adjusted general inpatient routine cost per	•				1, 654. 96 670, 259	
07.00	Observation bed cost (line 87 x line 88) (se	le matruetrons)				010,239	09.00

Health Financial Systems COM	MUNI TY HOSPI TAL	OF BREMEN, INC	C.	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 05/01/2015 To 04/30/2016		
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	390, 659	2, 424, 516	0. 16112	9 670, 259	107, 998	90.00
91.00 Nursing School cost	0	2, 424, 516	0.00000	0 670, 259	0	91.00
92.00 Allied health cost	0	2, 424, 516	0.00000	0 670, 259	0	92.00
93.00 All other Medical Education	0	2, 424, 516	0.00000	670, 259	0	93.00

	ncial Systems CO ANCILLARY SERVICE COST APPORTIONMENT	MMUNITY HOSPITAL OF BRI	rovi der		51300	Per	ri od:	u of Form CMS-: Worksheet D-3	
			i ovi dei	0011. 1	01000	Fro	om 05/01/2015		
						То	04/30/2016		
			Ti +1	e XVII	1		Hospi tal	9/28/2016 3:4 Cost	8 pm
	Cost Center Description		11 (1		of Cos	:+	Inpatient	Inpati ent	
	Cost center beschiption				Charges			Program Costs	
					sinai goo			(col. 1 x col.	
							g	2)	
				1	1.00		2.00	3.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS								
30.00 0300	0 ADULTS & PEDIATRICS			1			612, 031		1 30. OC
43.00 0430	0 NURSERY								43.00
ANCI I	LLARY SERVICE COST CENTERS								1
50.00 0500	O OPERATING ROOM				0.39974	49	411, 013	164, 302	50.00
52.00 0520	O DELIVERY ROOM & LABOR ROOM				0.33864	49	0	0	52.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C				0.52520	08	41, 290	21, 686	54.00
57.00 0570	O CT SCAN				0.15236	64	44, 635	6, 801	57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)				0.4029	74	19, 799	7, 978	58. OC
	O CARDI AC CATHETERI ZATI ON				0.0000	00	0	0	59. OC
60.00 0600	0 LABORATORY				0.2990	92	146, 764	43, 896	60. OC
60.01 0600	1 BLOOD LABORATORY				0.0000	00	0	0	60.01
64.00 0640	0 INTRAVENOUS THERAPY				0.38436	68	0	0	64.00
65.00 0650	0 RESPI RATORY THERAPY				0.9680	97	1, 232	1, 193	65. OC
66.00 0660	0 PHYSI CAL THERAPY				0.5216	94	83, 875	43, 757	66.00
67.00 0670	0 OCCUPATI ONAL THERAPY				0.0000	00	0	0	67.00
68.00 0680	O SPEECH PATHOLOGY				0.0000	00	0	0	68.00
	0 ELECTROCARDI OLOGY				0.02836	69	4, 900	139	69.00
	2 SLEEP LAB				0.49812		0	0	
70.00 0700	0 ELECTROENCEPHALOGRAPHY				0.0000	00	0	0	70.00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS				0.8389	51	49, 057	41, 156	71.00
72.00 0720	OIMPL. DEV. CHARGED TO PATIENTS				0.4979	73	234, 427	116, 738	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS				0.6019	53	219, 790	132, 303	73.00
OUTP	ATIENT SERVICE COST CENTERS								
90.00 0900	O CLINIC				0.0000	00	0	0	90.00
	0 EMERGENCY				1.19529		2, 333	2, 789	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART)				0.58748	83	0	0	
200.00	Total (sum of lines 50-94 and 96-98)						1, 259, 115	582, 738	200.00
201.00	Less PBP Clinic Laboratory Services-P	rogram only charges (li	ne 61)				0		201.00
202.00	Net Charges (line 200 minus line 201)						1, 259, 115		202.00

	Financial Systems COMMUNITY HOSPITAL OF B NT ANCILLARY SERVICE COST APPORTIONMENT	REMEN, IN Provider	CCN: 151300	Peri od:	Worksheet D-3	3
				From 05/01/2015	5	
		Component	CCN: 15Z300	To 04/30/2016		
		Ti †I	e XVIII	Swing Beds - SN	9/28/2016 3:4 F Cost	48 pm
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
			J	Charges	(col. 1 x col.	
				5	2)	
			1.00	2.00	3.00	
1	NPATIENT ROUTINE SERVICE COST CENTERS		•			
	3000 ADULTS & PEDI ATRI CS			(		30. 00
43.00 0	04300 NURSERY					43.00
A	NCILLARY SERVICE COST CENTERS		•			
50.00 0	5000 OPERATING ROOM		0. 3997	49 (	0 0	50.0
52.00 0	5200 DELIVERY ROOM & LABOR ROOM		0. 3386	49 (	0 0	52.0
54.00 0	05400 RADI OLOGY-DI AGNOSTI C		0. 5252	08 6, 75 ⁴	3, 546	54.0
57.00 0	15700 CT SCAN		0. 1523	64 6, 881	1, 048	57.0
58.00 0	5800 MAGNETIC RESONANCE IMAGING (MRI)		0. 4029	74 (	0 0	58.0
59.00 0	5900 CARDI AC CATHETERI ZATI ON		0.0000	00 0	0 0	59.0
50.00 0	06000 LABORATORY		0. 2990	92 34, 361	10, 277	60. 0
50.01 0	06001 BLOOD LABORATORY		0. 0000	00 0	0 0	60. 0
54.00 0	06400 I NTRAVENOUS THERAPY		0. 3843	68 (	0 0	64.0
55.00 0	06500 RESPI RATORY THERAPY		0. 9680	97 528	511	65. C
6.00 0	06600 PHYSI CAL THERAPY		0. 5216	94 86, 517	45, 135	66. C
57.00 0	06700 OCCUPATI ONAL THERAPY		0.0000	00 0	0 0	67. C
8.00 0	06800 SPEECH PATHOLOGY		0.0000	00 0	0 0	68.0
9.00 0	06900 ELECTROCARDI OLOGY		0. 0283	69 392	2 11	69.0
9. 02 0	06902 SLEEP LAB		0. 4981	20 (	0 0	69. C
70.00 0	07000 ELECTROENCEPHALOGRAPHY		0.0000	00 0	0 0	70. C
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 8389	51 2, 679	2, 248	8 71. C
2.00 0	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4979	73 (	0 0	72.0
73.00 0	07300 DRUGS CHARGED TO PATIENTS		0. 6019	53 62, 986	37, 915	73.0
0	UTPATIENT SERVICE COST CENTERS					
90.00 0	99000 CLI NI C		0.0000		-	90.0
91.00 0	9100 EMERGENCY		1. 1952	93 1, 971	2, 356	91. C
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5874		0 0	92.0
200.00	Total (sum of lines 50-94 and 96-98)			203, 066	103, 047	200. 0
201.00	Less PBP Clinic Laboratory Services-Program only charges (	ine 61)		(		201.0
202.00	Net Charges (line 200 minus line 201)			203, 066		202.0

Health Financial Systems COMMUNITY HOSPITAL C INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151300	Period: From 05/01/2015 To 04/30/2016	Date/Time Pre	pared:
		le XIX	Hospi tal	9/28/2016 3:4 Cost	8 pm
Cost Center Description	111	Ratio of Cos		Inpatient	
		To Charges		Program Costs	
		j is sharges	Charges	(col. 1 x col.	
			J	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				•	
30. 00 03000 ADULTS & PEDIATRICS			26, 376		1 30. 00
43. 00 04300 NURSERY			6, 594		43.00
ANCI LLARY SERVI CE COST CENTERS					1
50. 00 05000 OPERATI NG ROOM		0.3997	49 30, 713	12, 277	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3386	49 4, 090	1, 385	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 5252	08 431	226	54.00
57.00 05700 CT SCAN		0. 1523	64 325	50	57.0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 4029	74 0	0	58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000	00 00	0	59.00
60. 00 06000 LABORATORY		0. 2990	92 4, 756	1, 422	60.00
60. 01 06001 BLOOD LABORATORY		0.0000	00 00	0	60.0
64. 00 06400 I NTRAVENOUS THERAPY		0. 3843	68 0	0	64.0
65. 00 06500 RESPI RATORY THERAPY		0. 9680	97 295	286	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 5216	94 0	0	66.0
67. 00 06700 OCCUPATI ONAL THERAPY		0.0000	00 0	0	67.0
68. 00 06800 SPEECH PATHOLOGY		0.0000	00 0	0	68.0
69. 00 06900 ELECTROCARDI OLOGY		0. 0283	69 472	13	69.0
69. 02 06902 SLEEP LAB		0. 4981	20 0	0	69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.8389	51 4, 319	3, 623	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4979	73 0	0	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 6019	53 3, 853	2, 319	73.0
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.0000	00 00	0	90.0
91. 00 09100 EMERGENCY		1. 1952		488	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5874	83 0	0	1 /2.0
200.00 Total (sum of lines 50-94 and 96-98)			49, 662		
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.0
202.00 Net Charges (line 200 minus line 201)			49, 662		202.00

Health Financial Systems	COMMUNI TY HOSPI TA	AL OF BREMEN, INC.	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT S	ETTLEMENT	Provider CCN: 151300	Peri od: From 05/01/2015 To 04/30/2016	Worksheet E Part B Date/Time Prep 9/28/2016 3:48	
		Title XVIII	Hospi tal	Cost	
				1.00	
PART B - MEDICAL AND OTH	IER HEALTH SERVICES				
1.00 Medical and other servi	ces (see instructions)			4, 001, 557	1.00
2.00 Medical and other servi	ces reimbursed under OPPS (see ins	tructions)		0	2.00
3.00 PPS payments				0	3.00
4.00 Outlier payment (see in	structions)			0	4.00
5.00 Enter the hospital spec	fic payment to cost ratio (see in	structions)		0. 000	5.00
6.00 Line 2 times line 5				0	6.00
7.00 Sum of line 3 plus line	4 divided by line 6			0.00	7.00

9.00       Ancillary service other pass through costs from Wkst. 0, Pt. IV, col. 13, line 200       0       9.00         10.00       Total cost (sum of lines 1 and 10) (see instructions)       4.001,557         11.00       Cost (sum of lines 1 and 10) (see instructions)       4.001,557         12.00       Ancillary service charges       0         12.01       Ancillary service charges       0         12.01       Ancillary service charges       0         13.00       Total reasonable charges (sum of lines 12 and 13)       0         15.00       Apgregate amount actually collected from patients liable for payment for services on a charge basis       0         15.00       Apgregate amount actually collected from patients liable for payment for services on a charge basis       0         15.00       Apgregate amount actually collected from patients liable for payment for services on a charge basis       0         15.00       Apgregate amount actually collected from patients (liable for payment for services on a charge basis)       0         16.00       Total customary charges or reasonable cost (complete only if line 18 exceeds line 11) (see       0         17.00       Ratio of lines 15 (see instructions)       4.041,573       21.00         17.00       Exceeds of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see cost over charges (line 11 minus line 20) (for CAH se	7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
10.00       Organ activity sittions       0       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       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       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       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       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       10.00       10.00       10.00<	8.00	Transitional corridor payment (see instructions)	0	8.00
11.00       Total cost (sam of lines 1 and 10) (see instructions)       4.001,557       11.00         COMPACTION OF LESSER OF COST OR CHARGES         Reasonable charges         Compacting its it on charges (from Wkst. 0-4, Pt. 111, col. 4, line 69)       0       12.00         Controp of the charges (sum of lines 12 and 13)         Controp of the charges (sum of lines 12 and 13)         Controp of the colspan="2">Controp of the colspan="2"         Controp of	9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
COMPUTATION OF LESSER OF COST OR CHARGES           Reasonable charges           12.00         Ancillary service charges         0           13.00         Total reasonable charges (sum of lines 12 and 13)         0           15.00         Aggregate amount actually collected from patients liable for payment for services on a chargebasis         0           16.00         Aggregate amount actually collected from patients liable for payment for services on a chargebasis         0           17.00         Netto of line 15 to line 10 (not to exceed tho00000)         0         0           18.00         Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see linstructions)         0         0           19.00         Excess of cost or charges (see instructions)         4         0         0           10.00         Excess of cost or charges (see instructions)         4         0         0         0           20.00         Excess of cost or charges (ine 11 minus line 20) (for CAH see instructions)         2         0         2         0           21.00         Interns and residents (see instructions)         4         0         2         0         2         0         2         0         2         0         2         0         2         0         2         0         2	10.00	Organ acqui si ti ons	0	10.00
Reasonable charges         0           12.0         Ancil lary service charges         0           13.00         Organ acquisition charges (from Wkst. D-4, Pt. 111, col. 4, line 69)         0           13.00         Organ acquisition charges (from Wkst. D-4, Pt. 111, col. 4, line 69)         0           14.00         Total reasonable charges (sum filmes 12 and 13)         0           15.00         Aggregate amount actually collected from patients liable for payment for services on a charge basis         0           15.00         Anounts that would have been realized from patients liable for payment for services on a charge basis         0           16.00         Total custemary charges (see Instructions)         0         0           17.00         Ratio of line 15 to line 16 (not to exceed 1.000000)         10         0           19.00         Exerticef (costomary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)         0         20.00           20.00         Exerticef (see instructions)         0         23.00         23.00           20.00         Instructions)         2.0, 21.00         23.00         23.00         23.00           20.00         Instructions)         2.0, 11.01         2.0, 00         23.00         23.00         23.00         23.00         23.00         23.00	11.00	Total cost (sum of lines 1 and 10) (see instructions)	4, 001, 557	11.00
12:00       Ancillary service charges       0       12:00       Fragma causistion charges (from Wkst. D-4, Pt. III, col. 4, line 69)       0       13:00         13:00       Total reasonable charges (sum of lines 12 and 13)       0       14:00       0         14:00       Aggregate amount actually collected from patients liable for payment for services on a charge basis       0       16:00         10:00       Aggregate amount actually collected from patients liable for payment for services on a charge basis       0       16:00         10:00       Reaction of line 15:00       10:00:00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       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		COMPUTATION OF LESSER OF COST OR CHARGES		
13.00       Organ acquisition charges (from Wkst. D-4, Pt. 111. col. 4, line 69)       0       13.00         14.00       Total reasonable charges (sum of lines 12 and 13)       0         15.00       Agregate amount actually collected from patients liable for payment for services on a charge basis       0         16.00       Nounts that would have been realized from patients liable for payment for services on a charge basis       0         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0       0.000000         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0       0         18.00       Excess of customary charges (see instructions)       0       0       0         20.00       Excess of customary charges (see instructions)       4,041.573       21.00         20.00       Interns and residents (see instructions)       0       23.00       0       23.00         21.00       Lesser of Cost or charges (line 11 minus line 20) (for CAH see instructions)       0       24.01.73       21.00         22.00       Total prospective payment (sum of lines 3, 4, 8 and 9)       0       24.01.73       20.00         20.00       Boductibles and col nsurance (for CAH, see instructions)       27.111       25.00       25.00       27.991.792       27.00       27.992.700       27.992.700       2		Reasonable charges		
14.00       Total resenable charges (sum of lines 12 and 13)       0       14.00         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)       0       16.00         10.00       Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see linstructions)       0.000000       0.000000         10.00       Total customary charges over reasonable cost (complete only if line 11 exceeds line 18) (see linstructions)       0.000000       0.000000         10.00       Exceeds or customary charges over reasonable cost (complete only if line 11 exceeds line 18) (see linstructions)       0.00000       0.00000         20.00       Exceeds or customary charges over customary charges cline 11 mus line 20) (for CAH see instructions)       0.00000       0.00000         21.00       Exceeds or customary charges over customary charges cline 110 (see instructions)       0.00000       0.000000         22.00       Exceeds or customary charges over customary charges cline 110 (see instructions)       0.000000       0.00000000000000000000000000000000000	12.00	Ancillary service charges	0	12.00
Customary charges         Current of the second of the	13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)       0       15.00         16.00       Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)       0       0         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0       0.000000 17.00         18.00       Total customary charges (see instructions)       0       0.000000 17.00         18.00       Total customary charges (see instructions)       4.041.573       21.00         19.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0       22.00         10.01       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0       23.00         21.00       Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)       0       23.00       23.00         22.00       Interns and residents (see instructions)       1.018.073       24.00       24.00         22.00       Lesser of cost or charges (10 cM in see instructions)       1.018.073       24.00         23.00       Detect paduate medical education payments (From Wkst. E-4, line 50)       0       2.995,789       <	14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
16. 00       Amount's that would have been realized from patients liable for payment for services on a chargebasis had such payment been rade in accordance with 42 CR \$413.13(e)       0         17. 00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0.000000       0.000000         18.00       Decess of customary charges (see instructions)       0.000000       0       18.00         20.00       Excess of customary charges (see instructions)       4.041.573       21.00       18.00       0.00000       18.00       0.00000       18.00       0.00000       19.00         21.00       Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)       4.041.573       21.00       22.00         22.00       Cost of physicians' services in a teaching hospital (see instructions)       0       23.00       0.23.00       0.23.00       0.24.00       0.24.00       0.24.00       0.24.00       0.24.00       0.24.00       0.24.00       0.24.00       0.24.00       0.24.00       0.24.00       0.24.00       0.29.00       2.99.789       2.09.789       2.09.789       2.09.789       2.09.789       2.09.789       2.09.789       2.09.789       2.09.789       2.09.789       2.00       2.99.789       2.09.789       2.00       2.99.789       2.00       2.99.789       2.00       2.99.789       2.00       2.99.7		Customary charges		
had such payment been made in accordance with 42 CFR §413.13(e)       0       0         17.00 Ratio of line 15 to line 16 (not to exceed 1.000000)       0       0         08.00 Total customary charges (see instructions)       0.000000         09.00 Excess of customary charges (complete only if line 18 exceeds line 11) (see instructions)       0         01.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0         01.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0         01.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0         01.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0         01.00 Excess of reasonable cost over reasonable cost (complete only if line 11 exceeds line 18) (see instructions)       0         01.00 Excess of reasonable cost over reasonable cost (complete only if line 11 exceeds line 18) (see instructions)       0         02.00 Excess of reasonable cost over reasonable cost (complete only if line 11 exceeds line 18) (see instructions)       0         02.00 Excess of reasonable cost over reasonable cost (from Wkst. E-4, line 30)       0         03.00 Direct graduate medical education payments (from Wkst. E-4, line 30)       2,995,789       0         03.00 Composite rate ESR0 (from Wkst. E-5, line 11)	15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
17.00       Ratio of line 15 to line 16 (not to exceed 1.00000)       0.000000       17.00         18.00       Total customary charges (see instructions)       0.000000       17.00         18.00       Total customary charges (see instructions)       0.000000       17.00         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0.000000       17.00         21.00       Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)       4.041.573       21.00         20.00       Cost of physicians' services in a teaching hospital (see instructions)       0.024.00       0.024.00         20.00       Cost of physicians' services in a teaching hospital (see instructions)       0.024.00       0.024.00         21.00       Deductible sand Coinsurance relating to amount on line 24 (for CAH, see instructions)       1.018.073       26.00         21.00       Deductible sand Coinsurance (for CAH, see instructions)       0.2995.789       27.00         22.00       Destital (line 32 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 minus       2.995.789       2.90         20.00       Destital (line 371 moruph 29)       2.995.789       2.90       2.995.789       2.90         21.00       Destital (line 371 moruph 29)       2.995.789       2.90       2.995.789	16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.00
18.00       Total customary charges (see instructions)       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       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 <t< td=""><td></td><td>had such payment been made in accordance with 42 CFR §413.13(e)</td><td></td><td></td></t<>		had such payment been made in accordance with 42 CFR §413.13(e)		
19.00       Excess of customary Charges over reasonable cost (complete only if line 18 exceeds line 11) (see       0       0.00         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see       0       0.00         21.00       Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)       4.041,573       21.00         20.00       Cost of physicians' services in a teaching hospital (see instructions)       0       02.00         20.00       Cost of physic lans' services in a teaching hospital (see instructions)       0       0         50.00       Deductibles and Colnsurance (for CAH, see instructions)       1.018,073       26.00         27.00       Deductible and Colnsurance (for CAH, see instructions)       1.018,073       26.00         28.00       Detect aduate medical education payments (from Wkst, E-4, line 50)       2.995,789       2.995,789         20.00       Detuctible sand Colnsurance for CAH, see instructions)       2.995,789       30.00         20.00       Detuctal (cost of aduate medical education payments (from Wkst, E-4, line 50)       2.995,789       30.00         20.00       Detuctal (cost of aduate medical education payments)       2.995,789       30.00       2.995,789       30.00         20.00       Distotal (lines 21 and 24 minus the sum of lines 22 and 23)       (see instructions)	17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
instructions)       20.00         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       20.00         21.00       Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)       4.041.573       21.00         22.00       Interns and residents (see instructions)       4.041.573       21.00         23.00       Cost of physic line's services in a teaching hospital (see instructions)       0.23.00       0.00         24.00       Total prospective payment (sum of lines 3, 4.8 and 9)       0.00       0.00       0.00         25.00       Deductibles and coinsurance (for CAH, see instructions)       27.711       25.00         26.00       Deductibles and coinsurance (for CAH, see instructions)       1.018.073       27.00         28.00       Direct graduate medical education payments (from Wkst. E-4, line 50)       0.00       29.95,789       27.00         20.00       Exet graduate medical education costs (from Wkst. E-4, line 36)       2.995,789       27.00       29.00       2.995,789       27.00       29.00       2.995,789       27.00       29.00       2.995,789       27.00       29.00       2.995,789       27.00       29.00       2.995,789       27.00       29.00       2.995,789       27.00       29.95,789       27.00       29.0	18.00	Total customary charges (see instructions)	0	18.00
20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions)       0       20.00         21.00       Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)       4,041,573       21.00         22.00       Interns and residents (see instructions)       0       23.00       0       23.00         22.00       Total prospective payment (sum of lines 3, 4, 8 and 9)       0       23.00       0       24.00         25.00       Deductibles and coinsurance (for CAH, see instructions)       1,018,073 26.00       27.711       25.00         26.00       Deductibles and coinsurance relating to anount on line 24 (for CAH, see instructions)       1,018,073 26.00       29.95,789       27.00         27.00       Subtotal (lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)       2,995,789       20.00         28.00       Direct graduate medical education costs (from Wkst. E-4, line 36)       2,995,789       20.00        29.00       StBN direct medical education costs (from Wkst. E-4, line 36)       2,995,789       20.00         30.00       Subtotal (line 30 minus line 31)       2,993,604       32.00       33.00         31.00       Crimary payer payments       3,302       33.00       33.00       33.00         30.00	19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	19.00
Instructions)4,041,57321.0022.00Interns and residents (see instructions)4,041,57321.0023.00Cost of physicians' services in a teaching hospital (see instructions)022.0023.00Cost of physicians' services in a teaching hospital (see instructions)024.0000Total prospective payment (sum of lines 3, 4, 8 and 9)024.0000COMPUTATION OF REIMBURGEMENT SETTLEMENT27.71125.0026.00Deductibles and coinsurance (for CAH, see instructions)1,018,07326.0027.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)1,018,07326.0028.00Direct graduate medical education payments (from Wkst. E-4, line 50)029.0029.0028.00Direct graduate medical education costs (from Wkst. E-4, line 36)029.0029.0020.00ESRN direct medical education costs (from Wkst. E-4, line 36)029.9030.0020.01Dirmary payer payments2,995,78930.0030.0020.02Dirmary payer payments2,996,7892.995,78930.0020.03Dirmary payer payments2,993,6042.995,78930.0020.05Dirmary payer payments2,993,6042.993,60430.0020.05Dirmary payer payments128.9031.0030.0020.05Dirmary payer payment adjustment (see instructions)188,26336.0030.00Composite rate ESRD (from wkst. E-5, line 11)033.00 <td></td> <td>instructions)</td> <td></td> <td></td>		instructions)		
21.00       Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)       4,041,573       21.00         22.00       Interns and residents (see instructions)       0       23.00         24.00       Total prospective payment (sum of lines 3, 4, 8 and 9)       0       23.00         25.00       Deductibles and coinsurance (for CAH, see instructions)       1,018,073       26.00         26.00       Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)       1,018,073       26.00         27.00       Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)       2.995,789       27.00         28.00       Direct graduate medical education payments (from Wkst. E-4, line 50)       0       28.00       2.995,789       30.00         29.00       ESR direct medical education costs (from Wkst. E-4, line 36)       2.995,789       30.00       2.993,604       32.00         30.00       Subtotal (uing 30 minus line 33)       2.993,604       32.00       33.00       33.00         31.00       Composite rate ESRD (from Wkst. I-5, line 11)       0       33.00       33.00       38.03       34.00       38.02       38.03       38.00         30.00       Adjusted reinbursable bad debts (see instructions)       188,810.00       38.00       39.00<	20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
22.00       Interns and residents (see instructions)       0       22.00         23.00       Cost of physicians' services in a teaching hospital (see instructions)       0       23.00         24.00       Total prospective payment (sum of lines 3, 4, 8 and 9)       0       24.00         COMPUTATION OF REIMBURSEMENT SETLEMENT       27.711       25.00         Deductibles and coinsurance (for CAH, see instructions)       27.711       25.00         27.00       Distortal (lines 21 and 24 minus the sum of lines 25 and 26) plus the seu mof lines 22 and 23] (see linstructions)       1,018,073       26.00         28.00       Direct graduate medical education payments (from Wkst. E-4, line 36)       0       28.00       0       295,789       27.00         20.00       ESRD direct medical education costs (from Wkst. E-4, line 36)       0       28.00       0       2.995,789       0.00       29.00       29.903,604       32.00         20.00       Subtotal (line 30 minus line 31)       2,993,804       2.00       2.993,804       32.00       33.00         31.00       Composite rate ESRD (from Wkst. I-5, line 11)       0       0       33.00       33.00         32.00       Subtotal (line 30 minus line 31)       198,323       34.00       33.00       33.00       33.00       33.00       33.00       3		instructions)		
22.00         Cost of physicians' services in a teaching hospital (see instructions)         0         23.00           24.00         Total prospective payment (sum of lines 3, 4, 8 and 9)         0         24.00           COMPUTATION OF REIMBURSEMENT SETTLEMENT         27,711         25.00         0         24.00         7.711         25.00         27,711         25.00         27.01         25.00         0         27.01         25.00         27.01         25.00         27.01         25.00         27.01         25.00         27.01         25.00         27.01         25.00         27.01         25.00         27.01         25.00         27.02         25.05         27.02         27.00         28.00         27.02         25.05         27.00         28.00         27.01         25.00         29.05         28.00         29.95,789         27.00         29.00         29.05         29.95,789         20.00         29.95,789         20.00         29.995,789         20.00         29.995,789         20.00         29.995,789         20.00         29.995,789         20.00         29.995,789         20.00         29.995,789         20.00         29.995,789         20.00         29.995,789         20.00         29.995,789         20.00         29.995,789         20.00         29.995,789	21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4, 041, 573	21.00
24.00       Total prospective payment (sum of lines 3, 4, 8 and 9)       0       24.00         25.00       Deductibles and coinsurance (for CAH, see instructions)       27,711       25.00         25.00       Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)       1,018,073       26.00         27.00       Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)       1,018,073       26.00         28.00       Direct graduate medical education payments (from Wkst. E-4, line 50)       0       28.00       0         20.00       ESRD direct medical education costs (from Wkst. E-4, line 36)       0       29.995,789       20.00         20.01       Subtotal [(sum of lines 32) fine 30 minus line 31)       2.995,789       21.85       31.00         21.00       Distructions)       1.018,073       2.995,789       32.00         22.01       Subtotal [(sum of lines 32) fine 30 minus line 31)       2.995,789       2.995,789       32.00         22.01       Subtotal [(ne 30 minus line 31)       2.995,789       32.00       2.995,789       32.00         33.00       Composite rate ESRD (from Wkst. I-5, line 11)       0       33.00       33.00       33.00       33.00       33.00       33.00       33.00       33.00       33.00	22.00	Interns and residents (see instructions)	0	22.00
COMPUTATION OF REINBURSTENTLEMENT25:00Deductibles and coinsurance (for CAH, see instructions)27,71125:00Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)1,018,07326:00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see2,995,78927:00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see2,995,78927:00Direct graduate medical education costs (from Wkst. E-4, line 36)029:00ESRD direct medical education costs (from Wkst. E-4, line 36)020:00Subtotal (sum of lines 27 through 29)2,995,78920:01Subtotal (sum of lines 27 through 29)2,995,78920:01Subtotal (see instructions)2,18321:00Subtotal (line 30 minus line 31)2,993,60422:00Subtotal (see instructions)198,32330:00Composite rate ESRD (from Wkst. I-5, line 11)030:00Gomposite rate ESRD (from Wkst. I-5, line 11)030:00Malborable bad debts (see instructions)158,26030:00Mibustol (see instructions)158,26030:00MSP-LCC reconciliation amount from PS&R3,122,51430:00MSP-LCC reconciliation payment (see instructions)030:00MSP-LCC reconciliation payment adjustment (see instructions)030:00Subtotal (see instructions)030:00Subtotal (see instructions)030:00Stote instructions)030:00M	23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
25.00Deductibles and coinsurance (for CAH, see instructions)27,71125.0026.00Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)1,018,07326.0027.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)1,018,07326.0028.00Direct graduate medical education payments (from Wkst. E-4, line 50)029.0029.00ESRD direct medical education costs (from Wkst. E-4, line 36)029.0030.00Subtotal (line 30 minus line 31)2,993,60431.00ALLOMABLE BAD DEBTS FCR PROFESSIONAL SERVICES)033.0031.00Composite rate ESRD (from Wkst. 1-5, line 11)033.0040.04 lowable bad debts (see instructions)158,26036.0035.00Adjusted reimbursable bad debts (see instructions)158,26036.0037.00Subtotal (see instructions)158,26036.0039.00OTHER ADUSTINGINE INSTRUCTIONS)39.5039.5239.99RECOVERY OF ACCELERATED DEPRECIATION039.9940.00Subtotal (see instructions)3,122,51440.01Interim payments039.9941.00Interim payments039.9042.00Tortactors use only)039.9943.00Geuestration adjustment (see instructions)039.9944.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0044.00Protested amounts (nonallowable c	24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
26.00Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)1,018,07326.0027.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)2,995,78927.0028.00Direct graduate medical education payments (from Wkst. E-4, line 50)028.0090ESD direct medical education costs (from Wkst. E-4, line 36)028.0030.00Subtotal (sum of lines 27 through 29)2,995,78930.0021.00Subtotal (ine 30 minus line 31)2,993,60432.00ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)033.0030.00Composite rate ESRD (from Wkst. I-5, line 11)033.0030.01Allowable bad debts (see instructions)198,32334.0031.02Subtotal (line 30 minus line 31)128,91035.0031.03Adjusted reimbursable bad debts (see instructions)198,32334.0030.00MALlowable bad debts (see instructions)158,6036.0031.03Ocomposite rate SERD (from Mast. I-5, line 11)033.0030.01Minus Hore SAR3,122,51437.0030.02Subtotal (see instructions)198,32334.0030.03OOHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)39.0030.03OOHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)39.5030.99Pertial or chill credit received from manufacturers for replaced devices (see instructions)39.9930.03Subtotal (see instructions)		COMPUTATION OF REIMBURSEMENT SETTLEMENT		
27.00       Subtotal [[lines 21 and 24 minus the sum of lines 25 and 26] plus the sum of lines 22 and 23] (see instructions)       2, 995, 789       27.00         28.00       Direct graduate medical education payments (from Wkst. E-4, line 50)       0       28.00       0       28.00       0       28.00       0       29.00       29.00       29.00       29.00       29.95, 789       30.00       29.00       29.95, 789       30.00       29.95, 789       30.00       2.995, 789       30.00       2.995, 789       30.00       2.995, 789       30.00       2.995, 789       30.00       2.995, 789       30.00       2.995, 789       30.00       2.995, 789       30.00       2.995, 789       30.00       2.995, 789       30.00       2.995, 789       30.00       2.995, 789       30.00       30.00       30.00       2.993, 604       32.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       31.00       2.993, 604       32.00       33.00       30.00       31.00       32.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00	25.00	Deductibles and coinsurance (for CAH, see instructions)	27, 711	25.00
instructions)28.00Direct graduate medical education payments (from Wkst. E-4, line 50)028.0029.00ESRD direct medical education costs (from Wkst. E-4, line 36)029.0030.00Subtotal (sum of lines 27 through 29)2,995,78930.0031.00Primary payments2,18531.0032.00Subtotal (line 30 minus line 31)2,993,60432.00ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)198,32334.00ALLOWABLE BAD DEBTS (exclude Ead bets (see instructions)198,32334.0035.00Allowable bad debts (see instructions)158,26036.0036.00Allowable bad debts for dual eligible beneficiaries (see instructions)158,26036.0037.00Subtotal (see instructions)158,26036.0038.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.9999Partial or full credits received from manufacturers for replaced devices (see instructions)39.9939.9939.99RECOVERY OF ACCELERATED DEPRECIATION3,102,52440.0041.00Interim payments3,122,51440.0043.00Balance due provider/program (see instructions)-44,47843.0044.00Protested amount (nonaliowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2-44,47843.0045.00Original outlier amount (see instructions)099.0090.00Outlier reconciliation adjustment am	26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1, 018, 073	26.00
28.00         Direct graduate medical education payments (from Wkst. E-4, line 50)         0         28.00         0         28.00         0         28.00         0         29.00         29.00         29.00         29.00         29.00         29.00         29.00         29.00         29.00         29.00         29.95,78         30.00         29.95,78         30.00         2.995,78         30.00         2.995,78         30.00         2.995,78         30.00         2.995,78         30.00         2.995,78         30.00         2.995,78         30.00         2.995,78         30.00         2.995,78         30.00         2.995,78         30.00         2.995,78         30.00         2.995,78         30.00         2.995,78         30.00         2.995,78         30.00         2.995,78         30.00         30.00         30.00         2.995,78         31.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         31.00         40.04 bt ts (see instructions)         128,910         35.00         31.20,214         37.00         30.00         30.00         30.122,514         37.00         38.00         39.20         39.90         39.90         39.99         90.00         Sub	27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	2, 995, 789	27.00
29.00ESRD direct medical education costs (from Wkst. E-4, line 36)0030.00Subtotal (sum of lines 27 through 29)2, 995, 78930.0031.00Primary payer payments2, 18531.0032.00Subtotal (line 30 minus line 31)2, 993, 60432.00ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)033.0033.00Composite rate ESRD (from Wkst. 1-5, line 11)033.0034.00Allowable bad debts (see instructions)198, 32334.0035.00Adjusted reimbursable bad debts (see instructions)158, 26036.0036.00Allowable bad debts for dual eligible beneficiaries (see instructions)158, 26036.0036.00Allowable bad debts for dual eligible beneficiaries (see instructions)38.0039.0036.00MSP-LCC reconciliation amount from PS&R039.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.99Partial or full credits received from manufacturers for replaced devices (see instructions)039.9939.99RECOVERY OF ACCELERATED DEPRECIATION039.9940.01Sequestration adjustment (see instructions)62, 45040.0141.00Interim payments3, 104, 54241.0042.00Fortested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2070TO BE COMPLETED BY CONTRACTOR091.0070.00Outlier reconciliation adjustment amount (see instructions)091.00 </td <td></td> <td>instructions)</td> <td></td> <td></td>		instructions)		
30.00Subtotal (sum of lines 27 through 29)2,995,78930.0031.00Primary payer payments2,18531.0022.01Subtotal (line 30 minus line 31)2,993,60432.00ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)33.0033.0033.0033.00Composite rate ESRD (from Wkst. 1-5, line 11)033.0041.0wable bad debts (see instructions)198,32334.0035.00Adjusted reimbursable bad debts (see instructions)128,91035.0036.00Allowable bad debts (see instructions)158,26036.0037.00Subtotal (see instructions)3,122,51437.0039.00OTHER ADJUSTNENTS (SEE INSTRUCTIONS) (SPECIFY)039.0099.8Partial or full credits received from manufacturers for replaced devices (see instructions)039.9039.99RECOVERY OF ACCELERATED DEPRECIATION039.9040.00Subtotal (see instructions)3,122,51440.0039.99RECOVERY OF ACCELERATED DEPRECIATION62,45040.0140.01Sequestration adjustment (see instructions)3,104,54241.0041.00Balance due provider/program (see instructions)-44,47843.0042.00Tentative settlement (for contractors use only)-44,47843.0043.00Balance due provider/program (see instructions)090.0044.00Deriested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, of 15.2090.0070.00Ori	28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
31.00Primary payer payments2,18531.0032.00Subtotal (1ine 30 minus line 31)2,993,60432.00ALLOWABLE BAD DEBTS [EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)33.0033.00Composite rate ESRD (from Wkst. 1-5, line 11)034.00Allowable bad debts (see instructions)198,32335.00Adjusted reimbursable bad debts (see instructions)128,91036.00Allowable bad debts for dual eligible beneficiaries (see instructions)158,26036.00Allowable bad debts for dual eligible beneficiaries (see instructions)3,122,51437.00Subtotal (see instructions)38.0038.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.99RECOVERY OF ACCELERATED DEPRECIATION039.99RECOVERY OF ACCELERATED DEPRECIATION3,122,51440.00Subtotal (see instructions)3,122,51439.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION041.00Interim payments3,104,54241.00Interim payments3,104,54241.00Interim adjustment (see instructions)-44,47843.00Balance due provider/program (see instructions)-44,47843.00Original outlier amount (see instructions)044.00Fortistication adjustment amount (see instructions)070.00Original outlier amount (see	29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
32.00Subtotal (in: 30 minus line 31)2,993,60432.00ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)33.0033.00Composite rate ESRD (from Wkst. 1-5, line 11)034.00Allowable bad debts (see instructions)198,32336.00Allowable bad debts for dual eligible beneficiaries (see instructions)188,26036.00Allowable bad debts for dual eligible beneficiaries (see instructions)38.0037.00Subtotal (see instructions)188,26038.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.90Partial or full credits received from manufacturers for replaced devices (see instructions)039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)039.9841.00Interim payments3,104,54241.0042.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-44,47843.0044.00Original outlier amount (see instructions)090.0090.00Original outlier amount (see instructions)091.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructi	30.00	Subtotal (sum of lines 27 through 29)	2, 995, 789	30.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)33.00Composite rate ESRD (from Wkst. 1-5, line 11)034.00Allowable bad debts (see instructions)198, 32335.00Adjusted reimbursable bad debts (see instructions)128, 91035.00Adjusted reimbursable bad debts (see instructions)128, 91036.00Allowable bad debts for dual eligible beneficiaries (see instructions)188, 26036.00Allowable bad debts for dual eligible beneficiaries (see instructions)188, 26037.00Subtotal (see instructions)3, 122, 51438.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.99Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION039.99RECOVERY OF ACCELERATED DEPRECIATION62, 45040.00Subtotal (see instructions)62, 45041.00Interim payments3, 104, 54241.00Interim payments042.00Tentative settlement (for contractors use only)044.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2070Original outlier amount (see instructions)090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.00 <tr< td=""><td>31.00</td><td>Primary payer payments</td><td>2, 185</td><td>31.00</td></tr<>	31.00	Primary payer payments	2, 185	31.00
33.00Composite rate ESRD (from Wkst. I-5, line 11)033.0034.00All owable bad debts (see instructions)198, 32334.0035.00Adj usted reimbursable bad debts (see instructions)128,91035.0036.00All owable bad debts for dual eligible beneficiaries (see instructions)128,91035.0037.00Subtotal (see instructions)158,26036.0037.00Subtotal (see instructions)3,122,51437.0038.00MSP-LCC reconciliation amount from PS&R39.0039.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.90Partial or full credits received from manufacturers for replaced devices (see instructions)39.9039.99RECOVERY OF ACCELERATED DEPRECIATION39.9040.00Subtotal (see instructions)3,122,51440.01Sequestration adjustment (see instructions)62,45040.01Interim payments3,104,54242.00Tentative settlement (for contractors use only)3,104,54243.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, S115.2070DE COMPLETED BY CONTRACTOR090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The value of Money (see instructions)093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)093.00	32.00	Subtotal (line 30 minus line 31)	2, 993, 604	32.00
34.00Allowable bad debts (see instructions)198,32334.0035.00Adjusted reimbursable bad debts (see instructions)128,91035.0036.00Allowable bad debts for dual eligible beneficiaries (see instructions)158,26036.0037.00Subtotal (see instructions)3,122,51437.0038.00MSP-LCC reconciliation amount from PS&R038.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.90Pioneer ACO demonstration payment adjustment (see instructions)039.5039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9039.99RECOVERY OF ACCELERATED DEPRECIATION039.9040.01Sequestration adjustment (see instructions)039.9240.01Sequestration adjustment (see instructions)039.9241.00Interim payments042.0042.00Fortative settlement (for contractors use only)-44,47843.0044.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.0070.00Original outlier amount (see instructions)090.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00Time Value of Money (see instructions)091.0093.00Time Value of Money (see instructions)093.00		ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
35.00Adjusted reimbursable bad debts (see instructions)128,91035.0036.00Allowable bad debts for dual eligible beneficiaries (see instructions)158,26036.0037.00Subtotal (see instructions)3,122,51437.0038.00MSP-LCC reconciliation amount from PS&R039.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9839.98RECOVERY OF ACCELERATED DEPRECIATION039.9840.00Subtotal (see instructions)039.9840.01Sequestration adjustment (see instructions)039.9841.00Interim payments62,45040.0142.00Tentative settlement (for contractors use only)041.0043.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, S115.2090.0090.00Original outlier amount (see instructions)091.0090.00Original outlier amount (see instructions)091.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00Time Value of Money (see instructions)091.0093.00Time Value of Money (see instructions)093.00	33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
36.00Allowable bad debts for dual eligible beneficiaries (see instructions)158,26036.0037.00Subtotal (see instructions)3,122,51437.0038.00MSP-LCC reconciliation amount from PS&R038.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.90Partial or full credits received from manufacturers for replaced devices (see instructions)039.5039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9039.99RECOVERY OF ACCELERATED DEPRECIATION039.9840.00Subtotal (see instructions)039.9940.01Sequestration adjustment (see instructions)039.9940.02Subtotal (see instructions)03,122,51440.03Sequestration adjustment (see instructions)039.9840.01Sequestration adjustment (see instructions)042.0041.00Interim payments3,104,54241.0042.00Frotative settlement (for contractors use only)-44,47843.0043.00Balance due provider/program (see instructions)090.0044.00Sil15.2090.0070Def ECOMPLETED BY CONTRACTOR091.0090.00Original outlier amount (see instructions)091.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0093.00 <td< td=""><td>34.00</td><td>Allowable bad debts (see instructions)</td><td>198, 323</td><td>34.00</td></td<>	34.00	Allowable bad debts (see instructions)	198, 323	34.00
37.00Subtotal (see instructions)3,122,51437.0038.00MSP-LCC reconciliation amount from P&R038.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.5039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9039.99RECOVERY OF ACCELERATED DEPRECIATION039.9940.00Subtotal (see instructions)3,122,51440.0040.01Sequestration adjustment (see instructions)3,122,51440.0040.01Interim payments3,104,54241.0041.00Interim payments3,104,54241.0042.00Tentative settlement (for contractors use only)-44,47843.0043.00Protested amounts (nonal owable cost report items) in accordance with CMS Pub. 15-2, chapter 1,44.0090.00Original outlier amount (see instructions)091.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.0093.00Time Value of Money (see instructions)093.00	35.00	Adjusted reimbursable bad debts (see instructions)	128, 910	35.00
38.00MSP-LCC reconciliation amount from PS&R38.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.50Pioneer ACO demonstration payment adjustment (see instructions)039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtatal (see instructions)3, 122, 51440.01Sequestration adjustment (see instructions)62, 45040.01Sequestration adjustment (see instructions)62, 45041.00Interim payments3, 104, 54241.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2-44, 47843.00Original outlier amount (see instructions)090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.0093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)093.00Oney (see instructions)093.00Oney (see instructions)093.00Oney (see instructions)093.00Oney (see instructions)093.00Oney (see instruct	36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	158, 260	36.00
39.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.50Pioneer ACO demonstration payment adjustment (see instructions)039.5039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9039.99RECOVERY OF ACCELERATED DEPRECIATION039.9040.00Subtotal (see instructions)039.9040.01Sequestration adjustment (see instructions)031.122,51441.00Interim payments3,104,54241.0042.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-44,47843.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2090.0090.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money092.0093.00Time Value of Money (see instructions)093.00	37.00	Subtotal (see instructions)	3, 122, 514	37.00
39.50Pioneer ACO demonstration payment adjustment (see instructions)039.5039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9039.99RECOVERY OF ACCELERATED DEPRECIATION039.9940.00Subtotal (see instructions)3,122,51440.0040.01Sequestration adjustment (see instructions)62,45040.0141.00Interim payments3,104,54241.0042.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-44,47843.0044.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2090.0090.00Original outlier amount (see instructions)091.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00	38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9839.99RECOVERY OF ACCELERATED DEPRECIATION039.9840.00Subtotal (see instructions)3,122,51440.0040.01Sequestration adjustment (see instructions)62,45040.0141.00Interim payments3,104,54241.0042.00Balance due provider/program (see instructions)042.0043.00Balance due provider/program (see instructions)-44,47843.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2090.0090.00Original outlier amount (see instructions)091.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00	39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9839.99RECOVERY OF ACCELERATED DEPRECIATION039.9840.00Subtotal (see instructions)3,122,51440.0040.01Sequestration adjustment (see instructions)62,45040.0141.00Interim payments3,104,54241.0042.00Balance due provider/program (see instructions)042.0043.00Balance due provider/program (see instructions)-44,47843.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2090.0090.00Original outlier amount (see instructions)091.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00			0	39.50
40.00Subtotal (see instructions)3, 122, 51440.0040.01Sequestration adjustment (see instructions)62, 45040.0141.00Interim payments3, 104, 54241.0042.00Tentative settlement (for contractors use only)042.0043.00Bal ance due provider/program (see instructions)-44, 47843.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.0090.00Original outlier amount (see instructions)90.0090.0091.00Outlier reconciliation adjustment amount (see instructions)090.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00			0	39. 98
40.00Subtotal (see instructions)3, 122, 51440.0040.01Sequestration adjustment (see instructions)62, 45040.0141.00Interim payments3, 104, 54241.0042.00Tentative settlement (for contractors use only)042.0043.00Bal ance due provider/program (see instructions)-44, 47843.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.0090.00Original outlier amount (see instructions)90.0090.0091.00Outlier reconciliation adjustment amount (see instructions)090.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00	39, 99	RECOVERY OF ACCELERATED DEPRECIATION	o	39, 99
40.01Sequestration adjustment (see instructions)62,45040.0141.00Interim payments3,104,54241.0042.00Tentative settlement (for contractors use only)042.0043.00Bal ance due provider/program (see instructions)-44,47843.0044.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00			3, 122, 514	40,00
41.00Interim payments3, 104, 54241.0042.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-44, 47843.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)090.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00				
42.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-44,47843.0044.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00				
43.00Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, S115.2 TO BE COMPLETED BY CONTRACTOR-44, 478 43.00 44.0090.00Original outlier amount (see instructions) 0 Utlier reconciliation adjustment amount (see instructions)0 90.0090.00 0 91.0090.00 092.00The rate used to calculate the Time Value of Money 93.000 0 00 93.000 0 93.0093.00		15		
44.00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, <u>\$115.2</u> <u>TO BE COMPLETED BY CONTRACTOR</u> 90.00       44.00 90.00 91.00 91.00 92.00       The rate used to calculate the Time Value of Money 93.00       Time Value of Money (see instructions) 93.00 93.00 90.00 91.00 91.00 92.00 93.00 93.00 93.00 93.00 90.00 90.00 90.00 90.00 90.00 91.00 91.00 91.00 92.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00				
§115.2       TO BE COMPLETED BY CONTRACTOR         90.00       Original outlier amount (see instructions)       0         91.00       Outlier reconciliation adjustment amount (see instructions)       0         92.00       The rate used to calculate the Time Value of Money       0.00         93.00       Time Value of Money (see instructions)       0				
TO BE COMPLETED BY CONTRACTOR90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00			Ű	
90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00				
91.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00	90.00		0	90.00
92.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00		5		
93.00 Time Value of Money (see instructions) 0 93.00				
		5		93.00
			91	

ANALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 151300	Period: From 05/01/2015 To 04/30/2016		pared:
		Ti tl	e XVIII	Hospi tal	Cost	
		I npati er	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		969, 7	71 0	3, 104, 542 0	1.00
3.00	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3.02				0	0	3.02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
3.05	Provider to Program			U	0	3.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3. 5
3.52				0	0	3.5
3.53 3.54				0	0	3.53 3.54
3.94 3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3.99
0. , ,	3. 50-3. 98)			0	, i i i i i i i i i i i i i i i i i i i	01.7
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		969, 7	71	3, 104, 542	4.00
	TO BE COMPLETED BY CONTRACTOR	1				
5.00	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					5.00
5.01	TENTATI VE TO PROVIDER			0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program	1	1	0	0	
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.5
5.52				0	0	5.52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.9
o. 00 o. 01	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER		133, 28	80	0	6.0
5. 01 5. 02	SETTLEMENT TO PROVIDER		133, 20	0	44, 478	6.02
7.002	Total Medicare program liability (see instructions)		1, 103, 0	-	3, 060, 064	7.0
			· · · ·	Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED			eriod: rom 05/01/2015 o 04/30/2016		
		Component	L CCN. 152300 1	0 04/30/2010	9/28/2016 3:4	iparec 18 pm
		Titl	e XVIII Sv	ving Beds - SNF		
		I npati en	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		398, 250		0	1.0
00	Interim payments payable on individual bills, either		0		0	2.1
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
~~	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	1		<u> </u>		
01	ADJUSTMENTS TO PROVIDER		0		0	3.
02			0		0	3.
03			0		0	3.
04			0		0	3.
)5			0		0	3.
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM		0		0	
51			0		0	
52			0		0	
53			0		0	
54			0		0	-
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99)		398, 250		0	4.
50	(transfer to Wkst. E or Wkst. E-3, line and column as		370,200			ή ^{τ.}
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			l.		
0	List separately each tentative settlement payment after					] 5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	1				
)1 )2	TENTATI VE TO PROVIDER		0		0	-
)2 )3						-
55	Provider to Program		0		0	
50	TENTATI VE TO PROGRAM	1	0		0	5
51			0		0	
52			0		0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines		0		0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6.
1	the cost report. (1)		10 105		_	
)1	SETTLEMENT TO PROVIDER		10, 105		0	
02	SETTLEMENT TO PROGRAM		0 409 255		0	
00	Total Medicare program liability (see instructions)		408, 355	Contractor	NPR Date	7.
				Number	(Mo/Day/Yr)	
			0	1.00	2.00	
0	Name of Contractor		0	1.00	2.00	8

Heal th	Financial Systems COMMUNITY HOSPITAL OF	BREMEN, INC.	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151300	Period:	Worksheet E-1	
			From 05/01/2015 To 04/30/2016		arod
			10 047 307 2010	9/28/2016 3:48	
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S		14	379	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-1	2		396	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	2		862	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			33, 686, 255	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lin			1, 079, 621	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of cer	tified HIT technology	Wkst. S-2, Pt. I	0	7.00
	line 168			_	
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00
9.00	Sequestration adjustment amount (see instructions)			0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (s	ee instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and lin	e 31) (see instruction	s)	0	32.00

Heal th	Financial Systems COMMUNITY HOSPITAL OF I	BREMEN, INC.	In Lie	u of Form CMS-2	2552-10
CALCU	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151300 Component CCN: 15Z300	Period: From 05/01/2015 To 04/30/2016	Worksheet E-2 Date/Time Pre	
		component con. 152300	10 047 307 2010	9/28/2016 3:4	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		014 000		1 00
1.00	Inpatient routine services - swing bed-SNF (see instructions)		314, 383	0	1.00
2.00 3.00	Inpatient routine services - swing bed-NF (see instructions) Ancillary services (from Wkst. D-3, col. 3, line 200, for Part.		104 077	0	2.00
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst		104, 077	0	3.00
4.00	Per diem cost for interns and residents not in approved teachin			0.00	4.00
4.00	instructions)	g program (see		0.00	4.00
5.00	Program days		189	0	5.00
6.00	Interns and residents not in approved teaching program (see ins	tructions)	107	0	6.00
7.00	Utilization review - physician compensation - SNF optional meth		0	0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		418, 460	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		418, 460	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applica	ble to physician	0	0	11.00
	professional services)			-	
12.00	Subtotal (line 10 minus line 11)		418, 460	0	12.00
13.00	Coinsurance billed to program patients (from provider records) for physician professional services)	(excl ude coi nsurance	1, 771	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14	)	416, 689	0	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	
	410A RURAL DEMONSTRATION PROJECT		0		16.55
17.00	Allowable bad debts (see instructions)		0	0	
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	
18.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)	0	0	18.00
19.00	Total (see instructions)		416, 689	0	
19.01	Sequestration adjustment (see instructions)		8, 334	0	19.01
20.00	Interim payments		398, 250	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
	Balance due provider/program (line 19 minus lines 19.01, 20, an		10, 105	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordanc chapter 1, §115.2	e with CMS Pub. 15-2,	0	0	23.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151300	Period: From 05/01/2015 To 04/30/2016	Worksheet E-3 Part V Date/Time Pre	
				9/28/2016 3:4	8 pm
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDI	CARE PART A SERVICES - COST		1.00	
00	Inpatient services			1, 234, 922	1 1.
00	Nursing and Allied Health Managed Care payment (see instr	ructions)		0	
00	Organ acqui si ti on			0	
00	Subtotal (sum of lines 1 through 3)			1, 234, 922	4
00	Primary payer payments			0	5
00	Total cost (line 4 less line 5). For CAH (see instruction	ns)		1, 247, 271	6
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
00	Routine service charges			0	
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
. 00	Total reasonable charges			0	10
~~	Customary charges				
. 00	Aggregate amount actually collected from patients liable	1 5	9	0	
. 00	Amounts that would have been realized from patients liable	1 3	n a charge basis	0	12
. 00	had such payment been made in accordance with 42 CFR 413. Ratio of line 11 to line 12 (not to exceed 1.000000)	13(e)		0.000000	13
	Total customary charges (see instructions)			0.000000	
. 00	Excess of customary charges over reasonable cost (complet	e only if line 14 exceeds li	ne 6) (see	0	
. 00	instructions)			0	'`
. 00	Excess of reasonable cost over customary charges (complet	e only if line 6 exceeds lin	e 14) (see	0	16
	instructions)	, , , , , , , , , , , , , , , , , , ,			
. 00	Cost of physicians' services in a teaching hospital (see	instructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Direct graduate medical education payments (from Workshee	et E-4, line 49)		0	
	Cost of covered services (sum of lines 6, 17 and 18)			1, 247, 271	
	Deductibles (exclude professional component)			131, 796	
	Excess reasonable cost (from line 16)			0	
	Subtotal (line 19 minus line 20 and 21)			1, 115, 475	
	Coinsurance			0	
	Subtotal (line 22 minus line 23)			1, 115, 475	
. 00	Allowable bad debts (exclude bad debts for professional s	services) (see instructions)		15, 518	
	Adjusted reimbursable bad debts (see instructions)	instructions)		10,087	
. 00	Allowable bad debts for dual eligible beneficiaries (see Subtotal (sum of lines 24 and 25, or line 26)	HISTI UCTI ONS)		12, 238 1, 125, 562	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			1, 125, 562	
. 50	Pioneer ACO demonstration payment adjustment (see instructions)	tions)		0	
. 99	Recovery of Accel erated Depreciation			0	
	Subtotal (see instructions)			1, 125, 562	
. 00	Sequestration adjustment (see instructions)			22, 511	
	Interim payments			969, 771	
	Tentative settlement (for contractor use only)			0	
. 00	Balance due provider/program (line 30 minus lines 30.01,	31, and 32)		133, 280	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151300	Period: From 05/01/2015 To 04/30/2016	Worksheet E-3 Part VII Date/Time Pre 9/28/2016 3:4	pared	
		Title XIX	Hospi tal	Cost		
			Inpatient	Outpati ent		
			1.00	2.00		
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	TCES FOR TITLES V OR X	TX SERVICES		-	
00	COMPUTATION OF NET COST OF COVERED SERVICES		E0. 270		1	
00	Inpatient hospital/SNF/NF services		50, 370	0	1	
00 00	Medical and other services Organ acquisition (certified transplant centers only)		0	0	2	
00	Subtotal (sum of lines 1, 2 and 3)		50, 370	0	4	
00	Inpatient primary payer payments		50, 570	0	5	
00	Outpatient primary payer payments		Ŭ	0	le	
00	Subtotal (line 4 less sum of lines 5 and 6)		50, 370	0		
	COMPUTATION OF LESSER OF COST OR CHARGES				1	
	Reasonabl e Charges				1	
. 00	Routi ne servi ce charges		32, 970		8 [	
00	Ancillary service charges		49, 662	0		
D. 00	Organ acquisition charges, net of revenue		0		10	
	Incentive from target amount computation		0		11	
2.00	Total reasonable charges (sum of lines 8 through 11)		82, 632	0	12	
	CUSTOMARY CHARGES					
3.00	Amount actually collected from patients liable for payment for basis	0	0	13		
ł. 00	Amounts that would have been realized from patients liable for	n 0	0	14		
	a charge basis had such payment been made in accordance with 42					
	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0.000000			
	Total customary charges (see instructions)		82, 632	0	16	
17.00	Excess of customary charges over reasonable cost (complete only	32, 262	0	17		
8.00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only		0	18		
5.00	16) (see instructions)	e 0	0			
9.00	Interns and Residents (see instructions)		0	0	19	
	Cost of physicians' services in a teaching hospital (see instru	0	0	20		
				0		
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c		ders.			
2.00	Other than outlier payments		0	0	22	
	Outlier payments		0	0		
	Program capital payments		0		24	
	Capital exception payments (see instructions)		0		25	
	Routine and Ancillary service other pass through costs		0	0		
	Subtotal (sum of lines 22 through 26)	0	0	27		
	Customary charges (title V or XIX PPS covered services only)		50, 370	0		
7.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		50, 370	0	29	
0. 00	Excess of reasonable cost (from line 18)		0	0	30	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	50, 370	0	3		
2.00	Deducti bl es	0	0	32		
	Coinsurance	0	0			
	Allowable bad debts (see instructions)	0	0			
	Utilization review	0		35		
5.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	50, 370	0	36		
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	37	
	Subtotal (line 36 ± line 37)	50, 370	0			
	Direct graduate medical education payments (from Wkst. E-4)	0		39		
	Total amount payable to the provider (sum of lines 38 and 39)	50, 370	0	40		
	Interim payments		51, 365	0	41	
	Balance due provider/program (line 40 minus line 41)		-995	0		
3.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43	

nd-t	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column onl	y)		rom 05/01/2015	Data /T: D	
			Т	o 04/30/2016	Date/Time Pre 9/28/2016 3:4	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
~~	CURRENT ASSETS	702.025		0	0	1 1
00 00	Cash on hand in banks Temporary investments	703, 035 985, 502			0	
00 00	Notes receivable	703, 302	0	-	0	
00	Accounts receivable	3, 059, 359		-	0	
00	Other receivable	0	0		0	
00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	
00	Inventory	136, 344		0	0	
)0 )0	Prepaid expenses Other current assets	634, 885	0	-	0	
00	Due from other funds	034,003	0	-	0	
00	Total current assets (sum of lines 1-10)	5, 519, 125			0	
	FI XED ASSETS					
00	Land	0			0	
00	Land improvements	0			0	
00	Accumulated depreciation		0		0	
00 00	Buildings Accumulated depreciation	14, 531, 427	0	-	0	
00	Leasehold improvements		0		0	
00	Accumulated depreciation	0	0	-	0	
00	Fixed equipment	0	0	0	0	19
00	Accumulated depreciation	0	0	-	0	
00	Automobiles and trucks	0	0		0	
00	Accumulated depreciation	0	0		0	
00 00	Major movable equipment Accumulated depreciation		0	-	0	
00	Minor equipment depreciable		0	-	0	
00	Accumulated depreciation	0	0	0	0	
00	HIT designated Assets	0	0	0	0	
00	Accumulated depreciation	0	0	0	0	28
	Minor equipment-nondepreciable	0	0		0	
00	Total fixed assets (sum of lines 12-29)	14, 531, 427	0	0	0	30
00	OTHER ASSETS Investments	0	0	0	0	31
00	Deposits on Leases	0			0	
00	Due from owners/officers	0	0	-	0	
00	Other assets	773, 158	0	0	0	34
00	Total other assets (sum of lines 31-34)	773, 158			0	35
00	Total assets (sum of lines 11, 30, and 35)	20, 823, 710	0	0	0	36
~~	CURRENT LI ABI LI TI ES	2/5 / 20			0	1
00 00	Accounts payable Salaries, wages, and fees payable	265, 620 795, 535			0	
	Payrol I taxes payable	0			0	
	Notes and Loans payable (short term)	717, 210			0	
00	Deferred income	0	0	0	0	
00	Accelerated payments	0				42
00	Due to other funds	0	0	-	0	
00	Other current liabilities	55, 132			0	
00	Total current liabilities (sum of lines 37 thru 44)	1, 833, 497	0	0	0	45
00	LONG TERM LIABILITIES Mortgage payable	13, 450, 673	0	0	0	46
00	Notes payable	13, 430, 073	0		0	
00	Unsecured Loans	0	Ő	0	0	
00	Other long term liabilities	0	0	0	0	
00	Total long term liabilities (sum of lines 46 thru 49)	13, 450, 673	0	0	0	50
00	Total liabilities (sum of lines 45 and 50)	15, 284, 170	0	0	0	51
00	CAPITAL ACCOUNTS	E 500 540				
00	General fund balance Specific purpose fund	5, 539, 540	0			52
00 00	Specific purpose fund Donor created - endowment fund balance - restricted			n		54
00	Donor created - endowment fund balance - restricted			0		55
00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant			_	0	
00	Plant fund balance - reserve for plant improvement,				0	58
o -	replacement, and expansion					
00 00	Total fund balances (sum of lines 52 thru 58)	5, 539, 540		0	0	
(11)	Total liabilities and fund balances (sum of lines 51 and	20, 823, 710	y U	0	0	60

Health Financial Systems         COMMUNITY HOSPI           STATEMENT OF CHANGES IN FUND BALANCES         Community Hospi				CCN: 151300	Peri od:		u of Form CMS- Worksheet G-	
				From 05/01/				
		General	Fund	Speci al	Purpose	Fund	Endowment Fund	1
		1.00	2.00	3,00		4. 00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance		6, 937, 399 -1, 397, 859 5, 539, 540 5, 539, 540 5, 539, 540 0 5, 539, 540			0 0 0 0 0 0 0 0		5.00         6.00           6.00         7.00           8.00         9.00           10.00         11.00           11.00         12.00           13.00         14.00           15.00         16.00
	sheet (line 11 minus line 18)	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	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0			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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	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	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0 0			18.00 19.00

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 151300	Pe Fr To	riod: om 05/01/2015 04/30/2016	Worksheet G-2 Parts I & II Date/Time Pre 9/28/2016 3:4	pared:
	Cost Center Description		Inpati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal		2, 228, 2	85		2, 228, 285	1.00
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVIDER						4.00
5.00	Swing bed - SNF			0		0	
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE		2 2 2 2 2	OF		2 220 205	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		2, 228, 2	85		2, 228, 285	10.00
11.00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT						111.00
12.00	CORONARY CARE UNIT						12.00
12.00	BURN INTENSIVE CARE UNIT						12.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of li	nes		0		0	
10.00	11-15)	1105		Ŭ		0	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		2, 228, 2	85		2, 228, 285	17.00
18.00	Ancillary services		3, 775, 9		24, 455, 469	28, 231, 433	
19.00	Outpatient services		44, 3		3, 182, 175	3, 226, 537	
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULANCE SERVICES						23.00
24.00	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPICE						26.00
27.00	PHYSI CI AN PROFESSI ONAL FEES		119, 8		1, 883, 329	2,003,134	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	o Wkst.	6, 168, 4	16	29, 520, 973	35, 689, 389	28.00
	G-3, line 1)						-
29.00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)				19, 268, 729		29.00
30.00	FOUNDATION UNRESTRICTED EXPENSES		48, 2	75	17, 200, 727		30.00
31.00			40, 2	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)			Ŭ	48, 275		36.00
37.00	DEDUCT (SPECIFY)			0	107270		37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)			-	0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	transfer			19, 317, 004		43.00
	to Wkst. G-3, line 4)	• • •		1			

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 151300	Peri od:	Worksheet G-3	
			From 05/01/2015 To 04/30/2016	Date/Time Prep 9/28/2016 3:48	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			35, 689, 389	1.00
2.00	Less contractual allowances and discounts on patients' accounts			18, 287, 620	2.00
3.00	Net patient revenues (line 1 minus line 2)			17, 401, 769	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	)		19, 317, 004	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-1, 915, 235	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication 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 tha	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	Governmental appropriations			0	23.00
24.00	OTHER REVENUE			398, 899	24.00
24.01	GRANTS AND OTHER PUBLIC SUPPORT			118, 477	24.01
25.00	Total other income (sum of lines 6-24)			517, 376	
26.00	Total (line 5 plus line 25)			-1, 397, 859	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			-1, 397, 859	29.00