In Lieu of Form CMS-2552-10

	s required by law (42 USC 1395g; 42 CFR 413.20(b)). Fa since the beginning of the cost reporting period being			0 FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019
HOSPITAL AND F AND SETTLEMENT	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provider CCN: 15-1329	From 01/01/2016	
PART I - COST	REPORT STATUS			
Provi der use only	 [X]Electronically filed cost report 2. []Manually submitted cost report 3. [0]If this is an amended report enter the number 4. [F]Medicare Utilization. Enter "F" for full or " 		Date: 5/25/20 resubmitted this c	
Contractor use only	 5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended (5) Amended (6) Date Received: (6) Date Received: (7) Contractor No. (8) Date Received: (9) Date Received: (1) As Submitted (2) Date Received: (3) Date Received: (4) Repend (5) Amended 	11 or this Provider CCN 12		

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARGARET MARY COMMUNITY HOSPITAL (15-1329) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si	ar	ned)

Officer or Administrator of Provider(s)

Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	389, 807	-347, 299	0	-58, 559	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		61, 861		0	10.00
200.00	Total	0	389, 807	-285, 438	0	-58, 559	200.00

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

SPL	AL AND HOSPITAL HEALTH CARE COMPLEX	I DENTI FI (CATION	DATA	Provi	der CCN:	15-1329	Period: From 01/01	/2016	Worksh Part I	eet S-2	2
								To 12/31	/2016	Date/T 5/25/2		
	1.00			2.00		3.00			4.00			
00	Hospital and Hospital Health Care Co Street: 321 MITCHELL	omplex Ad	dress: PO Bo									1.1
00	City: BATESVILLE		State		Zip Co	de: 47006	- Cour	nty: RIPLEY				2.
			ponent		CCN	CBSA	Provi de	er Date		ent Syst	em (P,	
					Number	Number	r Type	Certi fi ed	-	, 0, or		4
			1.00		2.00	3.00	4.00	5.00	V	XVIII 7.00	XI X 8.00	-
	Hospital and Hospital-Based Componen	t Identi			2.00	3.00	4.00	5.00	0.00	/ /.00	0.00	
00	Hospi tal	MARGARET	MARY	COMMUNI TY	151329	99915	1	01/07/1966	6 N	0	0	3.
00		HOSPI TAL										
00 00	Subprovi der – IPF Subprovi der – IRF											4. 5.
00	Subprovider - (Other)											6.
00	Swing Beds - SNF											7.
00	Swing Beds - NF											8.
00	Hospital-Based SNF											9.
. 00 . 00	Hospital-Based NF Hospital-Based OLTC											10.
. 00		MARGARET	MARY	COMMUNI TY	157143	99915		03/01/1985	5 N	P	N	12.
	•	HOSPI TAL										
00	Separately Certified ASC											13.
. 00			MARY	COMMUNI TY	151551	99915		12/31/2003	3			14.
00		HOSPI TAL	MARY	COMMUNI TY	158511	99915		09/03/2013	B N	0	N	15.
00	•	HOSPI TAL		COMMONT	130311	77713	·	07/03/2013				13.
00	Hospital-Based Health Clinic - FQHC											16.
00	Hospital-Based (CMHC) I											17.
00	Renal Dialysis Other											18.
00	other							From	.	Тс).	19.
								1.00		2.		1
00	Cost Reporting Period (mm/dd/yyyy)							01/01/2	2016	12/31	/2016	20.
00	Type of Control (see instructions)							2				21.
00	Inpatient PPS Information Does this facility qualify and is it	current			monto f	or dicor	oportiona	te N				22.
00	share hospital adjustment, in accord											22.
	for yes or "N" for no. Is this facil											
	amendment hospital?) In column 2, en											
01	Did this hospital receive interim un							g N		Ν	l	22.
	period? Enter in column 1, "Y" for y reporting period occurring prior to											
	for no for the portion of the cost r											
	(see instructions)		1									
02	Is this a newly merged hospital that									Ν	l	22.
	determined at cost report settlement	? (see i	nstruc	tions) Ent	ter in co	olumn 1,	"Y" for	yes				
	or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for											
	or after October 1.	10, 101	ene pu		0031	, opor tri	ng porrou					
03	Did this hospital receive a geograph									Ν	I	22.
	of the OMB standards for delineating							er				
	in column 1, "Y" for yes or "N" for prior to October 1. Enter in column							the				
	cost reporting period occurring on o											
	hospital contain at least 100 but no	t more tl	han 49	9 beds (as	s counte			i th				
	42 CFR 412.105)? Enter in column 3,						.					
00	Which method is used to determine Me								0			23.
	1, enter 1 if date of admission, 2 i method of identifying the days in th											
	used in the prior cost reporting per											
				In-Sta		State	Out-of		Medi ca		ther	
				Medi ca		cai d	State		HMO da	~	di cai d	
				paid da	·		ledicaid aid days	Medicaid eligible			days	
						ays	and days	unpaid				
				1.00		00	3.00	4.00	5.00		5.00	1
			the		0	0	0	0		0		24.
00	If this provider is an IPPS hospital	, enter								1		1
00	in-state Medicaid paid days in colum	n 1, in-s										
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	n 1, in-s umn 2,										
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c	n 1, in-s umn 2, olumn 3,	state	Imn								
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	n 1, in-s umn 2, olumn 3, d days in	state n colu									

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		Peri od:		Works	orm CMS-: heet S-2	
				From 01/		Part Date/		eparec
	In-State Medicaid paid days	In-State Medi cai d el i gi bl e unpai d days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ays Me	Other edi cai d days	
5.00 If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	5.00	0	6.00	25.0
Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0					
					. 00		of Geogr .00	1
0.00 Enter your standard geographic classification (not wa		at the be	ginning of		2	2		26. (
cost reporting period. Enter "1" for urban or "2" for 2.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	age) status ~ "2" for r	rural. If a		st	2	2		27.
enter the effective date of the geographic reclassifi 5.00 f this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		C			35.
					<u>nni ng:</u> . 00		<u>li ng:</u> . 00	-
0.00 Enter applicable beginning and ending dates of SCH st		script line	36 for num			_		36.
of periods in excess of one and enter subsequent date 7.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	r the numbe	·		us	C			37.
7.01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)					Ν			37.
8.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.
					//N		(/N	
0.00 Does this facility qualify for the inpatient hospital	pavment a	diustment	for low volu		. 00 N	2	. 00 N	39.
hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage red CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Énter i quirements or "N" for	n column 1 in accorda no. (see	"Y" for yes nce with 42 instructions	s)	N		N	40.
0.00 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.	per 1. Ente	er "Y" for			N V	XVII		40.
Prospective Payment System (PPS)-Capital					1.0	0 2.00	3.00	
5.00 Does this facility qualify and receive Capital paymer	nt for disp	proporti ona	te share in	accordan	ce N	N	N	45.
with 42 CFR Section §412.320? (see instructions) 0.00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst					N N	N	N	46.
Pt. III. 2.00 Is this a new hospital under 42 CFR §412.300 PPS capi					N	N N	N N	47. 48.
8.00 Is the facility electing full federal capital payment	t? Enter	Y TOP yes						56.
				Y" for yes	s N			1 50.
 B. 00 Is the facility electing full federal capital payment Teaching Hospitals D. 00 Is this a hospital involved in training residents in or "N" for no. 	approved (GME program	s? Enter "'	5	s N			
 B. 00 Is the facility electing full federal capital payment Teaching Hospitals D0 Is this a hospital involved in training residents in 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 "N" 	approved (period duri r yes or "N th of this Y", complet	ME program ng which r " for no i cost repor e Workshee	s? Enter " esidents in n column 1. ting period	approved If column ? Enter '	ח 1 'Y"			
 8.00 Is the facility electing full federal capital payment Teaching Hospitals 9.00 Is this a hospital involved in training residents in or "N" for no. 9.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 8.00 If line 56 is yes, did this facility elect cost reimt 	approved (period duri r yes or "N th of this (", complet , if appli pursement f	ME program ng which r " for no i cost repor ce Workshee cable. Tor physici	s? Enter "` esidents in n column 1. ting period' t E-4. If co	approved If column ? Enter ' olumn 2 is	ח 1 'Y"			57.
 8.00 Is the facility electing full federal capital payment Teaching Hospitals 9.00 Is this a hospital involved in training residents in or "N" for no. 9.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N", "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 8.00 If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 	approved (period duri yes or "N th of this (", complet ursement f complete V	ME program ng which r " for no i cost repor ce Workshee cabl e. for physici /kst. D-5.	s? Enter " esidents in n column 1. ting period' t E-4. If co ans' servico	approved If column ? Enter ' olumn 2 is	1 1 'Y" S			57. 58.
 8.00 Is the facility electing full federal capital payment Teaching Hospitals 9.00 Is this a hospital involved in training residents in or "N" for no. 9.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 8.00 If line 56 is yes, did this facility elect cost reimt 	approved (period duri r yes or "N th of this (", complet (, if appli pursement f complete V s, complete costs for	ME program ng which r " for no i cost repor e Workshee cable. For physici /kst. D-2 a program	s? Enter " esidents in n column 1. ting period t E-4. If co ans' servico , Pt. I. that meets	approved If column ? Enter ' olumn 2 is es as the	1 1 'Y" 5 N N N			58. 58. 59. 60.
 B.00 Is the facility electing full federal capital payment Teaching Hospitals D.00 Is this a hospital involved in training residents in 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 If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes 	approved (period duri r yes or "N th of this (", complet (, if appli pursement f complete V s, complete costs for	ME program ng which r " for no i cost repor e Workshee cable. For physici /kst. D-2 a program	s? Enter " esidents in n column 1. ting period t E-4. If co ans' servico , Pt. I. that meets	approved If column ? Enter ' olumn 2 is es as the tructions	1 1 'Y" 5 N N N	Dire	ct GME	57. 58. 59.
 B.00 Is the facility electing full federal capital payment Teaching Hospitals D.00 Is this a hospital involved in training residents in 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 If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes 	approved (period duri r yes or "N th of this (", complet , if appli pursement f complete complete costs for for yes or	ME program "for no i cost repor e Workshee cable. For physici /kst. D-2. a program "N" for n	s? Enter " esidents in n column 1. ting period t E-4. If co ans' servico , Pt. I. that meets o. (see ins	approved If column ? Enter ' olumn 2 is es as the tructions; E I	n 1 'Y" 5 N N N		ct GME	57. 58. 59.
 B.00 Is the facility electing full federal capital payment Teaching Hospitals D.00 Is this a hospital involved in training residents in 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 If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes 	approved (period duri r yes or "N th of this (", complet , if appli pursement f complete V s, complete V s, complete V s, complete S costs for for yes or Y/N	ME program ng which r " for no i cost repor e Workshee cable. for physici /kst. D-5. e Wkst. D-2 a program IME	s? Enter " esidents in n column 1. ting period' t E-4. If co ans' servico , Pt. I. that meets o. (see ins Direct GM	approved If column ? Enter ' olumn 2 is es as the tructions; E I	n 1 'Y" s N N N ME	5	. 00	57. 58. 59.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TΑ	Provider CC		eriod: rom 01/01/2016 p 12/31/2016	Worksheet S-2 Part I Date/Time Pre 5/25/2017 2:4	pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
1.02 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	0.00			61.02
1.03 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 instructions)		0.00	0.00			61.03
 04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 		0.00	0.00			61.04
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00				61.06
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.10
 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 				0. 00	0. 00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital	rvices traine	<u>Administration</u>	(HRSA)	iod for which	0.00	62.00
2.00 Enter the number of FTE residents that your hospital received HRSA PCRE funding (see instruct 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ctions) a Teach	ing Health Cen	ter (THC) into			62.00
Teaching Hospitals that Claim Residents in Nonprovide			113)			
3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1.				period? Enter	Ν	63.00
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settinas	1.00 This base year	2.00 is your cost	<u> </u>	
period that begins on or after July 1, 2009 and befor 4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in	r <u>e June</u> ty trai n-prima	<u>30, 2010.</u> ned residents ry care	0. 00			64.00
settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter ir of (column 1 divided by (column 1 + column 2)). (see	d non-p n colum <u>instru</u>	rimary care n 3 the ratio ctions)				
Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	

	EX IDENTIFICATION D	ATA Provider C	Fr	eriod: com 01/01/2016	Worksheet S-2 Part I	
			To	12/31/2016	Date/Time Pre 5/25/2017 2:4	eparec
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	1
00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3			0.00	0.00	0. 000000	05.
divided by (column 3 + column 4)). (see instructions)			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovider Site	Hospi tal	col . 2))	
Section 5504 of the ACA Current	Voor ETE Docidante :	n Nonnrovidor Cattin	1.00	2.00	3.00	
beginning on or after July 1, 20		n Nonprovider Settin	ysLitective i	UI CUST TEPUIT	ing perious	
			-			
.00 Enter in column 1 the number of a FTEs attributable to rotations of Enter in column 2 the number of a FTEs that trained in your hospita	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. Try care resident 3 the ratio of	0.00	0.00	0. 000000	66.
.00 Enter in column 1 the number of a FTEs attributable to rotations of Enter in column 2 the number of a	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. Try care resident 3 the ratio of	0.00 Unweighted FTEs Nonprovider Site	0.00 Unweighted FTEs in Hospital	0.000000 Ratio (col. 3/ (col. 3 + col. 4))	66.
 00 Enter in column 1 the number of a FTEs attributable to rotations of Enter in column 2 the number of a FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see in	provider settings. ary care resident 3 the ratio of astructions)	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
00 Enter in column 1 the number of o FTEs attributable to rotations of Enter in column 2 the number of o FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see in</u> Program Name	provider settings. hry care resident 3 the ratio of hstructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
 OD Enter in column 1 the number of the FTEs attributable to rotations of Enter in column 2 the number of the FTEs that trained in your hospita (column 1 divided by (column 1 + (column 2 divided by (column 1 + (column 2 divided by (column 3 divided by the program code. 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 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see in</u> Program Name <u>1.00</u>	provider settings. hry care resident 3 the ratio of hstructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Rati o (col . 3/ (col . 3 + col . 4)) 5.00 0.000000	
 OD Enter in column 1 the number of of FTEs attributable to rotations of Enter in column 2 the number of of FTEs that trained in your hospita (column 1 divided by (column 1 + OD 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 3 divided by (column 3 + column 4)). (see instructions) 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see in</u> <u>Program Name</u> <u>1.00</u>	Provi der settings. Iny care resident 3 the ratio of Istructions) Program Code 2.00	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	0 67.
 Enter in column 1 the number of of FTEs attributable to rotations of Enter in column 2 the number of of FTEs that trained in your hospita (column 1 divided by (column 1 + 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 5, the ratio of (column 3 divided by (column 3 divided by (column 3 divided by (column 4)). (see instructions) Inpatient Psychiatric Facility P 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see in Program Name 1.00 1.00 1.00 95 ychiatric Facility (e facility have an a efore November 15, 2 umn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	Improvi der settings. Improvi der settings. Improviewer der seident 3 the ratio of istructions) Program Code 2.00 2.00 IPF), or does it con ipproved GME teaching 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subp program in the yes or "N" for r s in a new teact	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N most no. (see ni ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	

Health Financial Systems MARGARET MARY COM	MUNITY HOSPITA	L	١n	Li eu	of Form	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		Period: From 01/01/2 To 12/31/2	016 016	Workshe Part I Date/Ti 5/25/20	me Pre	pared:
		I					
76.00 If line 75 yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 7 no. Column 2: Did this facility train residents in a new te CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no indicate which program year began during this cost reporting	15, 2004? Enter eaching program b. Column 3: 11	"Y" for yes in accordanc column 2 is	e most or "N" for e with 42 Y,	1.00	2.00	0	76.00
				+	1.0	0	-
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for ye 81.00 Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.			g period? Er	nter	N		80.00 81.00
TEFRA Providers15.00Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.6.00Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							85.00 86.00
87.00 Is this hospital a "subclause (II)" LTCH classified under s for yes or "N" for no.	section 1886(d)	(1)(B)(iv)(II)? Enter "Y"		N		87.00
			V 1.00		XI) 2. 0		-
70.00 Title V and XIX Services 70.00 Does this facility have title V and/or XIX inpatient hospity 70.00 Ves or "N" for no in the applicable column.	tal services? E	Enter "Y" for	N		Y		90.00
91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app			N		Y		91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (c	dual certificat				Ν		92.00
 instructions) Enter "Y" for yes or "N" for no in the applic 93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column. 		nd XIX? Enter	N		Ν		93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for r	no in the	N		Ν		94.00
95.00 \overrightarrow{If} line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for years			0. 00 N		0. 0 N	0	95.00 96.00
 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the approvements Rural Providers 	oplicable colum	nn.	0.00		0.0	0	97.00
105.00 Does this hospital qualify as a critical access hospital ((106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		hod of paymen	t N				105.00 106.00
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 colum yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.	nn 1. (see inst	ructions) If	t				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.	e CRNA fee sche	edul e? See 42	N				108.00
	Physi cal 1.00	Occupational 2.00	Speech 3.00		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	N		N		109.00
				_	1.0	0	-
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"	tal Demonstrati 'for no.	on project (4	10A Demo)for	-	N		110.00
			-	1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y"	2. If column 2 ent for long te ers) based on 1	is "E", enter erm care (incl che definition	in column udes	N		0	115.00
117.00 Is this facility legally-required to carry malpractice insu no.			"N" for	N			117.00
118.00 Is the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	olicy? Enter 1	if the policy	is	1			118.00

Premiums Losses Insurance 118.01L1st amounts of malpractice premiums and paid lesses: 0	Health Financial Systems MARGARET MARY COMMU HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		Period: From 01/01/2016 To 12/31/2016		5-2 Prepared:
18.00Lust amounts of malpractice premiums and paid Losses: 0 0 0111 18.00Late malpractice premiums and paid Losses reported in a cost center other than the malpractice premiums and paid Losses reported in a cost center other than the malpractice premiums and paid Losses reported in a cost center other than the malpractice premiums and paid Losses reported in a cost center other than the malpractice premiums and paid Losses reported in the cost center other than the malpractice premiums and paid Losses (instructions) 100 100 19.00D And the premiums and paid Losses reported in a cost center other than the malpractice premiums and paid Losses (instructions) N N 111 10.00D And the spectral cost center other than the malpractice premiums and paid Losses (instructions) N N 122 11.00D This is a SCH or Cost in the Cost instructions) Y 5.00 12 12 12.00Does the cost report costs for high cost inplantable devices charged to patients? Include. Y 5.00 12 12.00Does the cost report costs and paid Losses. Inclum 2.1 N 12			Premi ums	Losses		
118. 02Are mail practice premiums and paid losses reported in a cost center other than the Amin instruct and manufactoria and paid losses reported in a cost center other than the Amin instruct and therein. 1.00 2.00 118. 02Are mail practice premiums and paid losses reported in a cost center other than the Amin instruct and applicable amendments? (see instructions) Enter in column 1. "Y for yes or N" for no. Is this a rural hospital with < 100 betwise for the Outputient Hold Harnless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2. "Y for yes or "N" for no. N N 21.0001d this facility incur and report cests for high cost implantable devices charged to report hospital facility engrands. The facility engrands. Y 5.00 22.000ex the scale report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "V", enter in column 2 the Warksheet A line number where those taxes are included. N 12 22.000ex the facility engrands at transplant center, enter the certification date in column 1 and tremmapiant center? Enter "Y" for yes and "N" for no. If N this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date. If applicable, in colum 2. 12 23.001f this is a Medicare certified provide transplant center, enter the certification date in column 1 and termination date. If applicable, in colum 2. 13 23.001f this is a Medicare certified there transplant center, enter the certification date in colum 1 and termination date. If applicable, in colum 2. 3.00 23.001f this is a Me			1.00	2.00	3.00	
110. C2/Mere malpractice premiums and paid losses reported in a cost center other than the Administrative and central? If yes, submit supporting schedule listing cost centers and amounts contained therein. N 11 110. 000 MC 105 Tills LIME The MC 100	118.01 List amounts of malpractice premiums and paid losses:			0	C	0118.01
110. C2/Mere malpractice premiums and paid losses reported in a cost center other than the Administrative and central? If yes, submit supporting schedule listing cost centers and amounts contained therein. N 11 110. 000 MC 105 Tills LIME The MC 100				1.00	2.00	_
120. 0015 this a SCH or EACH that qualifies for the Outpatient Hold Hamless provision in ACA 312 and applicable exists instructions) Enter in column 1, "Y for yes or "N" for no. Is this a rural hospital and applicable exemendents? (see instructions) Enter in column 1, 2, "Y" for yes or "N" for no. N N 12 121. 005 this a rural hospital and applicable exemendents? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Y 12 <t< td=""><td>Administrative and General? If yes, submit supporting schedu and amounts contained therein.</td><td>center other ule listing c</td><td>than the ost centers</td><td></td><td>2.00</td><td>118.02</td></t<>	Administrative and General? If yes, submit supporting schedu and amounts contained therein.	center other ule listing c	than the ost centers		2.00	118.02
121.00D/ld this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y for yes or "N" for no. Y 12 122.00D/00es the cost report contain state health or similar taxes? Enter "Y" for yes or "N" Y 5.00 12 122.00D/00es the cost report contain state health or similar taxes? Enter "Y" for yes or "N" Y 5.00 12 125.00D/00es this facility operate a transplant center. P for yes or "N" for no. If N N 12 126.00D/00es this facility operate a transplant center. P for yes and "N" for no. If N N 12 126.00D/00es this facility operate a transplant center, enter the certification date in column 1 and termination date. If applicable, in colum 2. N 12 120.00T this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date. If applicable, in colum 2. 12 12 120.00T this is a Medicare certified lung transplant center, enter the certification date in colum 1 and termination date. If applicable, in colum 2. 13 13 120.00T this is a Medicare certified thesthal transplant center, enter the certification date in colum 1 and termination date. If applicable, in colum 2. 13 13 120.00T this is a Medicare certified thesthal transplant center, enter the certification date in colum 1 and termination date. If applicable, in colum 2. 13 13 121.00DT this is a Medicare certified thesthal transplant cent	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 amendmen	column 1, "Y alifies for t	" for yes or he Outpatien		N	120.00
122. 00Does the cost report contain state heal th or similar taxes? Enter "Y" for yes or "N" Y 5.00 12 122. 00Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If N 12 125. 00Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If N 12 126. 00Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If N 12 126. 00Des this facility operate a transplant center? Enter "Y" for yes and "N" for no. If N 12 126. 00Des this facility operate a transplant center? Enter "W" for yes and "N" for no. If N 12 126. 00Des this facility operate a transplant center? Enter "W" for yes and "N" for no. If N 12 127. 00If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date. If applicable, in column 2. 12 12 120. 00If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 13 13 120. 00If this is a Medicare certified intestinal transplant center, enter the certification date in column 1. 13 13 120. 00If this is a Medicare certified intestinal transplant center, enter the certification date in column 1. 13 13 120. 00If this is a Medicare certified intestinal tra	121.00Did this facility incur and report costs for high cost impla	ntable device	s charged to	Y		121.00
for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number		ntor "V" for	NOC OF "N"	V	E 00	122.00
125. coDoes this facility operate a transplant center? Enter "Y" for yes and "N" for no. If New Pes, enter certification date() (m/dd/yyy) below. 12 126. coD(If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 12 127. coD(If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 12 128. coD(If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 12 129. coD(If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 13 130. coD(If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 13 131. coD(If this is a Medicare certified other transplant center, enter the certification date in colum 1 and termination date, if applicable, in column 2. 13 132. coD(If this is a norgan procurement organization (OPO), enter the OPO number in column 1 and termination date. If applicable, in column 2. 13 133. doD(If this is an organ procurement organization, enter on lines 141 through 143 the name and address of the home office costs as defined in CMS Pub. 15-1, chapter 107 Enter "Y" for yes or "N" for no in column 2. 14 141. Providers 1.00 2.00 3.00 <td>for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.</td> <td></td> <td></td> <td></td> <td>5.00</td> <td>122.00</td>	for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.				5.00	122.00
yes, enter certification date(s) (mm/dd/yyy) below. 2 26. 001 F fhis is a Medicare certification date, if applicable, in column 2. 12 21.001 F fhis is a Medicare certification date, if applicable, in column 2. 12 22.001 F fhis is a Medicare certification date, if applicable, in column 2. 12 23.001 F fhis is a Medicare certification date, if applicable, in column 2. 12 20.001 F fhis is a Medicare certification date, if applicable, in column 2. 12 20.001 F fhis is a Medicare certification date, if applicable, in column 2. 12 20.01 F fhis is a Medicare certification date, if applicable, in column 2. 13 20.01 F fhis is a Medicare certification date, if applicable, in column 2. 13 20.01 F fhis is a Medicare certification date, if applicable, in column 2. 13 20.01 F fhis is a Medicare certification date, if applicable, in column 2. 13 20.01 F fhis is a Medicare certification date, in column 2. 13 20.01 F fhis is a Medicare certification (POP), enter the Certification date in column 1 and termination date, if applicable, in column 2. 13 20.01 F fhis is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 13 20.01 F fhis is a medicare certified ot for transplant center, enter the certif		r ves and "N"	for no lf	N		125.00
in column 1 and termination date, if applicable, in column 2. 12 20.001 ft his is a Medicare certification date, if applicable, in column 2. 12 12.001 ft his is a Medicare certification date, if applicable, in column 2. 12 12.001 ft his is a Medicare certification date, if applicable, in column 2. 12 12.001 ft his is a Medicare certification date, if applicable, in column 2. 12 12.001 ft his is a Medicare certification date, if applicable, in column 2. 12 13.001 ft his is a Medicare certification date, if applicable, in column 2. 13 13.001 ft his is a Medicare certification date, if applicable, in column 2. 13 13.001 ft his is a Medicare certification date, if applicable, in column 2. 13 13.001 ft his is a Medicare certification date, if applicable, in column 2. 13 13.001 ft his is a Medicare certification (DPD), enter the Certification date in column 1 and termination date, if applicable, in column 2. 13 13.001 ft his is a Medicare certification (OPD), enter the CPD number in column 1 and termination date, if applicable, in column 2. 14 140.00 Are there any related organization or home office costs as defined in CWP ub. 15-1. N 14 141.00 Viame. 2.00 0.00 151.00 100 2.00 1.00 142.00 Street: 10	yes, enter certification date(s) (mm/dd/yyyy) below.					
127. 00 if this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 12 128. 00 if this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 13 130. 00 if this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 13 131. 00 if this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 13 132. 00 if this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 13 133. 00 if this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 13 130. 00 if this is an angen procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. 13 140. 00 Are there any related organization or home office costs as defined in CMS Pub. 15-1. N N 44 142. 00 Are there any related organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor in Number:			fication date	e		126.00
in column 1 and termination date, if applicable, in column 2. 22.001f this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.001f this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.001f this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.001f this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.001f this is a Medicare certified to ther transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.001f this is a organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. All Providers 140.00Are there any related organization or home office costs as defined in CMS Pub. 15-1, N 141.00Name: 142.00Street: 142.00Street: 144.00Name: 142.00Street: 144.00Name: 143.00City: 144.00Name: 144.00Name: 144.00Name: 144.00Name: 145.00Has the cost all physicians' costs included in Worksheet A? 144.00Name: 145.00Has the cost all aysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in colum 1. 145.00Has the cost all aysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in colum 2. 145.00Has the cost all aysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in colum 1. 145.00Has the cost all aysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no. 146.00Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147.00Was there a change in the statistical basis? Enter "Y"	127.00 If this is a Medicare certified heart transplant center, enter	er the certif	ication date			127.00
129. 001 ft his is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 121 130. 001 ft his is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 131 131. 001 ft his is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 133 132. 001 ft his is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 133 130. 001 ft his is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 133 140. 001 ft his is a medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 134 141. 001 ft his is an organ procurement organization (OPO), enter the OPO number in column 1 133 142. 001 ft his is an Medicare certified organization or home office costs as defined in CMS Pub. 15-1, chapter 102 Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are cell med, enter in column 2. 144 141. 00Name: Contractor's Name: Contractor's Number: 144 142. 00Street: P0 Box: Contractor's Number: 14 143. 002 ft for sts for renal services are claimed on Wkst. A, line			ication date			128.00
130. 00 If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 131. 00 If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 132. 00 If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 133. 00 If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 133. 00 If this is an other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 134. 00 If this is an organ procurement organization (0PO), enter the 0PO number in column 1 and termination date, if organization (0PO), enter the PO number in column 1 and termination of the organization (0PO), enter the PO number in column 1 and termination of the organization (0PO), enter the PO number in column 1 and termination of the organization (0PO), enter the PO number in column 1 and termination date, if applicable, in column 2. 134. 00 If this is an organization or home office costs as defined in CMS Pub. 15-1, N N 144. 140. 00 Are there any related 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. 3.00 144. 141. 00 Name: Contractor's Name: 1.00 1.00 144. 142. 00 Street: P0 Box: Contractor's Number: 144. 1.00 1.00 1	129.00 If this is a Medicare certified lung transplant center, enter		cation date i	i n		129.00
date in column 1 and termination date, if applicable, in column 2. 132.00 132.00 141 fits is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 131.00 133.00 151 fits is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 131.00 <td< td=""><td>130.00 If this is a Medicare certified pancreas transplant center, e</td><td></td><td>ti fi cati on</td><td></td><td></td><td>130.00</td></td<>	130.00 If this is a Medicare certified pancreas transplant center, e		ti fi cati on			130.00
in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 If this is a medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 If this is a medicare certified other transplant center, enter the OPO number in column 1 and termination date, if applicable, in column 2. 133.00 If this is a medicare certified other transplant center, enter the OPO number in column 1 and termination date, if applicable, in column 2. 133.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. 133.00 If this is an organ procurement organization or home office costs as defined in CMS Pub. 15-1, N N 144.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, N N 144.00 Are there any related organization, enter on lines 141 through 143 the name and address of the home office contractor' name and contractor number. 144.00 Are provider based physicians' costs included in Worksheet A? 144.00 Are provider based physicians' costs included in Worksheet A? 144.00 Are ther enal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. N N 144.00 Are the cost allocation methodology changed from the previously filed cost report? N 144.00 Are the approval date (mm/dd/yyyy) in column 2.	date in column 1 and termination date, if applicable, in colu	umn 2.				131.00
In column 1 and termination date, if applicable, in column 2. 134.00 154.00 16 this is an organ procurement organization (OPO), enter the OPO number in column 1 13 134.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1 13 140.00 All Providers 1 14 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office cost (see instructions) 140 1 1.00 2.00 3.00 1 1.00 2.00 3.00 1 1.00 2.00 3.00 141.00 Name: Contractor's Name: Contractor's Number: 141.00 Name: Contractor's Name: 142.00 142.00 State: Zip Code: 144 143.00 City: State: Zip Code: 144 144.00 Are provider based physicians' costs included in Worksheet A? Y 144 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization fo	in column 1 and termination date, if applicable, in column 2.					132.00
134.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. All Providers 13. 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 140.00 141.00 Name: 2.00 3.00 142.00 Name: Contractor's Name: 0.0 142.00 Street: PO Box: Contractor's Number: 14. 143.00 City: State: Zip Code: 14. 144.00 Name: Contractor's Name: Contractor's Number: 14. 142.00 Street: PO Box: Zip Code: 14. 143.00 City: State: Zip Code: 14. 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for in patient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 1.00 146.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 14. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N N 14. 148.00			ication date			133.00
140.00 Åre there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 144 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 contractor namber. 3.00 141.00 Name: Contractor's Name: Contractor's Number: 144 143.00 City: State: Zip Code: 144 144.00 Åre provider based physicians' costs included in Worksheet A? Y 144 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dial ysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. N N 144 146.00 Has the cost allocation methodology changed from the previously filed cost report? N N N 144 147.000 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N N 144 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 144	134.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.		in column 1			134.00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 3.00 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. Contractor's Number: 141.000 141.000 Name: Contractor's Name: Contractor's Number: 141.42.00 Street: P0 Box: 142.00 Street: 141.000 143.00 City: State: Zip Code: 143.00 1.00 2.00 144.00 144.00 Are provider based physicians' costs included in Worksheet A? Y 144.00 1.00 2.00 1.00 1.00 1.00 145.000 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. N 144.00 146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 2. 1.00 144.00 147.000 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N N 144.00		efined in CMS	Pub. 15-1,	N		140.00
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. 143 the name and address of the home office and enter the home office contractor name and contractor number. 143 the name and address of the home office and enter the home office contractor name and contractor number. 143 the name and address of the home office and enter the home office contractor name and contractor number. 144 the name and address of the home office and enter the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home office contractor is Number: 144 the name and address of the home of	chapter 10? Enter "Y" for yes or "N" for no in column 1. If yare claimed, enter in column 2 the home office chain number.	yes, and home	office costs			
office and enter the home office contractor name and contractor number. 141.00 Name: Contractor's Name: Contractor's Number: 14 142.00 Street: P0 Box: 14		ines 141 thro	ugh 143 the		s of the home	2
142.00 Street: P0 Box: I43.00 Iai Iai <td>office and enter the home office contractor name and contrac</td> <td></td> <td></td> <td></td> <td></td> <td></td>	office and enter the home office contractor name and contrac					
143.00 City: Zip Code: 14: 143.00 City: Zip Code: 14: 144.00 Are provider based physicians' costs included in Worksheet A? Y 14: 144.00 Are provider based physicians' costs included in Worksheet A? Y 14: 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. N N 14: 146.00 Hat cost allocation methodology changed from the previously filed cost report? N N 14: 14: 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 14: 147.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 14:			Contract	or's Number:		141.00
144.00 Are provider based physicians' costs included in Worksheet A? 1.00 144.00 Are provider based physicians' costs included in Worksheet A? Y 14 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for N N N 14 145.00 If costs for renal services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is N N 14 145.00 Hat in patient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is N N 14 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 14 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If N 14 146.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 14 147.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 14			Zip Code			142.00 143.00
144.00 Are provider based physicians' costs included in Worksheet A? Y 14. 144.00 Are provider based physicians' costs included in Worksheet A? 1.00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for N N N 145.00 If costs for renal services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. N 14. 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 14. 146.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 1.00 1.00 147.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 14.			p coue			
1.00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for N N 145.00 145.00 If costs for renal services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. N N 145.00 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146.00 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146.00 146.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 1.00 1.00 147.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 147.00		2				
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. N N 14 146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. N 14 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 14 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 14	144.UUJARE provider based physicians' costs included in Worksheet A'	!			Y	144.00
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for name of the cost of the				1.00	2.00	
146.00 Has the cost allocation methodology changed from the previously filed cost report? N 14. Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If N 14. yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 1.00 14.00 N 14. 1.00 14.00 N 1.00 1.00 14.00 N 1.00 1.00 14.00 N 1.40 1.00 14.00 N 1.40 1.00 14.00 N 1.00 1.00 14.00 N 1.00 1.00	inpatient services only? Enter "Y" for yes or "N" for no in a no, does the dialysis facility include Medicare utilization	column 1. If	column 1 is	N	N	145.00
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 14 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 14	146.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 19					146.00
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148					1.00	
148. UUWas there a change in the order of allocation? Enter "Y" for yes or "N" for no. N [14]						147.00
149.00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 14	148.00Was there a change in the order of allocation? Enter "Y" for	yes or "N" f	OF NO. Ves or "N" for	r po		148.00 149.00

Health Financial Systems	MARGARET MARY COM	MUNITY HOSPITA	L		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Provider CO	CN: 15-1329		d: 01/01/2016 12/31/2016		
						5/25/2017 2:	<u>42 pm</u>
		Part A	Part B		Title V	Title XIX	_
Does this facility contain a prov	iden that qualifies for a	1.00	2.00	ootion	3.00	4.00	_
or charges? Enter "Y" for yes or							
155. 00 Hospi tal		N	N		N	N	155.00
156.00 Subprovi der – IPF		Ν	N		Ν	N	156.00
157.00 Subprovi der – IRF		Ν	N		Ν	N	157.00
158.00 SUBPROVI DER							158.00
159.00 SNF		N	N		N	N	159.00
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
161.00 CMHC			N		N	N	161.00
						1.00	-
Multicampus						1.00	
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has o	ne or more camp	ouses in dif	ferent	CBSAs?	N	165.00
	Name	County	State 2	Zip Code	CBSA	FTE/Campus	
166.00 If line 165 is yes, for each	0	1.00	2.00	3.00	4.00	5.00	0166.00
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							
						1.00	-
Health Information Technology (HI	T) incentive in the Ameri	can Recovery ar	nd Reinvestr	ment Act		1.00	
167.00 s this provider a meaningful use						Y	167.00
168.00 If this provider is a CAH (line 1) reasonable cost incurred for the			ne 167 is "Y	("), ent	er the		0168.00
168.01 If this provider is a CAH and is					rdshi p		168.01
exception under §413.70(a)(6)(ii)							
169.00 If this provider is a meaningful transition factor. (see instruction		d is not a CAH	(line 105 i	s "N"),	enter the	0.0	0169.00
				B	egi nni ng	Endi ng	
					1.00	2.00	-
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and ending	date for the r	eporti ng	01	/01/2016	12/31/2016	170.00
					1 00	0.00	_
	d data have any data for t	a alticul alcondia	l l a al l a		1.00	2.00	0171 00
171.00 If line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, Pt umn 1. If column 1 is yes	. I, line 2, co	l. 6? Enter		Ν		0171.00

MARGARET MARY COMMUNITY HOSPITAL

eal th	Financial Systems MARGARET MARY CON	IMUNI TY HOSPI TA	AL.	In Lie	u of Form CMS	-2552-1
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1329 F	Period: From 01/01/2016	Worksheet S- Part II Date/Time Pr	-2 repared:
	· · · · · · · · · · · · · · · · · · ·			V /N	5/25/2017 2:	42 pm
				Y/N 1.00	Date 2.00	_
	General Instruction: Enter Y for all YES responses. Enter Mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO r	esponses. Ente			
00	Provider Organization and Operation			N		1 1 0
. 00	Has the provider changed ownership immediately prior to th reporting period? If yes, enter the date of the change in			N		1.0
	reporting period: IT yes, enter the date of the change IT	<u>corumn 2. (366</u>	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colu voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, includi contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provi officers, medical staff, management personnel, or members of directors through ownership, control, or family and oth relationships? (see instructions)	offices, drug der or its of the board	N			3. (
		·	Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports		Ĩ	1		
. 00	Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.0
. 00	Are the cost report total expenses and total revenues diff those on the filed financial statements? If yes, submit re		N			5. (
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			-	2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is t	he provider is	N		6.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see i Were nursing school and/or allied health programs approved		d during the	N N		7. (8. (
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instructio		cal education	N		9. (
0. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in		N		10. (
1.00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N	N/ /41	11. (
					Y/N 1.00	
	Bad Debts	o oco inotruo	+1 000		V	12
2.00 3.00	Is the provider seeking reimbursement for bad debts? If ye If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			st reporting	Y N	12. 13.
4.00	If line 12 is yes, were patient deductibles and/or co-paym Bed Complement	ents waived? I	fyes, see ins	tructions.	N	14.
5.00	Did total beds available change from the prior cost report		yes, see inst t A		N t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
b. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/07/2017	Y	03/07/2017	16.
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		N		17.
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. (

Health Financial Systems

MARGARET MARY COMMUNITY HOSPITAL

In Lieu of Form CMS-2552-10

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 01/01/2016 To 12/31/2016		-2 repared:
		Descri	ption	Y/N	Y/N	
		()	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:			N	N	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		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS H	HOSPI TALS)	-		
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprais	sals made dur	ing 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 re	porting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during instructions.	g the cost repor	rting period?	lf yes, see	N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	the cost reporti	ing period? I	f yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during the copy.	ne cost reportin	ng period? If	yes, submit	Ν	27.00
	Interest Expense				1	_
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	entered into dur	ring the cost	reporti ng	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 R	eserve 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 instructions.	ssuance of new	debt? If yes	, see	Ν	31.00
	Purchased Servi ces	undara Cumiaki			N	
	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr	ructions.	0		N	32.00
	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	pried pertainin	ng to competi	tive bidding? It	N	33.00
	Provi der-Based Physi ci ans					
	Are services furnished at the provider facility under an a lf yes, see instructions.	0	•		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i		nts with the	provi der-based	Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs			N		
	Were home office costs claimed on the cost report?	roparad by +	home office?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	prepared by the	nome office?	N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year er	fice different d of the home of	from that of	N		38.00
39.00	If line 36 is yes, did the provider render services to oth see instructions.			, N		39.00
40.00	If line 36 is yes, did the provider render services to the instructions.	e home office?	lf yes, see	Ν		40.00
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	KYLE		SMI TH		41.00
42.00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LL	C			42.00
	preparer.					
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43.00

MCRI F32 - 10. 5. 160. 2

Health Fina	ancial Systems	MARGARET MARY CO	OMMUN	NI TY HOSPI TAL			In Lieu	u of Form CM	S-25!	52-10
HOSPI TAL AN	ND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provider CCN	: 15-1329	Peri From	od: 01/01/2016	Worksheet S Part II	-2	
						То	12/31/2016	Date/Time F 5/25/2017 2	repa : 42	pm
				3.00	1					
Cost	Report Preparer Contact Information									
41.00 Ente	er the first name, last name and the f	itle/position	SEN	VIOR MANAGER					1	41.00
hel d	d by the cost report preparer in colum	nns 1, 2, and 3,								
resp	becti vel y.									
42.00 Ente	er the employer/company name of the co	ost report							2	42.00
prep	barer.									
43.00 Ente	er the telephone number and email addr	ress of the cost							2	43.00
repo	ort preparer in columns 1 and 2, respe	ecti vel y.								

USITIAL	AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C		Period: From 01/01/2016	Worksheet S-3 Part I	i
					To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
						I/P Days / 0/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
8 Ho fo . 00 HM . 00 HM	spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 or the portion of LDP room available beds) 10 and other (see instructions) 10 IPF Subprovider 10 IRF Subprovider	30.00	18	6, 58	8 102, 216. 00	0	1.0 2.0 3.0 4.0
	spital Adults & Peds. Swing Bed SNF					0	
	spital Adults & Peds. Swing Bed NF					0	
	tal Adults and Peds. (exclude observation		18	6, 58	8 102, 216. 00	0	7.0
.00 IN	ds) (see instructions) ITENSIVE CARE UNIT IRONARY CARE UNIT	31.00	7	2, 56	2 6, 960. 00	0	8. (9. (
1. 00 SU 2. 00 OT	IRN I NTENSI VE CARE UNI T IRGI CAL I NTENSI VE CARE UNI T HER SPECI AL CARE (SPECI FY)	40.00					10. (11. (12. (
4.00 To 5.00 CA	IRSERY Ital (see instructions) H visits IBPROVIDER - IPF	43.00	25	9, 15	0 109, 176. 00	0 0 0	14.
7.00 SU 3.00 SU 9.00 SK 0.00 NU	IBPROVI DER – I RF IBPROVI DER I LLED NURSI NG FACI LI TY IRSI NG FACI LI TY						17. 18. 19. 20.
2. 00 HO	HER LONG TERM CARE ME HEALTH AGENCY	101.00				0	21. 22. 23.
4.00 H0 4.10 H0	IBULATORY SURGICAL CENTER (D.P.) ISPICE ISPICE (non-distinct part) IHC - CMHC	116. 00 30. 00	0		D		23. 24. 24. 25.
. 00 RU . 25 FE	RAL HEALTH CLINIC DERALLY QUALIFIED HEALTH CENTER	88. 00 89. 00	25			0	26.
.00 0b .00 Am	utal (sum of lines 14-26) pservation Bed Days ubulance Trips uployee discount days (see instruction)		20			0	
. 00 Em . 00 La . 01 To	ployee discount days - IRF bor & delivery days (see instructions) tal ancillary labor & delivery room tpatient days (see instructions)		0		D		31. 32. 32.

10SPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Pre 5/25/2017 2:4	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total 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 for the portion of LDP room available beds)	1, 771	88	4, 25	9		1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	443 0	386 0				2.00 3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
5.00	Hospital Adults & Peds. Swing Bed NF	4 774	0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 771	88	4, 25			7.0
8.00 9.00	INTENSIVE CARE UNIT	146	1	29	0		8.0
0.00	CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T						9. 0 10. 0
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY		0	97	7		13.0
4.00	Total (see instructions)	1, 917	89	5, 52		491.57	
5.00	CAH visits	0	0		0		15.0
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER - IRF						17.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE	(007	00/	44.40		00.70	21.0
2.00	HOME HEALTH AGENCY	6, 037	806	11, 12	6 0.00	20. 78	22.0
3.00 4.00	AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE	0	0		0.00	12.90	
4.00	HOSPICE HOSPICE (non-distinct part)	0	0		0.00	12.90	24.0
5.00	CMHC - CMHC	0	0		0		24.
6.00	RURAL HEALTH CLINIC	906	855	4, 24	6 0.00	7.06	
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0000	1, 21	0.00	0.00	
7.00	Total (sum of lines 14-26)		-		0.00	532.31	
8.00	Observation Bed Days		8	80	0		28.0
9.00	Ambul ance Trips	О					29.0
0.00	Employee discount days (see instruction)				0		30.0
1. 00	Employee discount days - IRF				0		31.(
2.00	Labor & delivery days (see instructions)	0	0		0		32.0
32.01	Total ancillary labor & delivery room				0		32.0
	outpatient days (see instructions)						
3.00	LTCH non-covered days	0					33.

	Financial Systems MAR	GARET MARY COMMU AL DATA	Provider C		Period: From 01/01/2016 To 12/31/2016		pared:
		Full Time Equivalents		Di se	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1	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) HMO and other (see instructions)		0	64		1, 693	1. 00 2. 00
4.00 5.00 6.00 7.00 8.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT				0		3.00 4.00 5.00 6.00 7.00 8.00 9.00
11.00 (12.00 (13.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions)	0.00	0	64	.6 31	1, 693	10.00 11.00 12.00 13.00 14.00
16.00 17.00 17.00 18.00 18.00 19.00 20.00 1 21.00 1	CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00					15.00 16.00 17.00 18.00 19.00 20.00 21.00
23.00 / 24.00 24.10	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0.00					22.00 23.00 24.00 24.10 25.00
26. 00 26. 25 27. 00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0.00 0.00 0.00					26.00 26.25 27.00 28.00
29.00 30.00 31.00 32.00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room						29.00 30.00 31.00 32.00 32.01
	outpatient days (see instructions) LTCH non-covered days						33.00

	Financial Systems MAR HEALTH AGENCY STATISTICAL DATA	RGARET MARY COM			In Lie eriod:	u of Form CMS-: Worksheet S-4	
	ILALITI AGENCI STATISTICAL DATA			F	rom 01/01/2016 o 12/31/2016	Date/Time Pre	epared:
					Home Health	5/25/2017 2:4 PPS	2 pm
					Agency I		
0.00	County				1.	00	0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	C			0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	320.00	0.00		0.00	
					Oyees (Full II	ille Equi vai ent)	
		Enter the numbe	or of bours in	Staff	Contract	Total	
		your normal		Starr	CONTRACT	TUTAI	
	····-	C)	1.00	2.00	3.00	
3.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40.00			0.00	
4.00 5.00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.00		0.00 6.46	
6.00 7.00	Direct Nursing Service Nursing Supervisor			7. 11 0. 00		7. 11 0. 00	
B. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			4.60 0.00		4.60 0.00	
10.00 11.00	Occupational Therapy Service Occupational Therapy Supervisor			1.30 0.00	0.00	1.30 0.00	10.00
12.00 13.00	Speech Pathol ogy Servi ce Speech Pathol ogy Supervi sor			0.03	0.00	0.03	12.00
14.00	Medical Social Service			0. 18	0.00	0. 18	14.00
15.00 16.00	Medical Social Service Supervisor Home Health Aide			0.00 1.09	0.00	0.00 1.09	16.00
17.00 18.00	Home Health Aide Supervisor Other (specify)			0.00		0.00	
19.00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where			6			19.00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			17140			20.00
20. 01	contains the first code).			50031			20.01
20. 02 20. 03				50034 50035			20.02
20. 04 20. 05				50042 99915			20.04
20.00		Full Ep Without		LUPA Epi sodes	PEP Only	Total (cols.	20.00
		0utliers 1.00	2.00	3.00	Epi sodes 4.00	<u> </u>	
21 00	PPS ACTIVITY DATA Skilled Nursing Visits	2, 850	38			2, 951	21.00
21.00	Skilled Nursing Visit Charges	478, 800	6, 384	10, 080	504	495, 768	22.00
24.00	Physical Therapy Visits Physical Therapy Visit Charges	2, 009 405, 818	4 808			2, 048 413, 696	24.00
25.00 26.00	Occupational Therapy Visits Occupational Therapy Visit Charges	632 136, 512	10 2, 160		4 864	646 139, 536	26.00
27.00 28.00	Speech Pathology Visits Speech Pathology Visit Charges	14 3, 052	0 0	0	0	14 3, 052	28.00
29.00 30.00	Medical Social Service Visits Medical Social Service Visit Charges	11 3, 520	0	0	-	11 3, 520	
31.00 32.00	Home Health Aide Visits Home Health Aide Visit Charges	341 33, 759	25 2, 475		0	367 36, 333	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5, 857	77		24	6, 037	
34.00 35.00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 1, 061, 461	0 11, 827	0 13, 815	-	0 1, 091, 905	
36.00	30, 32, and 34) Total Number of Episodes (standard/non	369	. 1, 021	32		404	
	outlier) Total Number of Outlier Episodes		2		0	2	
37.00							

Heal th	Financial Systems MAR	GARET MARY COM	MUNITY HOSPITA	۱L	In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	3
			Component		From 01/01/2016 To 12/31/2016	Date/Time Pre	
					RHC I	5/25/2017 2:4 Cost	42 pm
						1 0001	
				-	1.	. 00	
1 00	Clinic Address and Identification					- cT	1 00
1.00	Street		Ci	ty	112 N. BUCKEYE State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		OSGOOD			47037	2.00
2 00	HOSPITAL PASED FOLICE ONLY: Decignation Ent	or "D" for rur	al or "II" for	urban		1.00	2 00
3.00	HOSPITAL-BASED FOHCs ONLY: Designation - Ent				Award	Date	3.00
					. 00	2.00	
	Source of Federal Funds					•	
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00 7.00	Health Services for the Homeless (Section 34) Appalachian Regional Commission	U(d), PHS ACT)					6.00 7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
10.00			501100 5		1.00	2.00	10.00
10.00	Does this facility operate as other than a hurden yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	i ate number of o	other operatio	ns in column	N	C	10.00
		Sun	day	Mo	nday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) Clinic			08: 00	16: 30	08: 00	11.00
11.00				00.00	10. 50	00.00	11.00
					1.00	2.00	
	Have you received an approval for an exception				N		12.00
13.00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in col- number of providers included in this report. numbers below.	umn 1. lf yes,	enter in colu	mn 2 the	N	C	13.00
				Provid	ler name	CCN number	
				-	. 00	2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
15.00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
13.00	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						13.00
			Cou	inty			
			4.	00			
2.00	City, State, ZIP Code, County	Tugeday	14/-	aaday	T1	and a v	2.00
		Tuesday to	from Wedn	esday to	from	rsday to	
		6. 00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00		16: 30	08: 00	16: 30	08: 00	16: 30	11.00

Health Financial Systems MAR	RGARET MARY COM	u of Form CMS-2	2552-10			
HOSPI TAL-BASED RHC/FQHC STATI STI CAL DATA		Provider C	CN: 15-1329	Period:	Worksheet S-8	
		Component	CCN: 15-8511	From 01/01/2016 To 12/31/2016	Data/Tima Dra	narod
		Component	CCN. 15-6511	10 12/31/2010	5/25/2017 2:4	
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 Clinic	08: 00	12:00				11.00

HOSPI TAL-BA	ncial Systems ASED HOSPICE IDENTIFICATION	DATA		Provider CO Hospice CCI		Period: From 01/01/2016 To 12/31/2016	Worksheet S-9 PARTS I THROU Date/Time Pre 5/25/2017 2:4	GH IV
						Hospi ce I		
		Undupl i cated						
	-	Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
DADT		1.00	2.00	3.00	4.00	5.00	6.00	
	I - ENROLLMENT DAYS FOR CO	DST REPORTING	PERIODS BEGINN	ING BEFORE OCTO	DBER 1, 2015	-	-	1 1 0
	ice Continuous Home Care							1.0
	ice Routine Home Care							2.0
	ice Inpatient Respite Care							3.0
	ice General Inpatient Care							4.0
	I Hospice Days II - CENSUS DATA FOR COST							5.C
	er of patients receiving	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	R I, 2015			1 4 0
	ice care							6.0
	I number of unduplicated							7.0
	inuous Care hours billable							/.0
	edi care							
	age Length of Stay (line 5							8.0
	ne 6)							
	plicated census count							9.0
	I and II, columns 1 and 2	al so include	the days repor	ted in columns	3 and 4.		•	
				Title XVIII	Title XIX	Other	Total (sum of	
							cols. 1	
							through 3)	
				1.00	2.00	3.00	4.00	
	III - ENROLLMENT DAYS FOR	COST REPORTING	G PERIODS BEGI	NNING ON OR AF	TER OCTOBER 1	, 2015	I	
	ice Continuous Home Care			0		0 0	-	1
	ice Routine Home Care			10, 793		71 269		
	ice Inpatient Respite Care			7		0 9		12.0
	ice General Inpatient Care			17		0 17		13.0
	I Hospi ce Days			10, 817		71 295		14.0
	IV - CONTRACTED STATISTICA		SI REPORTING P	1			-	1 4 5 9
	ice Inpatient Respite Care			0		0 0		
6.00 HOSD	ice General Inpatient Care			0		0 0	y 0	16.0

Heal th	Financial Systems MARGARET MARY CO	MMUNITY HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-1329	Peri od:	Worksheet S-1	0
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
					0/20/2017 2.4	
					1.00	
	Uncompensated and indigent care cost computation				_	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column	3 divided by I	ine 202 colum	n 8)	0. 366180	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				1, 743, 348	
3.00	Did you receive DSH or supplemental payments from Medicaid				N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplem			ď?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments	s from Medicaid	1		0	5.00
6.00	Medicaid charges				6, 466, 965	6.00 7.00
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid proc	arom (lino 7 mi	nuc cum of li	noc 2 and E. if	2, 368, 073 624, 725	8.00
8.00	<pre> < zero then enter zero)</pre>	gram (inne / m	nus sum of fi	nes z anu s; i i	024,723	8.00
	Children's Health Insurance Program (CHIP) (see instruction	ons for each li	ne)			
9.00	Net revenue from stand-al one CHIP				0	9.00
10.00					0	•
	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
	Difference between net revenue and costs for stand-alone (CHIP (line 11 m	ninus line 9;	if < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see	e instructions	for each line)		
	Net revenue from state or local indigent care program (Not			,	0	13.00
14.00	Charges for patients covered under state or local indigent	t care program	(Not included	in lines 6 or	0	14.00
	10)					
15.00	5 1 5 1			45 1 11	0	
16.00	Difference between net revenue and costs for state or loca	al indigent car	re program (li	ne 15 minus line	• 0	16.00
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)					
17 00	Private grants, donations, or endowment income restricted	to funding cha	rity care		0	17.00
	Government grants, appropriations or transfers for support				0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and			s (sum of lines	624, 725	
	8, 12 and 16)			- (
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
	1		1.00	2.00	3.00	
	Charity care charges for the entire facility (see instruct		2, 590, 38		_/ /	
	Cost of patients approved for charity care (line 1 times I	ine 20)	948, 54			
22.00	Partial payment by patients approved for charity care			0 0		
23.00	Cost of charity care (line 21 minus line 22)		948, 54	17 0	948, 547	23.00
					1.00	
24 00	Does the amount in line 20 column 2 include charges for pa	tiont dave bay	and a longth	of ctoy limit	1.00	24.00
24.00	imposed on patients covered by Medicaid or other indigent		onu a renytn	OF Stay FIMEL		24.00
25 00	If line 24 is "yes," charges for patient days beyond an i	ndigent care n	rogram's leng	th of stay limit	0	25.00
	Total bad debt expense for the entire hospital complex (se			th of Stuy frim	7, 183, 005	
	Medicare bad debts for the entire hospital complex (see in		· /		751,042	
	Non-Medicare and non-reimbursable Medicare bad debt expens		us line 27)		6, 431, 963	
29.00				e 28)	2, 355, 256	
30.00					3, 303, 803	
31.00	Total unreimbursed and uncompensated care cost (line 19 pl				3, 928, 528	

ECLASSI FI	nancial Systems MAR	RGARET MARY COMMU OF EXPENSES	Provider C	CN: 15-1329	Peri od:	u of Form CMS-: Worksheet A	
					From 01/01/2016 To 12/31/2016		
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Recl assi fi cat i ons (See A-6)		
		1.00	2.00	3.00	4.00	5.00	
	ERAL SERVICE COST CENTERS				1		
	00 NEW CAP REL COSTS-BLDG & FIXT		3, 035, 997				
	01 NEW CAP REL COSTS-OFFSITE BLDG		666, 514				
	00 NEW CAP REL COSTS-MVBLE EQUIP		4, 273, 081				
	01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 00 EMPLOYEE BENEFITS DEPARTMENT	191, 642	0		0 154, 542 2 0		
	00 ADMINI STRATI VE & GENERAL	5, 287, 847	11, 513, 050 6, 222, 884				
	00 OPERATION OF PLANT	5, 207, 047	1, 268, 497				
	01 OPERATION OF PLANT -OFFSITE	0	111, 518				
	02 OPERATION OF PLANT - HOSPITAL & OFFS	515, 624	8, 340				
	00 LAUNDRY & LINEN SERVICE	85, 865	77, 379				
00 009	00 HOUSEKEEPI NG	807, 858	272, 853	1, 080, 71	1 0	1, 080, 711	9
	00 DI ETARY	775, 739	518, 980	1, 294, 71	9 -1, 201, 524	93, 195	10
00 011	00 CAFETERI A	0	0		0 1, 140, 731		
	00 NURSING ADMINISTRATION	722, 378	14, 468				
	00 CENTRAL SERVICES & SUPPLY	0	282, 233				
		598, 255	2, 322, 089				
	OO MEDICAL RECORDS & LIBRARY ATIENT ROUTINE SERVICE COST CENTERS	882, 066	184, 025	1, 066, 09	1 -1, 653	1, 064, 438	16
	00 ADULTS & PEDIATRICS	2, 645, 590	270, 079	2, 915, 66	9 491, 743	3, 407, 412	30
	00 I NTENSI VE CARE UNI T	302, 295	270, 079				
	00 NURSERY	0	85,089				
	I LLARY SERVICE COST CENTERS	<u> </u>		00,00	,	1007077	
	OO OPERATING ROOM	1, 367, 558	3, 304, 773	4, 672, 33	1 -2, 851, 091	1, 821, 240	50
00 052	OO DELIVERY ROOM & LABOR ROOM	1, 228, 030	228, 999	1, 457, 029	-1, 328, 425	128, 604	52
	00 RADI OLOGY-DI AGNOSTI C	2, 922, 355	5, 376, 868	8, 299, 22	3 -202, 954	8, 096, 269	54
	00 LABORATORY	1, 383, 042	2, 006, 621	3, 389, 66	3 -44, 314	3, 345, 349	
	01 BLOOD LABORATORY	0	0		0 0		
	00 RESPI RATORY THERAPY	469, 894	123, 699				
	00 PHYSI CAL THERAPY	1,048,319	86, 761				
	00 OCCUPATI ONAL THERAPY 00 SPEECH PATHOLOGY	367, 508	16, 310				
	00 ELECTROCARDI OLOGY	187, 430 558, 336	-516 313, 164				
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	313, 104 0		2, 510, 782		
	00 IMPL. DEV. CHARGED TO PATIENT	0	0		1, 799, 323		
00 073	00 DRUGS CHARGED TO PATIENTS	0	0		0 0		
OUT	PATIENT SERVICE COST CENTERS			· · · · · ·			
00 088	OO RURAL HEALTH CLINIC	578, 228	80, 821	659, 04	9 0	659, 049	88
00 090	OO CLINIC	1, 530, 766	298, 190	1, 828, 95			90
	01 WOUND CLINC	223, 556	337, 566				
	00 EMERGENCY	1, 701, 676	2, 326, 707	4, 028, 38	3 -89, 579	3, 938, 804	
	00 OBSERVATION BEDS (NON-DISTINCT PART)						92
	ER REIMBURSABLE COST CENTERS	4 500 700	040.045	1 744 00		4 744 000	11.0.1
	OO HOME HEALTH AGENCY CIAL PURPOSE COST CENTERS	1, 530, 783	213, 315	1, 744, 098	8 0	1, 744, 098	
	00 INTEREST EXPENSE		0		0 0	0	113
	00 HOSPI CE	659, 837	347, 294				
3. 00	SUBTOTALS (SUM OF LINES 1-117)	28, 572, 477	46, 208, 486				
	REIMBURSABLE COST CENTERS	20/0/2/1//	10/200/100	1 11/100/10	2777200	10/0/0/220	
	00 PHYSICIANS' PRIVATE OFFICES	8, 596, 521	1, 726, 537	10, 323, 05	в О	10, 323, 058	192
	01 PEDI ATRI CS	173, 561	9, 331				
2. 02 192	02 BROOKVI LLE	276, 204	33, 190				
. 00 079	50 COMMUNI TY RELATI ONS	269, 448	729, 377	998, 82	5 - 304, 301	694, 524	
	51 COMMUNITY BENEFITS	399, 465	238, 176	637, 64	1 0	637, 641	
	52 OTHER NON-REI MBURSABLE	0	0		7, 038		
4. 03 079		12, 399	37, 643				
D. 00	TOTAL (SUM OF LINES 118-199)	38, 300, 075	48, 982, 740	87, 282, 81	5 0	87, 282, 815	1200

Provider CCN: 15-1329

In Lieu of Form CMS-2552-10 Period: Worksheet A From 01/01/2016

				From 01/01/2016 To 12/31/2016 Date/Time Pre 5/25/2017 2:4	
	Cost Center Description	Adjustments	Net Expenses	372372017 2.4	
	·	(See A-8)	For		
			Allocation	-	
		6.00	7.00		
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	-882, 236	2, 142, 567	1	1.00
1.00	00101 NEW CAP REL COSTS-DEDG & TTXT	-002, 230	677, 708		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-272, 505			2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0			2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0			4.00
5.00	00500 ADMINI STRATI VE & GENERAL	-1, 639, 391	10, 174, 307	/	5.00
7.00	00700 OPERATION OF PLANT	-14, 115			7.00
7.01	00701 OPERATION OF PLANT -OFFSITE	0			7.01
7.02	00702 OPERATION OF PLANT - HOSPITAL & OFFS	0			7.02
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	-511	149, 702		8.00 9.00
9.00 10.00	01000 DI ETARY	-15, 810			10.00
11.00	01100 CAFETERI A	-368, 978			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	113		14.00
15.00	01500 PHARMACY	0	2, 918, 369		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-4, 920	1, 059, 518	3	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1	1	1	
30.00	03000 ADULTS & PEDIATRICS	-1, 133, 495			30.00
31.00	03100 INTENSIVE CARE UNIT	0			31.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	-84, 000	652, 097		43.00
50, 00	05000 OPERATING ROOM	-89, 583	1, 731, 657	1	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-09, 505			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-1,079,483			54.00
60.00	06000 LABORATORY	0	3, 345, 349		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60.01
65.00	06500 RESPI RATORY THERAPY	0	574, 327		65.00
66.00	06600 PHYSI CAL THERAPY	-27, 160			66.00
67.00	06700 OCCUPATIONAL THERAPY	-1, 875			67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0			68.00 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-166, 490	688, 547 2, 510, 782		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0			72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS				1
88.00	08800 RURAL HEALTH CLINIC	0	659, 049		88.00
90.00	09000 CLI NI C	-468, 549			90.00
90.01	09001 WOUND CLINC	0	210,201		90.01
91.00	09100 EMERGENCY	-1, 721, 430	2, 217, 374		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				92.00
101 00	10100 HOME HEALTH AGENCY	0	1, 744, 098	2	101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	1, 744, 070		101.00
113.00	11300 I NTEREST EXPENSE	0	0		113.00
	11600 HOSPI CE	0			116.00
118.00		-7, 970, 531	67, 107, 695		118.00
	NONREI MBURSABLE COST CENTERS	1	1	1	
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
192.01	19201 PEDI ATRI CS 19202 BROOKVI LLE	0	182, 892		192.01
	07950 COMMUNI TY RELATI ONS	0	309, 394 694, 524		192.02 194.00
	07950 COMMUNITY RELATIONS		694, 524		194.00
	07951 COMMONITE BENEFITS	0	7, 038		194.01
	07953 EMS	0	50, 042		194.02
200.00	TOTAL (SUM OF LINES 118-199)	-7, 970, 531			200.00

Heal th	Fi nanci al	Systems
RECLAS	SI FI CATI ON	S

ASSI FI CATI ONS			Provider CCN: 15-1:	From 01/01/2016 To 12/31/2016 Date/Ti	eet A-6 ime Prepare 017 2:42 pm
	Increases				
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - CAFETERIA		· · · · ·			
CAFETERIA	11.00	683, 476	457, 255		1.
0	- $ +$	683, 476	457, 255		
B - OB RECLASS					
ADULTS & PEDIATRICS	30.00	524, 190	56, 432		1.
NURSERY	43.00	587, 735	63, 273		2.
0	- $ +$	1, 111, 925	119,705		1
C - COMMUNITY RELATIONS	, 1				
ADMI NI STRATI VE & GENERA		94, 307	209, 994		1.
0		94, 307	209, 994		
D - OFFSITE BUILDING DE	PR RECLASS	,			
NEW CAP REL COSTS-OFFSI		0	11, 194		1.
BLDG		5			''
NEW CAP REL COSTS-MVBLE	2.01	o	154, 542		2.
EQUIP OFFSIT	2.01	5			
	+		165, 736		
E – IMPLANTABLE SUPPLIE	S RECLASS	-1			
IMPL. DEV. CHARGED TO	72.00	0	1, 799, 323		1.
PATIENT		-	.,,		
	0.00	0	0		2
0		0	1, 799, 323		
F - SPEECH RECLASS	1 1	-1	.,,		
OTHER NON-REIMBURSABLE	194.02	7, 085	0		1.
SPEECH PATHOLOGY	68.00	0	47		2.
0	- $ +$	7, 085	47		1
I - CENTRAL SUPPLY RECL	ASS				
MEDICAL SUPPLIES CHARGE	D TO 71.00	0	2, 510, 782		1.
PATI ENTS					
	0.00	0	0		2
	0.00	0	0		3
	0.00	0	0		4
	0.00	0	0		5
	0.00	0	0		6
	0.00	0	0		7
	0.00	0	0		8
	0.00	0	0		9
0	0.00	0	0		10
0	0.00	0	0		11
0	0.00	0	0		12
0	0.00	0	0		13
0	0.00	0	0		14
0	0.00	0	0		15
0	0.00	o	0		16
0	0.00	0	0		17
0	0.00	0	0		18
0	0.00	0	Ō		19
	0.00	0	Ő		20
	0.00	Ő	õ		21
	0.00	o	ō		22
	-+-		2, 510, 782		
1-		1, 896, 793	5, 262, 842		500

CLAS	SI FI CATI ONS			Provi der	CCN: 15-1329	Period: From 01/01/2016 To 12/31/2016	Worksheet A-6 Date/Time Prepared 5/25/2017 2:42 pm
		Decreases		1		I	0/20/2017 2. 12 pm
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ret	f.	
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
00	DI ETARY	10.00	683, 476	457, 25	5	0	1.0
	0		683, 476	457, 25	j	7	
	B - OB RECLASS						
00	DELIVERY ROOM & LABOR ROOM	52.00	1, 111, 925	119, 70	5	0	1.0
00		0.00	0	()	0	2.0
		T	1, 111, 925	119, 70	j	1	
	C - COMMUNITY RELATIONS						
00	COMMUNI TY RELATIONS	194.00	94, 307	209, 994	ļ	0	1.0
			94, 307	209, 99	ļ	1	
	D - OFFSITE BUILDING DEPR REC	LASS					
00	NEW CAP REL COSTS-BLDG &	1.00	0	11, 194	ļ	9	1.0
	FLXT						
00	NEW CAP REL COSTS-MVBLE	2.00	0	154, 542		9	2.0
	EQUI P						
			0	165, 730	,	1	
	E - IMPLANTABLE SUPPLIES RECL	ASS			1	1	
00	OPERATI NG ROOM	50.00	0	1, 797, 570	5	0	1.0
00	CLINIC	90.00	0	1, 74		0	2.0
		+		1, 799, 323		-	
	F - SPEECH RECLASS		-1	.,	-		
00	SPEECH PATHOLOGY	68.00	7,085	()	0	1.0
00	OTHER NON-REIMBURSABLE	194.02	0	4		0	2.0
	0		7,085	4		-	
	I - CENTRAL SUPPLY RECLASS	I			1		
00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 334		0	1.0
00	OPERATION OF PLANT	7.00	0	18		0	2.0
00	LAUNDRY & LINEN SERVICE	8.00	0	13, 03 ⁻		0	3.0
00	DI ETARY	10,00	0	60, 793		0	4. C
00	NURSING ADMINISTRATION	13.00	0	4		0	5.0
00	CENTRAL SERVICES & SUPPLY	14.00	0	282, 120		0	6.0
00	PHARMACY	15.00	0	1, 975		0	7.0
00	MEDICAL RECORDS & LIBRARY	16.00	0	1, 653		0	8.0
00	ADULTS & PEDIATRICS	30.00	0	88, 879		0	9.0
0.00	I NTENSI VE CARE UNI T	31.00	0	8, 742		0	10.0
. 00	OPERATING ROOM	50.00	0	1,053,51		0	11.0
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	96, 79		0	12.0
. 00 . 00	RADI OLOGY-DI AGNOSTI C	54.00	0	202, 954		0	13.0
1. 00	LABORATORY	60, 00		202, 954 44, 314		0	13.0
5. 00	RESPIRATORY THERAPY	65.00		44, 314		0	14.0
b. 00	PHYSICAL THERAPY	66. 00	0	19, 200		0	16.0
. 00 . 00	OCCUPATIONAL THERAPY		0			0	
		67.00	U U	7,602		0	17.0
3.00	SPEECH PATHOLOGY	68.00	U C	738		0	18.0
9.00	ELECTROCARDI OLOGY	69.00	0	16, 463		0	19.0
0.00		90.00	0	188, 619		0	20.0
. 00	WOUND CLINC	90.01	0	315, 888		0	21.0
2. 00	EMERGENCY	<u> </u>	0	<u>89, 579</u> 2, 510, 782		Q	22.0
					1		

Health Financial Sy	stems MA	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF (CAPITAL COSTS CENTERS		Provider C	CN: 15-1329	Period: From 01/01/2016 To 12/31/2016		pared:
				Acqui si ti on	S		
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
PART I – ANA	LYSIS OF CHANGES IN CAPITAL ASS	ET BALANCES					
1.00 Land		2, 371, 158	182, 500		0 182, 500		1.00
2.00 Land Improve		423, 901	44, 463		0 44, 463		2.00
3.00 Buildings an		69, 823, 878	4, 316, 246		0 4, 316, 246	0	3.00
4.00 Building Imp	rovements	0	0		0 0	0	4.00
5.00 Fixed Equipm	ent	6, 341, 285	0		0 0	0	5.00
6.00 Movable Equi	pment	47, 282, 966	13, 294, 437		0 13, 294, 437	6, 595, 283	6.00
7.00 HIT designat	ed Assets	0	0		0 0	0	7.00
8.00 Subtotal (su	m of lines 1-7)	126, 243, 188	17, 837, 646		0 17, 837, 646	6, 595, 283	8.00
9.00 Reconciling	ltems	0	0		0 0	0	9.00
10.00 Total (line	8 minus line 9)	126, 243, 188	17, 837, 646		0 17, 837, 646	6, 595, 283	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6.00	7.00				
PART I - ANA	LYSIS OF CHANGES IN CAPITAL ASS	ET BALANCES					
1.00 Land		2, 553, 658	0				1.00
2.00 Land Improve	ments	468, 364	0				2.00
3.00 Buildings an	d Fixtures	74, 140, 124	0				3.00
4.00 Building Imp	rovements	0	0				4.00
5.00 Fixed Equipm	ent	6, 341, 285	0				5.00
6.00 Movable Equi	pment	53, 982, 120	0				6.00
7.00 HIT designat	ed Assets	0	0				7.00
	m of lines 1-7)	137, 485, 551	0				8.00
9.00 Reconciling		0	0				9.00
10.00 Total (line	8 minus line 9)	137, 485, 551	0				10.00

Heal th	Financial Systems MAF	GARET MARY COM	MUNITY HOSPITA	L	In Lie	eu of Form CMS-:	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2016 To 12/31/2016		pared:
			SL	JMMARY OF CAP	ITAL		
	Cost Center Description	Depreciation	Lease	Interest	I nsurance (see i nstructi ons)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	/N 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 941, 082	0	1, 094, 9	15 0	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	666, 514	0		0 0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4, 273, 081	0		0 0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0		0 0	0	2.01
3.00	Total (sum of lines 1-2)	6, 880, 677	0	1, 094, 9	15 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at					
		ed Costs (see	9 through 14)				
		instructions)					
	1	14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3, 035, 997				1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	666, 514				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	4, 273, 081				2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0				2.01
3.00	Total (sum of lines 1-2)	0	7, 975, 592				3.00

Health Financial Systems MA	RGARET MARY CON	IMUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 2:42	bared:
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 -	Ratio (see instructions)	Insurance	
	1.00	2.00	col. 2) 3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS (2100	0.00		0100	
1.00 NEW CAP REL COSTS-BLDG & FIXT	59, 998, 133	0	59, 998, 13	3 0. 436396	0	1.00
1.01 NEW CAP REL COSTS-OFFSITE BLDG	17, 164, 013		17, 164, 01	3 0. 124842	0	1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	60, 323, 405	0	60, 323, 40	5 0. 438762	0	2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0		0. 000000	0	2.01
3.00 Total (sum of lines 1-2)	137, 485, 551	0	137, 485, 55	1 1.000000	0	3.00
ALLOCATI ON OF OTHER CAPITAL SUMMARY OF CAPITAL						
Cost Center Description	Taxes	Other Capital-Relat ed Costs		Depreciation	Lease	
	6, 00	7.00	through 7) 8.00	9, 00	10,00	
PART III - RECONCILIATION OF CAPITAL COSTS (7.00	0.00	7.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 1, 929, 888	0	1.00
1.01 NEW CAP REL COSTS-OFFSITE BLDG	0	0		0 677, 708	0	1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 3, 846, 034	0	2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0		0 154, 542	0	2.01
3.00 Total (sum of lines 1-2)	0	0		0 6, 608, 172	0	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at	(sum of cols.	
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS (-			0.440.547	4 00
1.00 NEW CAP REL COSTS-BLDG & FIXT	212, 679			0 0	2, 142, 567	1.00
1.01 NEW CAP REL COSTS-OFFSITE BLDG	0	0		0 0	677, 708	1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	3, 846, 034	2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0		0 0	154, 542	2.01
3.00 Total (sum of lines 1-2)	212, 679	0	1	0 0	6, 820, 851	3.00

ADJUSTMENTS TO EXPENSES	WAP	GARLI WART CON	Provi der CCN: 15-1329	Period:	Worksheet A-8	2002-1
				From 01/01/2016 To 12/31/2016		
			Expense Classification or To/From Which the Amount is			
Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 <u>Ref.</u> 5.00	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2) Investment income - NEW CAP REL COSTS-OFFSITE BLDG			NEW CAP REL COSTS-OFFSITE BLDG	1. 01	0	1.01
(chapter 2) .00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	2. 01
(chapter 2) .00 Investment income - other (chapter 2)		0		0.00	О	3.00
.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
.00 Refunds and rebates of expenses (chapter 8) .00 Rental of provider space by		0		0.00	0	5.00 6.00
suppliers (chapter 8) .00 Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
21) .00 Television and radio service		0		0.00	о	8. 0
(chapter 21) .00 Parking Lot (chapter 21) 0.00 Provider-based physician	A-8-2	0 -4, 250, 385		0.00	0 0	9.00 10.00
adjustment 1.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
2.00 Related organization transactions (chapter 10)	A-8-1	0			0	12.00
3.00 Laundry and linen service4.00 Cafeteria-employees and guests5.00 Rental of quarters to employee		0 0 0		0.00 0.00 0.00	0 0 0	13.00 14.00 15.00
and others 6.00 Sale of medical and surgical supplies to other than		0		0.00	0	16. 0
patients 7.00 Sale of drugs to other than		0		0.00	0	17.00
patients 8.00 Sale of medical records and abstracts		0		0.00	0	18.00
9.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	
0.00 Vending machines 1.00 Income from imposition of interest, finance or penalty		0		0.00 0.00	0 0	20.00 21.00
charges (chapter 21) 2.00 Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 0
3.00 Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 0
4.00 Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24.0
limitation (chapter 14) 5.00 Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
(chapter 21) 6.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
6. 01 Depreciation - NEW CAP REL COSTS-OFFSITE BLDG		0	NEW CAP REL COSTS-OFFSITE BLDG	1. 01	0	
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00

	Financial Systems	MAR	RGARET MARY CON	MUNITY HOSPITAL		u of Form CMS-2	
ADJUST	MENTS TO EXPENSES				eriod: rom 01/01/2016 o 12/31/2016	Date/Time Pre	pared:
				Expense Classification on To/From Which the Amount is		5/25/2017 2:4	2 pm
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
27.01	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2. 01	0	27.01
28.00	COSTS-MVBLE EQUIP OFFSIT Non-physician Anesthetist		0	EQUIP OFFSIT *** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30. 00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	А	-272, 505	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHEROPERATING GIRLS ON THE RUN REVE	В		ADMINISTRATIVE & GENERAL	5.00		
34.00 35.00	OTHEROPERATING OTHOP - INTERNAL SALE MMCH OTHER OPERATING	B		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5. 00 5. 00	0	
36.00	COMMBENEFITS SC OTHEROPERATING DIABETES	В		ADMI NI STRATI VE & GENERAL	5.00	0	
37.00	PROGRAM OTHEROPERATING OTHOP-COMMUNITY	В		ADMI NI STRATI VE & GENERAL	5.00	0	37.00
38.00	CLASS OTHEROPERATING OTHOP-PURCHASE	В	-203	ADMI NI STRATI VE & GENERAL	5.00	0	38.00
40.00	DI SCOU OTHEROPERATI NG OTHOP – MI SC REVENUE	В	-14, 016	OPERATION OF PLANT	7.00	0	40.00
41.00	MMCH NON-OPERATING R NONOP - MISCELL	В	-99	OPERATION OF PLANT	7.00	0	41.00
43.00	OTHEROPERATING OTHOP - LAUNDRY SERVI			LAUNDRY & LINEN SERVICE	8.00	0	
44.00 45.00	OTHEROPERATI NG OTHOP - VENDI NG SALES OTHEROPERATI NG OTHOP - DI ET	B		DI ETARY DI ETARY	10. 00 10. 00	0	
	SUPP/INS						
	CAFETERIA OFFSET NON-OPERATING OTHOP - CAFÉ SALES	B B		CAFETERI A CAFETERI A	11. 00 11. 00		
45.03	OTHEROPERATING OTHOP - MEDRED TRANSC	В	-4, 920	MEDI CAL RECORDS & LI BRARY	16.00	0	45.03
45.04	OTHEROPERATI NG OTHOP-PHYSI CAL THERAP	В		PHYSI CAL THERAPY	66.00		45.04
45.05	OTHEROPERATING OTHOP- OCCUPATIONAL T	В		OCCUPATIONAL THERAPY	67.00		
45.06	INTEREST OFFSET	A		NEW CAP REL COSTS-BLDG & FLXT	1.00	0	45.06
45.07 45.08	LOBBYING EXPENSE MEDICAL STAFF RETENTION COST	A		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00 5.00	0	
45.09	MEDICAL STAFF PLACEMENT FEE	А	-152, 295	ADMI NI STRATI VE & GENERAL	5.00	0	45.09
45.10	PHYSICIAN RECRUITMENT	A		ADMI NI STRATI VE & GENERAL	5.00	0	
45. 11 45. 12	HAF TELEPHONE & TV OFFSET	A		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00 5.00	0	
45.12	BOUTIQUE OFFSET	A		RADI OLOGY-DI AGNOSTI C	54.00	-	
45.14	HOSPI TALI ST OFFSET	A		ADULTS & PEDIATRICS	30.00	0	45.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7, 970, 531				50.00
(1) 5					·		

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

	Tinanciai Syste		ANDARLI MARI CO						
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT			Provider (1	Period: From 01/01/2016 Fo 12/31/2016	b Date/Time Pre	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Dro	fessi onal	Provi der	RCE Amount	5/25/2017 2: 4 Physi ci an/Prov	iz pili
	WKSL. A LINE #	I denti fi er	Remuneration		mponent	Component	KCL AIIOUITI	ider Component	
		ruentirrei	Reliance at 1 of 1		inponent	component		Hours	
	1.00	2.00	3.00		4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	727, 721		642, 721	85,000			1.00
2.00		NURSERY						-	
			84,000		84,000		-	0	2.00
3.00		OPERATING ROOM	134, 583		89, 583			0	3.00
4.00		RADI OLOGY-DI AGNOSTI C	240, 790		216, 790			0	4.00
5.00		RADI OLOGY-DI AGNOSTI C	549, 846		549, 846		-	0	5.00
6.00		RADI OLOGY-DI AGNOSTI C	344, 976		310, 976			0	6.00
7.00		LABORATORY	66, 800		0	66, 800	0	0	7.00
8.00		ELECTROCARDI OLOGY	166, 490		166, 490		0	0	8.00
9.00		ELECTROCARDI OLOGY	27, 996		0	27, 996		0	9.00
10.00		ELECTROCARDI OLOGY	9, 996		0	9, 996	0	0	10.00
11.00	90.00	CLINIC	468, 549		468, 549	0	0	0	11.00
12.00	91.00	EMERGENCY	16, 900		14, 610	2, 290	0	0	12.00
13.00	91.00	EMERGENCY	2, 176, 410		1, 684, 759	491, 651	0	0	13.00
14.00	91.00	EMERGENCY	22, 061		22, 061	0	0	0	14.00
200.00			5, 037, 118		4, 250, 385	786, 733		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Cost of		Physician Cost	
		I denti fi er				Memberships &		of Malpractice	
					, Limit	Conti nui ng	Share of col.	Insurance	
						Education	12		
	1.00	2.00	8.00		9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0		0	0			1.00
2.00		NURSERY	0		0	-		0	2.00
3.00		OPERATI NG ROOM	0		0			0	3.00
4.00		RADI OLOGY-DI AGNOSTI C	0		0	0	-	0	4.00
5.00		RADI OLOGY-DI AGNOSTI C	0		0	-		0	5.00
6.00		RADI OLOGY-DI AGNOSTI C	0		0	0	0	0	6.00
7.00		LABORATORY	0		0	0	0	0	7.00
8.00		ELECTROCARDI OLOGY	0		0	0	0	0	8.00
			0		0	0	0	0	
9.00		ELECTROCARDI OLOGY	0		0	0	0	0	9.00
10.00		ELECTROCARDI OLOGY	0	1	0	0	0	0	10.00
11.00		CLINIC	0		0	0	0	0	11.00
12.00		EMERGENCY	0	1	0	0	0	0	12.00
13.00		EMERGENCY	0		0	0	0	0	13.00
14.00	91.00	EMERGENCY	0		0	-	, o	0	14.00
200.00			0		0	-	°	0	200.00
	Wkst. A Line #		Provi der		usted RCE	RCE	Adjustment		
		I denti fi er	Component		Limit	Di sal I owance			
			Share of col.						
			14					-	
	1.00	2.00	15.00		16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	0	1	0				1.00
2.00		NURSERY	0		0	0			2.00
3.00		OPERATING ROOM	0	1	0	0	89, 583		3.00
4.00		RADI OLOGY-DI AGNOSTI C	0		0	0			4.00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	0		0	0	549, 846		5.00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	0		0	0	310, 976		6.00
7.00	60.00	LABORATORY	0		0	0	0		7.00
8.00		ELECTROCARDI OLOGY	0		0		166, 490		8.00
9.00		ELECTROCARDI OLOGY	0		0	0			9.00
10.00		ELECTROCARDI OLOGY	0		0		0		10.00
11.00		CLINIC	0		0		468, 549		11.00
12.00		EMERGENCY	0		0	-			12.00
13.00		EMERGENCY	0		0				13.00
14.00		EMERGENCY	0		0				14.00
200.00			0		0				200.00
200.00	I	1	. 0	1	0	. 0	1, 200, 000	1	200.00

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	Fr To		Worksheet B Part I Date/Time Pre 5/25/2017 2:4	pared: 2 pm
			CAPI TAL REL	ATED COSTS		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUI P	NEW MVBLE EQUIP OFFSIT	
	0	1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-OFFSITE BLDG 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFF	2, 142, 567 677, 708 3, 846, 034 FSI T 154, 542	2, 142, 567 0	677, 708	3, 846, 034 0	154, 542	1.00 1.01 2.00 2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT	11, 704, 692 10, 174, 307 1, 254, 364 111, 518	9, 463 274, 272 357, 776 0	0 0 0 0	16, 987 492, 335 642, 229 0	0 0 0 0	4.00 5.00 7.00 7.01
7. 02 00702 OPERATION OF PLANT - HOSPITAL & 0 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CAFETERIA	0FFS 523, 964 149, 702 1, 080, 711 77, 385 771, 753	0 24, 444 27, 320 4, 961 79, 390	0 0 0 0	0 43, 878 49, 041 8, 905 142, 509	0 0 0 0	7.02 8.00 9.00 10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	736, 799 736, 799 113 2, 918, 369 1, 059, 518	2, 112 0 11, 715 42, 384	0 0 0	3, 792 3, 792 21, 028 76, 082	0 0 0 0	13.00 14.00 15.00 16.00
30. 00 03000 ADULTS & PEDIATRICS	2, 273, 917	204, 735	0	367, 511	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	314, 391 652, 097	204, 733 20, 052 10, 214	0	35, 995 18, 334	0 0 0	31.00 43.00
ANCI LLARY SERVI CE COST CENTERS	1, 731, 657	44, 607	0	80, 073	0	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	128, 604 7, 016, 786 3, 345, 349	19, 385 265, 893 48, 359	0	34, 798 477, 293 86, 808	0 0 0	52.00 54.00 60.00
60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0 574, 327 1, 091, 463	0 36, 978 78, 042	0 0 0	0 66, 378 140, 090	0 0 0	60. 01 65. 00 66. 00
 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI I 	374, 341 179, 138 688, 547 ENTS 2, 510, 782	16, 245 14, 841 31, 698 10, 575	0 0 0	29, 160 26, 641 56, 899 18, 983	0 0 0 0	67.00 68.00 69.00 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0UTPATI ENT SERVI CE COST CENTERS	1, 799, 323 0	54, 654 0	0	98, 108 0	0	72.00 73.00
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC 90. 01 09001 WOUND CLINC 91. 00 09100 EMERGENCY 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT P/	659, 049 1, 170, 041 245, 234 2, 217, 374	0 194, 813 9, 380 127, 402	0	0 349, 701 16, 838 228, 694	7,228 4,809 0 0	90. 00 90. 01
OTHER RELIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 744, 098	47, 456	2, 192	85, 186	500	101.00
SILESTAL TEREST SILESTAL TEREST SILESTAL SILESTAL <thsilestal< th=""> <thsilestal< th=""> <thsi< td=""><td>1, 007, 131 67, 107, 695</td><td>0 2, 069, 166</td><td>0 54, 974</td><td>0 3, 714, 276</td><td></td><td>113. 00 116. 00 118. 00</td></thsi<></thsilestal<></thsilestal<>	1, 007, 131 67, 107, 695	0 2, 069, 166	0 54, 974	0 3, 714, 276		113. 00 116. 00 118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 PEDI ATRI CS 192. 02 19202 BROOKVI LLE	10, 323, 058 182, 892 309, 394	27, 348 26, 056 0		49, 091 46, 771 0	111, 396 0 30, 609	192.01
194.00 07950 COMMUNITY RELATIONS 194.01 07951 COMMUNITY BENEFITS 194.02 07952 OTHER NON-REIMBURSABLE 194.03 07953 EMS	694, 524 637, 641 7, 038 50, 042	3, 780 16, 217 0 0	0 0 0	6, 785 29, 111 0 0	0 0	194.00 194.01 194.02 194.03
200.00Cross Foot Adjustments201.00Negative Cost Centers202.00TOTAL (sum Lines 118-201)	79, 312, 284	0 2, 142, 567	0 677, 708	0 3, 846, 034		200. 00 201. 00

Heal th Financial	Systems	
OOCT ALLOOATLON		CED

	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1329	Period: From 01/01/2016 Fo 12/31/2016	Date/Time Pre 5/25/2017 2:4	pared:
	Cost Center Description	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	PLANT	OPERATION OF PLANT -OFFSITE	
		4.00	4A	5.00	7.00	7.01	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 00400 EMPLOYEE BENEFITS DEPARTMENT	11 701 140					2.01
4.00 5.00		11, 731, 142	12, 597, 735	10 507 700	-		4.00 5.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	1, 656, 821					7.00
7.00	00701 OPERATION OF PLANT -OFFSITE	0	2, 254, 369			122 574	7.00
7.01	00702 OPERATION OF PLANT - HOSPITAL & OFFS	158, 728	111, 518 682, 692			132, 576 0	7.01
7.02 8.00	00800 LAUNDRY & LINEN SERVICE	26, 432	244, 456			0	
8.00 9.00	00900 HOUSEKEEPI NG	248, 688	1, 405, 760			-	
10.00	01000 DI ETARY	248, 000	119, 653				10.00
11.00	01100 CAFETERI A	210, 399	1, 204, 051			0	11.00
	01300 NURSI NG ADMI NI STRATI ON					0	13.00
13.00		222, 374	965, 077				
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	104 144	2 125 274			0	14.00
15.00		184, 164	3, 135, 276			0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	271, 532	1, 449, 516	273, 712	2 75, 674	0	16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	975, 772	2 021 025	721, 696	365, 544	0	30.00
30.00 31.00	03100 INTENSIVE CARE UNIT	973, 772	3, 821, 935 463, 495				
43.00	04300 NURSERY					0	
43.00	ANCI LLARY SERVICE COST CENTERS	180, 926	861, 571	162, 690	18, 236	0	43.00
50.00	05000 OPERATING ROOM	420, 984	2, 277, 321	430, 027	7 79,644	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	35, 741	2, 277, 321 218, 528			0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	899, 606	8, 659, 578			-	54.00
60.00	06000 LABORATORY	425, 750				0	60.00
60. 00	06001 BLOOD LABORATORY	425, 750	3, 906, 266 0			0	60.00
65.00	06500 RESPIRATORY THERAPY	144, 650	822, 333			0	65.00
66.00	06600 PHYSI CAL THERAPY	322, 710	1, 632, 305			-	66.00
67.00	06700 OCCUPATI ONAL THERAPY	113, 132	532, 878			0	67.00
68.00	06800 SPEECH PATHOLOGY	55, 517	276, 137			0	68.00
69.00	06900 ELECTROCARDI OLOGY	171, 876	949, 020			0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 540, 340			0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	1, 952, 085			0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 752, 005			0	73.00
75.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0			0	/ 5.00
88.00	08800 RURAL HEALTH CLINIC	177, 999	875, 971	165, 410	0 0	6, 200	88.00
90.00	09000 CLINIC	471, 225	2, 211, 676				
90.01	09001 WOUND CLINC	68, 819	340, 271				
91.00	09100 EMERGENCY	523, 837	3, 097, 307				
92.00		525,057	3,077,307		227,407	0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101 00	10100 HOME HEALTH AGENCY	471, 230	2, 350, 662	443, 876	6 84, 730	429	101.00
101.00	SPECIAL PURPOSE COST CENTERS	171,200	2,000,002	110,070	01,700	127	101.00
113 00	D11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	203, 122	1, 210, 253	228, 532	0	0	116.00
118.00		8, 763, 493	63, 170, 148			10, 754	
	NONREI MBURSABLE COST CENTERS	0,100,110	00/1/0/110	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2/01//00/	10//01	1.10.00
192 00	19200 PHYSI CLANS' PRI VATE OFFI CES	2, 646, 312	13, 645, 712	2, 576, 749	9 48, 829	95, 564	192 00
	19201 PEDI ATRI CS	53, 428	309, 147				192.01
	19202 BROOKVI LLE	85, 026	559, 256				192.02
	07950 COMMUNITY RELATIONS	53, 915	759,004				194.00
	07951 COMMUNITY BENEFITS	122, 970	805, 939				194.01
	207952 OTHER NON-REI MBURSABLE	2, 181	9, 219				194.02
	307953 EMS	3, 817	53, 859				194.02
200.00		0,017	00,007			0	200.00
200.00		0	0		0	n	201.00
201.00		11, 731, 142	79, 312, 284			132, 576	
			, 5.2, 201		_, 000, 001		

In Lieu of Form CMS-2552-10

Health Financial Systems MA	RGARET MARY CON	IMUNITY HOSPITA	L	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1329 Pe Fr To	eriod: com 01/01/2016	Worksheet B Part I	epared:
Cost Center Description	OPERATI ON OF PLANT - HOSPI TAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	7.02	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS1. 0000100 NEW CAP REL COSTS-BLDG & FIXT1. 0100101 NEW CAP REL COSTS-OFFSITE BLDG2. 0000200 NEW CAP REL COSTS-MVBLE EQUIP2. 0100201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT4. 0000400 EMPLOYEE BENEFITS DEPARTMENT5. 0000500 ADMINISTRATIVE & GENERAL7. 0100701 OPERATION OF PLANT7. 0100701 OPERATION OF PLANT7. 0200702 OPERATION OF PLANT8. 0000800 LAUNDRY & LINEN SERVICE9. 0000900 HOUSEKEEPING10. 0001000 DI ETARY	811, 605 8, 550 9, 556 1, 735	342, 810 54, 455	1, 784, 000	150 505		1.00 1.01 2.00 2.01 4.00 5.00 7.00 7.01 7.02 8.00 9.00 10.00
11. 00 01100 CAFETERI A	27, 768			158, 595 0	1, 690, 953	
13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY	27, 788 739 0 4, 097 14, 825	0 3, 810 0	2, 348 0 13, 021	0 0 0 0	65, 487 0 48, 549	13.00 14.00 15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY	71, 610 7, 014 3, 572	2, 955	22, 288	151, 006 7, 589 0	37, 091	31.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	15 (02	24.042	40 501	0	1// 400	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	15, 602 6, 780 93, 001 16, 915 0	25, 854 50, 976 0	21, 547 295, 539 53, 751	0 0 0 0	166, 428 12, 761 171, 435 210, 996 0	52.00 54.00 60.00
65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	12, 934 27, 297 5, 682 5, 191	29, 236 0	86, 743 18, 056	0 0 0 0	57, 602 0 0 0	66.00 67.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0UTPATI ENT DERVICE COST CENTERS	11, 087 3, 699 19, 116 0	0 25, 901	11, 754 60, 748	0 0 0	62, 582 0 0	71.00 72.00
88.00 08800 RURAL HEALTH CLINIC	0	41	0	0	0	88.00
90.00 09000 CLINIC 90.01 09001 WOUND CLINC 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	68, 140 3, 281 44, 561	9, 424 5, 442	216, 534 10, 426	0 0 0		90. 00 90. 01
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	16, 599	0	52, 747	0	0	101.00
SPECIAL PURPOSE COST CENTERS	10, 377	0	52,747	0	0	
113. 00 11300 I NTEREST EXPENSE						113.00
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0 499, 351			0 158, 595		116.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 PEDI ATRI CS 192. 02 19202 BROOKVI LLE 194. 00 07950 COMMUNI TY RELATI ONS 194. 01 07951 COMMUNI TY BENEFI TS 194. 02 07952 OTHER NON-REI MBURSABLE	230, 958 9, 113 65, 189 1, 322 5, 672 0	0 0 0	28, 961 0 4, 201 18, 025 0	0 0 0 0 0 0 0	0 18, 355 45, 802 0	192.01 192.02 194.00 194.01 194.02
194.03 07953 EMS 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	0 0 811, 605	0 0 342, 810	0 0 1, 784, 000	0 0 158, 595	O	194.03 200.00 201.00 202.00

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1329	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Data/Time Bro	parad
						Date/Time Pre 5/25/2017 2:4	12 pm
	Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
	GENERAL SERVICE COST CENTERS	1			T		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 2.00	00101 NEW CAP REL COSTS-OFFSITE BLDG 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						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
7.01	00701 OPERATION OF PLANT -OFFSITE						7.01
7.02	00702 OPERATION OF PLANT - HOSPITAL & OFFS						7.02
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 219, 657					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 219, 037	3, 944				14.00
15.00	01500 PHARMACY	51, 911	1	3, 865, 80	05		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1	-,,	0 1, 977, 787		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	301, 435	65		0 1, 279, 360	7, 275, 157	30.00
31.00	03100 I NTENSI VE CARE UNI T	39, 659	7		0 0	703, 423	
43.00	04300 NURSERY	69, 072	0		0 0	1, 206, 149	43.00
	ANCI LLARY SERVICE COST CENTERS		1.0/7		0 100 011	2 170 424	
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 13, 644	1, 967 70		0 133, 811 0 0	3, 178, 424 375, 061	
54.00	05400 RADI OLOGY-DI AGNOSTI C	183, 305	243		0 378, 586	11, 942, 589	
60.00	06000 LABORATORY	225, 607	875		0 0	5, 238, 373	
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	61, 591	78		0 0	1, 222, 664	65.00
66.00	06600 PHYSI CAL THERAPY	0	14		0 0	2, 223, 163	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	8		0 0	686, 251	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	376, 465	
69.00	06900 ELECTROCARDI OLOGY	44, 162	27		0 26, 109	1, 366, 112	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	3, 054, 366 2, 524, 045	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	3, 865, 80	· · ·	3, 865, 805	
75.00	OUTPATIENT SERVICE COST CENTERS	0	<u> </u>	3,003,00	<u>, , , , , , , , , , , , , , , , , , , </u>	3,003,003	/ /3.00
88.00	08800 RURAL HEALTH CLINIC	0	8		0 0	1,047,630	88. 00
90.00	09000 CLINIC	0	129		0 133, 811	3, 409, 299	
90.01	09001 WOUND CLINC	0	213		0 0	440, 634	90.01
91.00	09100 EMERGENCY	227, 570	64		0 13, 055	4, 578, 867	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS					0.040.0/7	1101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	24		0 0	2, 949, 067	101.00
112 00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	9		0 0	1, 438, 794	
118.00		1, 217, 956	3, 803	3, 865, 80		59, 102, 338	
	NONREI MBURSABLE COST CENTERS		-, [-,,			1
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	134		0 13, 055	16, 931, 787	192.00
192.01	19201 PEDI ATRI CS	0	0		0 0	454, 032	192.01
	19202 BROOKVI LLE	0	1		0 0	756, 308	
	07950 COMMUNITY RELATIONS	0	0		0 0	932, 954	
	07951 COMMUNITY BENEFITS	0	6		0 0	1, 056, 584	
	07952 OTHER NON-REI MBURSABLE	0	0		0 0		194.02
101 00	07953 EMS	1, 701	0		0		194.03
	Croce East Adjustments					^	
194.03 200.00 201.00					0		200.00

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	LLOCATION - GENERAL SERVICE COSTS	RGARET MARY COMM	Provider CC	Period: In Lieu of Form	
				From 01/01/2016 Part I To 12/31/2016 Date/Tin	ne Prepared: 17 2:42 pm
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26. 00		
	GENERAL SERVICE COST CENTERS	25.00	20.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101 NEW CAP REL COSTS-OFFSITE BLDG				1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
7.01	00701 OPERATION OF PLANT -OFFSITE				7.01
7.02 8.00	00702 OPERATION OF PLANT - HOSPITAL & OFFS 00800 LAUNDRY & LINEN SERVICE				7.02
9.00	00900 HOUSEKEEPING				9.00
10.00	01000 DI ETARY				10.00
	01100 CAFETERI A				11.00
	01300 NURSING ADMINISTRATION				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00	01500 PHARMACY				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY			 	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1			
	03000 ADULTS & PEDIATRICS	0	7, 275, 157		30.00
	03100 I NTENSI VE CARE UNI T	0	703, 423		31.00
43.00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	0	1, 206, 149		43.00
50.00	05000 OPERATING ROOM	0	3, 178, 424		50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	375, 061		52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	11, 942, 589		54.OC
60.00	06000 LABORATORY	0	5, 238, 373		60.00
	06001 BLOOD LABORATORY	0	0		60.01
65.00	06500 RESPI RATORY THERAPY	0	1, 222, 664		65.00
	06600 PHYSI CAL THERAPY	0	2, 223, 163		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	686, 251		67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	376, 465 1, 366, 112		68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 054, 366		71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	2, 524, 045		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	3, 865, 805		73.00
	OUTPATIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC	0	1, 047, 630		88.00
	09000 CLINIC	0	3, 409, 299		90.00
	09001 WOUND CLINC	0	440, 634		90.01
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4, 578, 867		91.00
92.00	OTHER REIMBURSABLE COST CENTERS	0			92.00
101.00	10100 HOME HEALTH AGENCY	0	2,949,067		101.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>	_, ,		
	11300 INTEREST EXPENSE				113.00
	11600 HOSPI CE	0	1, 438, 794		116.00
118.00	· · · · · · · · · · · · · · · · · · ·	0	59, 102, 338	 	118.00
100.00			14 004 707		100.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 PEDI ATRI CS	0	16, 931, 787		192.00
	19201 PEDIATRICS 19202 BROOKVI LLE	0	454, 032 756, 308		192.01 192.02
	07950 COMMUNITY RELATIONS		932, 954		192.02
	07951 COMMUNITY BENEFITS	0	1, 056, 584		194.00
	07952 OTHER NON-REI MBURSABLE	o o	10, 960		194.02
194.02		0	67, 321		194.03
194.02 194.03	07933 EM3				
194.03 200.00	Cross Foot Adjustments	0	0		200.00
194.03	Cross Foot Adjustments Negative Cost Centers	000000000000000000000000000000000000000			200.00 201.00 202.00

Heal th	Fi na	nci	al	Syste	ems		
		OF	C A		DEL	ATED	0

Heal th Finar	ncial Systems MA	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provider C	CN: 15-1329 Pe Fi To	eriod: rom 01/01/2016 p 12/31/2016		epared:
				CAPI TAL REL	ATED COSTS	072072017 2. 1	
	Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUI P	NEW MVBLE EQUIP OFFSIT	
		0	1.00	1.01	2.00	2. 01	
	RAL SERVICE COST CENTERS						1 1 00
1. 01001012. 00002002. 0100201	NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-OFFSITE BLDG NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP OFFSIT EMPLOYEE BENEFITS DEPARTMENT	0	9, 463	0	16, 987	0	1.00 1.01 2.00 2.01 4.00
7.00 00700	ADMINISTRATIVE & GENERAL OPERATION OF PLANT OPERATION OF PLANT -OFFSITE	0	274, 272 357, 776 0	0	492, 335 642, 229 0	0 0 0	7.00
7.02 00702 8.00 00800 9.00 00900 10.00 01000	POPERATI ON OF PLANT – HOSPI TAL & OFFS LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG DI ETARY	0 0 0 0	0 24, 444 27, 320 4, 961	0	0 43, 878 49, 041 8, 905	0 0 0 0 0	7.02 8.00 9.00 10.00
13.00 01300) CAFETERI A) NURSI NG ADMI NI STRATI ON) CENTRAL SERVI CES & SUPPLY	0 0 0	79, 390 2, 112 0	0	142, 509 3, 792 0	0 0 0	13.00
16.00 01600	PHARMACY MEDICAL RECORDS & LIBRARY IENT ROUTINE SERVICE COST CENTERS	0	11, 715 42, 384		21, 028 76, 082	0	
30. 00 03000 31. 00 03100 43. 00 04300	ADULTS & PEDIATRICS INTENSIVE CARE UNIT NURSERY LARY SERVICE COST CENTERS	0 0 0	204, 735 20, 052 10, 214	0	367, 511 35, 995 18, 334	0 0 0	31.00
50.00 05000 52.00 05200	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	000	44, 607 19, 385	0	80, 073 34, 798	0	52.00
60.00 06000) RADI OLOGY-DI AGNOSTI C) LABORATORY BLOOD LABORATORY	0 0 0	265, 893 48, 359 0	0	477, 293 86, 808 0	0 0 0	60.00
66.00 06600	RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	36, 978 78, 042 16, 245	0	66, 378 140, 090 29, 160	0 0 0	66.00
68.00 06800 69.00 06900	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	14, 841 31, 698	0 0	26, 641 56, 899	0	68.00 69.00
72.00 07200 73.00 07300	MEDICAL SUPPLIES CHARGED TO PATIENTS MPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	0 0 0	10, 575 54, 654 0	0	18, 983 98, 108 0	0 0 0	72.00
OUTPA	TI ENT SERVICE COST CENTERS			01 (05			
90.00 09000 90.01 09001 91.00 09100) RURAL HEALTH CLINIC) CLINIC WOUND CLINC) EMERGENCY) OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 0	0 194, 813 9, 380 127, 402	21, 087 0	0 349, 701 16, 838 228, 694	7, 228 4, 809 0 0	90.00 90.01
OTHER 101.0010100	REIMBURSABLE COST CENTERS		47, 456	2, 192	85, 186	500	101.00
	AL PURPOSE COST CENTERS INTEREST EXPENSE HOSPICE SUBTOTALS (SUM OF LINES 1-117)	0	02,069,166	-	0 3, 714, 276		113. 00 116. 00 118. 00
NONRE 192. 00 19200	IMBURSABLE COST CENTERS PHYSICIANS' PRIVATE OFFICES	0	27, 348		49, 091	111, 396	1
192. 01 19201 192. 02 19202 194. 00 07950		0	26, 056 0 3, 780	134, 227	46, 771 0 6, 785	30, 609	192. 01 192. 02 194. 00
194.0107951	COMMUNITY BENEFITS OTHER NON-REIMBURSABLE	0	16, 217 0	0	29, 111 0	0 0	194. 01 194. 02 194. 03
200. 00 201. 00 202. 00	Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118-201)	0	0 2, 142, 567	0 0 677, 708	0 0 3, 846, 034	0	200. 00 201. 00
202.00	TOTAL (Sum TITIES TID-201)	ı U	2, 142, 307	1 077,700	5, 040, 034	104, 042	202.00

ALLOCA	Financial Systems MAF TION OF CAPITAL RELATED COSTS	RGARET MARY COM	Provider C	CN: 15-1329 F	Period: From 01/01/2016 To 12/31/2016	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/25/2017 2:4	pared:
	Cost Center Description	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	OPERATI ON OF PLANT -OFFSI TE	
		2A	4.00	5.00	7.00	7.01	
	GENERAL SERVICE COST CENTERS	1 1		1	1		
1.00 1.01 2.00 2.01 4.00 5.00 7.00 7.01 7.02 8.00 9.00 10.00 11.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-OFFSITE BLDG 00200 NEW CAP REL COSTS-OFFSITE BLDG 00201 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT -OFFSITE 00702 OPERATION OF PLANT - HOSPITAL & OFFS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA	26, 450 766, 607 1, 000, 005 0 68, 322 76, 361 13, 866 221, 899	26, 450 3, 735 0 358 60 561 64 474	770, 342 26, 03 1, 286 7, 88 2, 82 16, 232 1, 382	1, 026, 036 0 3 0 3 16, 708 2 18, 675 2 3, 391	1, 288 0 0 0 0 0 0 0 0 0	1.00 1.01 2.00 2.01 4.00 5.00 7.00 7.01 7.02 8.00 9.00 10.00 11.00
13.00	01300 NURSING ADMINISTRATION	5, 904	501	11, 144	1,444	0	13.00
15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0 32, 743 118, 466	0 415 612	36, 203		0 0 0	14.00 15.00 16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	110,100	012	10,700	20, 771		1 101 00
30.00	03000 ADULTS & PEDIATRICS	572, 246	2, 200	44, 132	139, 945	0	30.00
	03100 I NTENSI VE CARE UNI T	56, 047	210			0	31.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	28, 548	408	9, 949	6, 982	0	43.00
50.00	OSOOO OPERATING ROOM	124, 680	949	26, 296	30, 491	0	50.00
52.00 54.00 60.00 60.01	05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06001 BLOOD LABORATORY	54, 183 743, 186 135, 167 0	81 2, 028 960 0	2, 523 99, 992 45, 106	3 13, 251 2 181, 746 5 33, 056 0 0	0 0 0 0	52.00 54.00 60.00 60.01
65.00		103, 356	326			0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	218, 132 45, 405	728 255			0	66.00 67.00
	06800 SPEECH PATHOLOGY	41, 482	125			0	68.00
69.00	06900 ELECTROCARDI OLOGY	88, 597	387			0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 558	0			0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	152, 762 0	0 0			0	72.00 73.00
88.00	08800 RURAL HEALTH CLINIC	38, 923	401	10, 115	5 0	60	88.00
90.00	09000 CLINIC	570, 410	1,062			40	90.00
90.01 91.00	09001 WOUND CLINC 09100 EMERGENCY	26, 218 356, 096	155			0	90.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	350,090	1, 181	35, 765	67,065	0	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	135, 334	1, 062	27, 143	32, 438	4	101.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	1		1	1		113.00
	11600 HOSPICE	0	458	13, 975	ō 0		116.00
118.00		5, 850, 953	19, 756				118.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	676, 342	5, 969	157, 556	5 18, 694		192.00
	19201 PEDI ATRI CS	72, 827	120				192.01
	19202 BROOKVI LLE	164, 836	192				192.02
	07950 COMMUNITY RELATIONS 07951 COMMUNITY BENEFITS	10, 565 45, 328	122 277				194.00 194.01
	07952 OTHER NON-REI MBURSABLE	43, 328	5				194.01
	07953 EMS	0	9	622			194.03
		0					200. 00 201. 00
200.00 201.00	Negative Cost Centers			(

Health Financial Systems	MARGARET MARY COM	MUNITY HOSPITA	L	In Lieu	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2016	Worksheet B Part II	
			T		Date/Time Pre 5/25/2017 2:4	pared:
Cost Center Description	OPERATI ON OF PLANT - HOSPI TAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	
	7.02	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		[1			1.00
1.01 00101 NEW CAP REL COSTS-OFFSITE BLDG 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFS 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 7.01 00701 OPERATI ON OF PLANT 7.02 00702 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 O1400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY		88, 000 13, 979 62 458 0 978 0 0	125, 905 389 6, 228 166 0	19, 172 0 0 0 0 0 0	297, 510 11, 522 0 8, 542 20, 576	$\begin{array}{c} 1. \ 01 \\ 2. \ 00 \\ 2. \ 01 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 00 \\ 7. \ 01 \\ 7. \ 02 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \end{array}$
30. 00 3000 ADULTS & PEDIATRICS	727	13, 613	16,060	18, 255	49,600	30.00
31. 00 03100 I NTENSI VE CARE UNI T	71	758		917	6, 526	31.00
43.00 04300 NURSERY	36	3, 865	801	0	11, 366	43.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 0PERATI NG ROOM	158	6, 172	3, 499	0	29, 282	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	69	6, 637	1, 521	0	2, 245	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	944	13, 086		0	30, 163	
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	172	0	3, 793	0	37, 123 0	60.00 60.01
65. 00 06500 RESPIRATORY THERAPY	131	1, 469	°	0	10, 135	65.00
66. 00 06600 PHYSI CAL THERAPY	277	7, 505		0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	58	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	53	0 538	1, 164	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEI	NTS 113	538 0	2, 486 830	0	11, 011 0	69.00 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	194	6, 649		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	0	10	0	0	0	88.00
90. 00 09000 CLINIC	692	2, 419		0	0	90.00
90. 01 09001 WOUND CLINC	33	1, 397	736	0	0	90.01
91.00 09100 EMERGENCY	452	7, 582	9, 994	0	37, 446	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAI OTHER REIMBURSABLE COST CENTERS	(1)					92.00
101.00 10100 HOME HEALTH AGENCY	169	0	3, 723	0	0	101.00
SPECIAL PURPOSE COST CENTERS						1
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 H0SPI CE	0	0	0	0	0	113.00 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5, 072	87, 177	107, 929	19, 172	265, 537	
NONREI MBURSABLE COST CENTERS						
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 343	823		0		192.00
192. 01 19201 PEDI ATRI CS 192. 02 19202 BROOKVI LLE	93 662	0	2,044	0		192. 01 192. 02
194. 00 07950 COMMUNITY RELATIONS	13	0	297	0		194.00
194. 01 07951 COMMUNI TY BENEFI TS	58	0	1, 272	Ő	8, 058	194.01
194. 02 07952 OTHER NON-REI MBURSABLE	0	0	0	0		194.02
194.03 07953 EMS 200.00 Cross Foot Adjustments	0	0	0	0	280	194.03 200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	8, 241	88, 000	125, 905	19, 172	297, 510	202.00

	Financial Systems MA		Provider CC		Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pre 5/25/2017 2:4	epared:
	Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		1				1.00
1.00	00101 NEW CAP REL COSTS-DEDG & TTXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT -OFFSITE						7.01
7.02	00702 OPERATION OF PLANT - HOSPITAL & OFFS						7.02
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	30, 689					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	30, 089	979				14.00
15.00	01500 PHARMACY	1, 306	0	88, 17	7		15.00
	01600 MEDI CAL RECORDS & LI BRARY	0	Ő		0 188, 839		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	7, 585	16		0 122, 155	986, 534	30.00
31.00	03100 I NTENSI VE CARE UNI T	998	2		0 0	86, 161	31.00
43.00	04300 NURSERY	1, 738	0		0 0	63, 693	43.00
50.00	ANCI LLARY SERVICE COST CENTERS		104		0 40 77/	004 704	1 = 0 = 00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 343	491		0 12,776 0 0	234, 794	
52.00	05400 RADI OLOGY-DI AGNOSTI C	4, 612	17 60		0 36, 147	80, 870 1, 132, 820	
60.00	06000 LABORATORY	5, 677	217		0 30, 147	261, 271	
60.01	06001 BLOOD LABORATORY	0,0,7	0		0 0	0	1
65.00	06500 RESPI RATORY THERAPY	1, 550	19		0 0	154, 658	
66.00	06600 PHYSI CAL THERAPY	0	3		0 0	304, 960	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	2		0 0	64, 251	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	56, 158	
69.00	06900 ELECTROCARDI OLOGY	1, 111	7		0 2, 493	139, 368	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	66, 988	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	00 17	0 0 7 0	223, 792	
73.00	OUTPATIENT SERVICE COST CENTERS	0	U	88, 17	1 0	88, 177	73.00
88.00	08800 RURAL HEALTH CLINIC	0	2		0 0	49, 511	88.00
90.00	09000 CLINIC	0	32		0 12,776	761, 414	
90.01							
70. UT	09001 WOUND CLINC	0	53		0 0	38, 933	
91.00		-				38, 933 542, 589	90.01
	09001 WOUND CLINC	0	53		0 0		90.01
91. 00 92. 00	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0 5, 726	53 16		0 0 0 0 0 1, 246	542, 589	90.01 91.00 92.00
91. 00 92. 00	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	53		0 0	542, 589	90.01 91.00 92.00
91.00 92.00 101.00	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 5, 726	53 16		0 0 0 0 0 1, 246	542, 589	90. 01 91. 00 92. 00 101. 00
91.00 92.00 101.00 113.00	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	0 5,726	53 16 6		0 0 0 1, 246 0 0	542, 589 199, 879	90.01 91.00 92.00 101.00 113.00
91.00 92.00 101.00 113.00 116.00	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE	0 5, 726	53 16 6 2		0 0 0 1,246 0 0 0 0	542, 589 199, 879 14, 435	90. 01 91. 00 92. 00 101. 00 113. 00 116. 00
91.00 92.00 101.00 113.00	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	0 5,726	53 16 6		0 0 0 1,246 0 0 0 0	542, 589 199, 879	90. 01 91. 00 92. 00 101. 00 113. 00 116. 00
91.00 92.00 101.00 113.00 116.00 118.00	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE	0 5, 726	53 16 6 2 945	88, 17	0 0 0 1, 246 0 0 0 0 7 187, 593	542, 589 199, 879 14, 435	90. 01 91. 00 92. 00 101. 00 113. 00 116. 00 118. 00
91.00 92.00 101.00 113.00 116.00 118.00	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	0 5, 726 0 30, 646	53 16 6 2	88, 17	0 0 0 1, 246 0 0 0 0 7 187, 593	542, 589 199, 879 14, 435 5, 551, 256 898, 367	90. 01 91. 00 92. 00 101. 00 113. 00 116. 00 118. 00
91.00 92.00 101.00 113.00 116.00 118.00 192.00	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 19200 PHYSICIANS' PRIVATE OFFICES	0 5, 726 0 30, 646	53 16 6 2 945 33	88, 17	0 0 0 1, 246 0 0 0 0 7 187, 593 0 1, 246	542, 589 199, 879 14, 435 5, 551, 256 898, 367	90. 01 91. 00 92. 00 101. 00 113. 00 116. 00 118. 00 192. 00 192. 01
91. 00 92. 00 101. 00 113. 00 116. 00 118. 00 192. 00 192. 01 192. 02	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 19200 PHYSICIANS' PRIVATE OFFICES 19201 PEDIATRICS	0 5, 726 0 30, 646 0 0 0	53 16 6 945 33 0	88, 17	0 0 0 1, 246 0 0 7 187, 593 0 1, 246 0 0 0 0	542, 589 199, 879 14, 435 5, 551, 256 898, 367 96, 801 172, 403	90. 01 91. 00 92. 00 101. 00 113. 00 116. 00 118. 00 192. 00 192. 01
91.00 92.00 101.00 113.00 116.00 118.00 192.01 192.02 194.00 194.01	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 19200 PHYSICIANS' PRIVATE OFFICES 19200 PHYSICIANS' PRIVATE OFFICES 19201 PEDIATRICS 19202 BROOKVILLE 07950 COMMUNITY RELATIONS 07951 COMMUNITY BENEFITS	0 5, 726 0 30, 646 0 0 0 0 0 0 0 0 0	53 16 6 2 945 33 0 0 0	88, 17	0 0 0 0 1, 246 0 0 0 7 187, 593 0 1, 246 0 0 0 0 0 0	542, 589 199, 879 14, 435 5, 551, 256 898, 367 96, 801 172, 403 25, 574 75, 385	90. 01 91. 00 92. 00 101. 00 113. 00 116. 00 118. 00 192. 00 192. 01 192. 02 194. 00 194. 01
91.00 92.00 101.00 113.00 116.00 118.00 192.01 192.02 194.00 194.01	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 19200 PHYSICIANS' PRIVATE OFFICES 19200 PHYSICIANS' PRIVATE OFFICES 19201 PEDIATRICS 19202 BROOKVILLE 07950 COMMUNITY RELATIONS 07951 COMMUNITY BENEFITS 07952 OTHER NON-REIMBURSABLE	0 5, 726 0 30, 646 0 0 0 0 0 0 0 0 0 0 0 0	53 16 2 945 333 0 0 0 0 1 0	88, 17	0 0 0 0 1, 246 0 0 7 187, 593 0 1, 246 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	542, 589 199, 879 14, 435 5, 551, 256 898, 367 96, 801 172, 403 25, 574 75, 385 111	90. 01 91. 00 92. 00 101. 00 113. 00 114. 00 118. 00 192. 01 192. 01 194. 00 194. 01 194. 02
91.00 92.00 101.00 113.00 116.00 118.00 192.00 192.01 192.02 194.00 194.01 194.03	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 19200 PHYSICIANS' PRIVATE OFFICES 19200 PHYSICIANS' PRIVATE OFFICES 19200 PHYSICIANS' PRIVATE OFFICES 19200 COMMUNITY RELATIONS 07951 COMMUNITY RELATIONS 07952 OTHER NON-REIMBURSABLE 07953 EMS	0 5, 726 0 30, 646 0 0 0 0 0 0 0 0 0	53 16 6 945 33 0 0 0 1	88, 17	0 0 0 1, 246 0 0 7 187, 593 0 1, 246 0 0 0 0 0 0 0 0 0 0 0 0	542, 589 199, 879 14, 435 5, 551, 256 898, 367 96, 801 172, 403 25, 574 75, 385 111 954	90. 01 91. 00 92. 00 101. 00 113. 00 116. 00 118. 00 192. 01 192. 01 194. 00 194. 01 194. 02 194. 03
91.00 92.00 101.00 113.00 116.00 118.00 192.01 192.02 194.00 194.01 194.02 194.03 200.00	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 19200 PHYSICIANS' PRIVATE OFFICES 19200 PHYSICIANS' PRIVATE OFFICES 19202 BROOKVILLE 07950 COMMUNITY RELATIONS 07951 COMMUNITY BENEFITS 07952 OTHER NON-REIMBURSABLE 07953 EMS Cross Foot Adjustments	0 5, 726 0 30, 646 0 0 0 0 0 0 0 0 0 0 0 0	53 16 2 945 33 0 0 0 0 1 1 0 0 0	88, 17	0 0 0 0 1, 246 0 0 7 187, 593 0 1, 246 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	542, 589 199, 879 14, 435 5, 551, 256 898, 367 96, 801 172, 403 25, 574 75, 385 111 954 0	90. 01 91. 00 92. 00 101. 00 113. 00 116. 00 118. 00 192. 01 192. 02 194. 00 194. 01 194. 02 194. 03 200. 00
91.00 92.00 101.00 113.00 116.00 118.00 192.00 192.01 192.02 194.00 194.01 194.03	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 19200 PHYSICIANS' PRIVATE OFFICES 19201 PEDIATRICS 19202 BROOKVILLE 07950 COMMUNITY BELATIONS 07951 COMMUNITY BELATIONS 07952 OTHER NON-REIMBURSABLE 07953 EMS Cross Foot Adjustments Negative Cost Centers	0 5, 726 0 30, 646 0 0 0 0 0 0 0 0 0 0 0 0	53 16 2 945 333 0 0 0 0 1 0	88, 17	0 0 0 0 1, 246 0 0 0 7 187, 593 0 1, 246 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	542, 589 199, 879 14, 435 5, 551, 256 898, 367 96, 801 172, 403 25, 574 75, 385 111 954 0	90. 01 91. 00 92. 00 101. 00 113. 00 116. 00 118. 00 192. 01 192. 02 194. 00 194. 01 194. 02 194. 03 200. 00 201. 00

Health Financial Systems MA	RGARET MARY COMM	UNITY HOSPITAL		In Lieu (of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCI	N: 15-1329	From 01/01/2016 P To 12/31/2016 D	orksheet B art II ate/Time Prepared: /25/2017 2:42 pm
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	25.00	26.00			
GENERAL SERVICE COST CENTERS	1				1.00
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 1. 01 00101 NEW CAP REL COSTS-OFFSITE BLDG 2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2. 01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT					1.00 1.01 2.00 2.01 4.00 5.00 7.00
7.01 00701 OPERATION OF PLANT -OFFSITE 7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING					7.01 7.02 8.00 9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION					10. 00 11. 00 13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY					14.00 15.00 16.00
30. 00 03000 ADULTS & PEDIATRICS	0	986, 534			30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	0	86, 161 63, 693			31.00 43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	224 704			E0.00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	234, 794 80, 870			50.00 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 132, 820			54.00
	0	261, 271			60.00
60. 01 06001 BL00D LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	0 154, 658			60. 01 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	304, 960			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	64, 251			67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	56, 158 139, 368			68.00 69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66, 988			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	223, 792			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	88, 177			73.00
88.00 08800 RURAL HEALTH CLINIC	0	49, 511			88.00
90. 00 09000 CLINIC	0	761, 414			90.00
90.01 09001 WOUND CLINC	0	38, 933			90. 01
91.00 09100 EMERGENCY	0	542, 589			91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	0				92.00
101.00 10100 HOME HEALTH AGENCY	0	199, 879			101.00
SPECIAL PURPOSE COST CENTERS	1 1				
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE	0	14, 435			113.00 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	5, 551, 256			118.00
NONREI MBURSABLE COST CENTERS		· · · ·			
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	898, 367			192.00
192. 01 19201 PEDI ATRI CS 192. 02 19202 BROOKVI LLE	0	96, 801 172, 403			192. 01 192. 02
194. 00 07950 COMMUNITY RELATIONS	0	25, 574			194.00
194. 01 07951 COMMUNI TY BENEFI TS	0	75, 385			194.01
194. 02 07952 OTHER NON-REI MBURSABLE	0	111			194.02
194.0307953 EMS 200.00 Cross Foot Adjustments	0	954 0			194. 03 200. 00
201.00 Negative Cost Centers	0	o			200.00
202.00 TOTAL (sum lines 118-201)	0	6, 820, 851			202.00

Health Financial Systems MAR COST ALLOCATION - STATISTICAL BASIS	RGARET MARY COMM	Provi der CC	CN: 15-1329 P	eriod: rom 01/01/2016	u of Form CMS-2 Worksheet B-1	
				o 12/31/2016		
		CAPI TAL REL	ATED COSTS		5/25/2017 2:4	
Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	
	1.00	1.01	2.00	2. 01	4.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-OFFSITE BLDG 2.00 00200 NEW CAP REL COSTS-WVBLE EQUIP 2.01 00201 NEW CAP REL COSTS-WVBLE EQUIP 2.01 00201 NEW CAP REL COSTS-WVBLE EQUIP 3.01 00201 NEW CAP REL COSTS-WVBLE REV VEC REV REV VEC REV VEC REV VEC	154, 182 0 (01	67, 717	154, 182 0 (21	67, 717	20, 100, 422	1.00 1.0 ⁻¹ 2.00 2.0 ⁻¹
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT 7.02 00702 OPERATION OF PLANT	681 19, 737 25, 746 0 0	0 0 0 0	681 19, 737 25, 746 0 0		38, 108, 433 5, 382, 154 0 0 515, 624	4.00 5.00 7.00 7.01 7.02
8.00 00800 LAUNDRY & LI NEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING	1, 759 1, 966 357 5, 713 152	0 0 0 0	1, 759 1, 966 357 5, 713 152	0 0 0 0	85, 865 807, 858 92, 263 683, 476 722, 378	10.00 11.00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 10.00 01600 MEDICAL RECORDS & LIBRARY 30.00 03000 ADULTS & PEDIATRICS	0 843 3, 050 14, 733	0 0 0	0 843 3, 050 	0 0	0 598, 255 882, 066 3, 169, 780	16.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 443 735	0	1, 443 735	0	302, 295 587, 735	31.00 43.00
50.00 05000 0PERATI NG ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 60.00 06000 LABORATORY 60.01 06000 LABORATORY	3, 210 1, 395 19, 134 3, 480 0	0 0 0 0	3, 210 1, 395 19, 134 3, 480 0	0 0 0 0	1, 367, 558 116, 105 2, 922, 355 1, 383, 042 0	52.00 54.00 60.00 60.0
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS	2, 661 5, 616 1, 169 1, 068 2, 281	0 0 0 0 0	2, 661 5, 616 1, 169 1, 068 2, 281	0 0 0 0 0	469, 894 1, 048, 319 367, 508 180, 345 558, 336	65.00 66.00 67.00 68.00 69.00 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0UTPATI ENT SERVI CE COST CENTERS	761 3, 933 0	0 0 0	761 3, 933 0	0 0 0	000000000000000000000000000000000000000	72.0 73.0
88.00 08800 RURAL HEALTH CLINIC 90.00 09000 CLINIC 90.01 09001 WOUND CLINC 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 14, 019 675 9, 168	3, 167 2, 107 0 0	0 14, 019 675 9, 168	2, 107 0	578, 228 1, 530, 766 223, 556 1, 701, 676	90.00 90.0
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	3, 415	219	3, 415	219	1, 530, 783	101. 0
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE 118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	0 148, 900	0 5, 493	0 148, 900	0 5, 493	659, 837 28, 468, 057	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 PEDI ATRI CS 192. 02 19202 BROOKVI LLE 194. 00 07950 COMMUNI TY RELATI ONS	1, 968 1, 875 0 272 1 167	48, 812 0 13, 412 0	1, 968 1, 875 0 272 1, 167		8, 596, 521 173, 561 276, 204 175, 141 399, 465	192. 0 [.] 192. 0. 194. 00
194. 01 07951 COMMUNITY BENEFITS 194. 02 07952 OTHER NON-REIMBURSABLE 194. 03 07953 EMS 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers	1, 167 0 0	0 0 0	1, 167 0 0	0	7, 085 12, 399	194. 02 194. 03 200. 00 201. 00
202.00Cost to be allocated (per Wkst. B, Part I)203.00Unit cost multiplier (Wkst. B, Part I)204.00Cost to be allocated (per Wkst. B,	2, 142, 567 13. 896350	677, 708 10. 007945	3, 846, 034 24. 944767	154, 542 2. 282174	11, 731, 142 0. 307836 26, 450	203. 0
205.00 Unit cost multiplier (Wkst. B, Part II)					0. 000694	

ST ALLUCATION	N - STATISTICAL BASIS		Provider CC	N: 15-1329 P F T	eriod: rom 01/01/2016 o 12/31/2016	Worksheet B-1 Date/Time Pre	epare
Cos	st Center Description	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SOUARE FEET)	OPERATI ON OF PLANT -OFFSI TE (SQUARE FEET)	5/25/2017 2:4 OPERATI ON OF PLANT - HOSPI TAL & OFFS (SQUARE FEET)	12 pm
		5A	5.00	7.00	7.01	7. 02	-
GENERAL	SERVICE COST CENTERS						
01 00101 NEW 00 00200 NEW 01 00201 NEW 00 00400 EM 00 00500 ADI 00 00700 OPE 01 00701 OPE 00 00702 OPE 00 00900 HOI 00 01000 DI 00 01000 IA 00 01100 CA 00 01300 NUF 00 01400 CE 00 01500 PH 00 01500 PH 00 01600 ME	FETERIA RSING ADMINISTRATION NTRAL SERVICES & SUPPLY ARMACY DICAL RECORDS & LIBRARY	-12, 597, 735 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	66, 714, 549 2, 254, 369 111, 518 682, 692 244, 456 1, 405, 760 119, 653 1, 204, 051 965, 077 113 3, 135, 276 1, 449, 516	108, 018 0 1, 759 1, 966 357 5, 713 152 0 843 3, 050	67, 717 0 0 0 0 0 0 0 0 0 0 0 0	166, 979 1, 759 1, 966 357 5, 713 152 0 843 3, 050	8. 9. 10. 11. 13. 14. 15.
	T ROUTI NE SERVI CE COST CENTERS JLTS & PEDI ATRI CS	0	3, 821, 935	14, 733	0	14, 733	30.
	FENSIVE CARE UNIT	0	463, 495	1, 443	0	1, 443	
. 00 04300 NUF		0	861, 571	735	0	735	43
	Y SERVICE COST CENTERS	0	2, 277, 321	3, 210	0	3, 210	50
	LIVERY ROOM & LABOR ROOM	0	2, 277, 321 218, 528	1, 395	0	1, 395	
	DI OLOGY-DI AGNOSTI C	0	8, 659, 578	19, 134	0	19, 134	54
. 00 06000 LAE		0	3, 906, 266	3, 480	0	3, 480	
	DOD LABORATORY	0	0	0	0	0	
	SPI RATORY THERAPY	0	822, 333	2, 661	0	2,661	
	/SI CAL THERAPY CUPATI ONAL THERAPY	0	1, 632, 305 532, 878	5,616	0	5, 616	
	ECH PATHOLOGY	0	276, 137	1, 169 1, 068	0	1, 169 1, 068	
	ECTROCARDI OLOGY	0	949, 020	2, 281	0	2, 281	
	DICAL SUPPLIES CHARGED TO PATIENTS	0	2, 540, 340	761	0	761	
. 00 07200 I MF	PL. DEV. CHARGED TO PATIENT	0	1, 952, 085	3, 933	0	3, 933	72
	JGS CHARGED TO PATIENTS	0	0	0	0	0	73
	NT SERVICE COST CENTERS	_			- · · -		
. 00 08800 RUF . 00 09000 CLI	RAL HEALTH CLINIC	0	875, 971	0	3, 167	0	
. 01 09001 WOL		0	2, 211, 676 340, 271	14, 019 675		14, 019 675	90
00 09100 EME		0	3, 097, 307	9, 168		9, 168	
	SERVATION BEDS (NON-DISTINCT PART)	_	-, ,	.,	-	.,	92
OTHER RE	IMBURSABLE COST CENTERS						
	ME HEALTH AGENCY	0	2, 350, 662	3, 415	219	3, 415	101
	PURPOSE COST CENTERS						113
6. 00 11600 HOS		0	1, 210, 253	0	o	0	116
	STOTALS (SUM OF LINES 1-117)	-12, 597, 735	50, 572, 413	102, 736		102, 736	
	URSABLE COST CENTERS	·		· · · · ·	i	· · ·	
	/SICIANS' PRIVATE OFFICES	0	13, 645, 712	1, 968		47, 517	
2. 01 19201 PEI		0	309, 147	1, 875		1, 875	
2. 02 19202 BR		0	559, 256	0	13, 412	13, 412	
	MUNITY RELATIONS	0	759,004	272	0		194
	/MUNITY BENEFITS IER NON-REIMBURSABLE	0	805, 939 9, 219	1, 167 0	0	1, 167	194
4. 02 07952 01F 4. 03 07953 EMS			9, 219 53, 859	0	0		194
	oss Foot Adjustments	0	55, 557	0	0	0	200
	gative Cost Centers						201
2.00 Cos	st to be allocated (per Wkst. B,		12, 597, 735	2, 680, 061	132, 576	811, 605	
	rt I)						
	t cost multiplier (Wkst. B, Part I)		0. 188830	24.811244	1.957795	4.860521	
	st to be allocated (per Wkst. B,		770, 342	1, 026, 036	1, 288	8, 241	204
	rt II) t cost multiplier (Wkst. B, Part		0. 011547	9. 498750	0.019020	0. 049354	205
			0.011047	,. +,0,50	0.017020	0.047004	1-00

COST A	Financial Systems MA LLOCATION - STATISTICAL BASIS	RGARET MARY COM	Provider C		In Lie Period:	u of Form CMS-2 Worksheet B-1	
6031 A	LEGONTION - STATISTICAL DASIS				From 01/01/2016 To 12/31/2016		pared:
	Cost Center Description	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS OF SERVI CE)	NURSI NG ADMI NI STRATI O N (HOURS OF SERVI CE)	
		8.00	9.00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS						1 1 00
$\begin{array}{c} 1. \ 01 \\ 2. \ 00 \\ 2. \ 01 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 00 \\ 7. \ 01 \\ 7. \ 02 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-OFFSITE BLDG 00200 NEW CAP REL COSTS-OFFSITE BLDG 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT -OFFSITE 00702 OPERATION OF PLANT - HOSPITAL & OFFS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	321, 034 50, 995 226 1, 671 0 3, 568 0 0	115, 501 357 5, 713 152 0 843 3, 050	(3 0 440, 072 0 17, 043 0 0 12, 635 0 30, 436	296, 861 0 12, 635 0	
30.00	03000 ADULTS & PEDIATRICS	49, 663	14, 733	14, 48	5 73, 368	73, 368	30.00
	03100 I NTENSI VE CARE UNI T	2, 767	1,443			9,653	
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	14, 100	735	(16, 812	16, 812	43.00
50.00	05000 OPERATING ROOM	22, 516	3, 210		43, 313	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	24, 212	1, 395		0 3, 321 0 44, 616	3, 321	1
	06000 LABORATORY	47, 738 0	19, 134 3, 480		0 44,616 0 54,912	44, 616 54, 912	
	06001 BLOOD LABORATORY	0	0,100		0 0	0	60.01
65.00	06500 RESPI RATORY THERAPY	5, 358	2, 661	(0 14, 991	14, 991	65.00
	06600 PHYSI CAL THERAPY	27, 379	5, 616		0 0	0	66.00
	06700 OCCUPATIONAL THERAPY	0	1, 169		0	0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 1, 963	1, 068 2, 281		0 0 0 16,287	0 10, 749	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 703	2, 201		0 0	10, 749	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	24, 256	3, 933		0 0	0	72.00
	07300 DRUGS CHARGED TO PATI ENTS	0	0	(0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS	20	0			0	
	08800 RURAL HEALTH CLINIC 09000 CLINIC	38 8, 825	0 14, 019			0	88.00 90.00
	09001 WOUND CLINC	5, 096	675		0 0	0	•
91.00	09100 EMERGENCY	27, 661	9, 168	(55, 390	55, 390	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	3, 415		0 0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	5,415	<u> </u>		0	
113.00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0		0 0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	318, 032	99, 011	15, 21	3 392, 777	296, 447	118.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	3,002	13, 176	(29,686	0	192.00
	19201 PEDI ATRI CS	0	1, 875		498		192.01
	19202 BROOKVI LLE	0	0	(0 0		192.02
	07950 COMMUNITY RELATIONS	0	272	(4, 777	0	194.00
	07951 COMMUNITY BENEFITS 07952 OTHER NON-REIMBURSABLE	0	1, 167		0 11, 920		194.01 194.02
	07953 EMS	0	0		414		194.02
200.00	Cross Foot Adjustments		-				200.00
201.00							201.00
202.00		342, 810	1, 784, 000	158, 59	5 1, 690, 953	1, 219, 657	202.00
	Part I) Unit cost multiplier (Wkst. B, Part I)	1. 067831	15. 445754	10. 42496	3. 842446	4. 108512	203.00
203.00							
203. 00 204. 00		88, 000	125, 905	19, 17:	2 297, 510	30, 689	204.00
	Cost to be allocated (per Wkst. B, Part II)		125, 905 1. 090077	19, 17: 1. 26023			

		RGARET MARY COM	MUNITY HOSPITAL			of Form CMS-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider CC		From 01/01/2016	orksheet B-1
						ate/Time Prepared: /25/2017 2:42 pm
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14.00	PHARMACY (100% PHARMACY) 15.00	MEDI CAL RECORDS & LI BRARY (TI ME SPENT) 16.00	_	
	GENERAL SERVICE COST CENTERS	Ĩ				
11.00 13.00 14.00 15.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-OFFSITE BLDG 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT -OFFSITE 00702 OPERATION OF PLANT - HOSPITAL & OFFS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	5, 848, 640 1, 975 1, 653	100 0	60	6	$\begin{array}{c} 1.00\\ 1.01\\ 2.00\\ 2.01\\ 4.00\\ 5.00\\ 7.00\\ 7.01\\ 7.02\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ \end{array}$
30.00	03000 ADULTS & PEDIATRICS	95, 986	0	39	2	30.00
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	10, 477 0	0		0	31.00 43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	0	0		0	43.00
	05000 OPERATING ROOM	2, 912, 376	0	4		50.00
54.00 60.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY	104, 264 361, 033 1, 298, 759	0 0 0	11	0	52.00 54.00 60.00
	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0 116, 084	0		0	60. 01 65. 00
66.00	06600 PHYSI CAL THERAPY	20, 401	0		0	66.00
	06700 OCCUPATI ONAL THERAPY	11, 568	0		0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	738 40, 584	0		0 8	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	100		0	73.00
88.00	08800 RURAL HEALTH CLINIC	12, 421	0		0	88.00
	09000 CLINIC	191, 823	0	4		90.00
	09001 WOUND CLINC 09100 EMERGENCY	316, 458 95, 390	0 0		0	90.01 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,3,370	0		-	92.00
	OTHER REIMBURSABLE COST CENTERS		-		-1	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	35, 080	0		0	101.00
113.00	11300 I NTEREST EXPENSE					113.00
	11600 HOSPICE	13, 217	0		0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	5, 640, 287	100	60	2	118.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	198, 241	0		4	192.00
	19201 PEDI ATRI CS	0	0		0	192.01
	19202 BROOKVI LLE 07950 COMMUNI TY RELATI ONS	1, 484 255	0		0	192.02 194.00
	07951 COMMUNITY BENEFITS	8, 289	0		0	194.01
	07952 OTHER NON-REIMBURSABLE	0	0		0	194. 02
194.03 200.00	07953 EMS Cross Foot Adjustments	84	0		0	194. 03 200. 00
200.00						200.00
202.00	Cost to be allocated (per Wkst. B,	3, 944	3, 865, 805	1, 977, 78	7	202.00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 000674	38, 658. 050000	3, 263. 67491	7	203.00
203.00		979	38, 658. 050000 88, 177	3, 263, 67491 188, 83		203.00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 000167	881. 770000	311. 61551	2	205.00

MARGARET MARY COMMUNITY HOSPITAL

					Worksheet C Part I Date/Time Pre 5/25/2017 2:4	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj.		Di sal I owance		
	B, Part I,					
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 03000 ADULTS & PEDIATRICS	7, 275, 157		7, 275, 15		0	
1. 00 03100 INTENSIVE CARE UNIT	703, 423		703, 42		0	
3. 00 04300 NURSERY	1, 206, 149		1, 206, 14	9 0	0	43.00
ANCILLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	3, 178, 424		3, 178, 42	4 0	0	50.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	375, 061		375, 06	1 0	0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 942, 589		11, 942, 58	9 0	0	54.00
0. 00 06000 LABORATORY	5, 238, 373		5, 238, 37	3 0	0	60.00
0.01 06001 BLOOD LABORATORY	0			0 0	0	60.01
5. 00 06500 RESPI RATORY THERAPY	1, 222, 664	0	1, 222, 66	4 0	0	65.00
6. 00 06600 PHYSI CAL THERAPY	2, 223, 163	0	2, 223, 16	3 0	0	66.00
7.00 06700 OCCUPATI ONAL THERAPY	686, 251	0	686, 25	1 0	0	67.00
8.00 06800 SPEECH PATHOLOGY	376, 465	0	376, 46	5 0	0	68.00
9. 00 06900 ELECTROCARDI OLOGY	1, 366, 112		1, 366, 11	2 0	0	69.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 054, 366		3, 054, 36	6 0	0	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 524, 045		2, 524, 04	5 0	0	72.00
3.00 07300 DRUGS CHARGED TO PATIENTS	3, 865, 805		3, 865, 80	5 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
8.00 08800 RURAL HEALTH CLINIC	1,047,630		1,047,63	0 0	0	88.00
0. 00 09000 CLINIC	3, 409, 299		3, 409, 29		0	90.00
0.01 09001 WOUND CLINC	440, 634		440, 63	4 0	0	90.01
1. 00 09100 EMERGENCY	4, 578, 867		4, 578, 86	7 0	0	91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 150, 448		1, 150, 44		0	92.00
OTHER REIMBURSABLE COST CENTERS	1			-		
01.00 10100 HOME HEALTH AGENCY	2, 949, 067		2, 949, 06	7	0	101.00
SPECIAL PURPOSE COST CENTERS		1			-	
13. 00 11300 I NTEREST EXPENSE						113.00
16. 00 11600 HOSPI CE	1, 438, 794		1, 438, 79	4		116.00
00.00 Subtotal (see instructions)	60, 252, 786					200.00
01.00 Less Observation Beds	1, 150, 448		1, 150, 44			201.00
02.00 Total (see instructions)	59, 102, 338					202.00

	Financial Systems MAR ATION OF RATIO OF COSTS TO CHARGES	GARET MARY COMM	Provider C	CN: 15-1329	Period: From 01/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet C Part I Date/Time Pre 5/25/2017 2:4	epared:
			Title	XVIII	Hospi tal	Cost	
			Charges		nospi tui	0031	
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDI ATRI CS	5, 070, 866		5, 070, 86	6		30.00
31.00	03100 INTENSIVE CARE UNIT	535, 951		535, 95	51		31.00
43.00	04300 NURSERY	2, 510, 093		2, 510, 09	93		43.00
	ANCILLARY SERVICE COST CENTERS	· · ·					
50.00	05000 OPERATING ROOM	3, 548, 227	12, 780, 042	16, 328, 26	0. 194658	0.00000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	229, 345	33, 285	262, 63	1. 428097	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 501, 901	52, 329, 779	53, 831, 68	0. 221851	0.000000	54.00
60.00	06000 LABORATORY	2, 960, 502	22, 846, 572	25, 807, 07	4 0. 202982	0.00000	60.00
60.01	06001 BLOOD LABORATORY	0	0		0 0. 000000	0.00000	60.01
65.00	06500 RESPI RATORY THERAPY	3, 343, 178	1, 087, 126	4, 430, 30	0. 275977	0.00000	65.00
66.00	06600 PHYSI CAL THERAPY	205, 785	3, 845, 919	4, 051, 70	0. 548698	0.00000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	127, 856	1, 189, 511	1, 317, 36	0. 520926	0.00000	67.00
68.00	06800 SPEECH PATHOLOGY	74, 803	462, 294	537, 09	0. 700926	0.00000	68.00
	06900 ELECTROCARDI OLOGY	456, 393	3, 974, 552	4, 430, 94	0. 308312	0.00000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 219, 157	4, 396, 777	7, 615, 93	0. 401049	0.00000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 466, 042	1, 083, 121	2, 549, 16	0. 990147	0.00000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 524, 938	8, 334, 116	11, 859, 05	0. 325979	0.00000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	684, 001	684, 00)1		88.00
	09000 CLI NI C	138, 198	5, 652, 725	5, 790, 92		0.00000	
	09001 WOUND CLINC	23, 934	1, 723, 831	1, 747, 76		0.00000	90.01
91.00	09100 EMERGENCY	303, 970	6, 927, 507	7, 231, 47	7 0. 633186	0.00000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	19, 763	823, 818	843, 58	1. 363767	0.00000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	2, 076, 932	2, 076, 93	32		101.00
	SPECIAL PURPOSE COST CENTERS	r			- T		
	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	1, 889, 646				116.00
200.00		29, 260, 902	132, 141, 554	161, 402, 45	6		200.00
201.00							201.00
202.00	Total (see instructions)	29, 260, 902	132, 141, 554	161, 402, 45	56		202.00

Heal th	Fi nan	ici a	I Syst	ems		
COMPLIE			DATIO		COCTC	TO

Hearth Frhancial Systems Man	KGARET MARY CUMMU	NITY HUSPITAL	In Lieu	L OT FORM CMS-	-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1329	Peri od:	Worksheet C	
			From 01/01/2016 To 12/31/2016		oparod
			10 12/31/2010	5/25/2017 2:4	
		Title XVIII	Hospi tal	Cost	12 piii
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
60.01 06001 BLOOD LABORATORY	0. 000000				60.01
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88.00
90. 00 09000 CLINIC	0. 000000				90.00
90.01 09001 WOUND CLINC	0. 000000				90.01
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
· · · ·					

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

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1329	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 2:4	epared:
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj.		Di sal I owance		
	B, Part I,					
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS				1		
30. 00 03000 ADULTS & PEDI ATRI CS	7, 275, 157		7, 275, 15		7, 275, 157	30.00
31. 00 03100 INTENSIVE CARE UNIT	703, 423		703, 42			
43. 00 04300 NURSERY	1, 206, 149		1, 206, 14	9 0	1, 206, 149	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 178, 424		3, 178, 42	4 0	3, 178, 424	
52.00 05200 DELIVERY ROOM & LABOR ROOM	375, 061		375,06	1 0	375, 061	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 942, 589		11, 942, 58	9 0	11, 942, 589	54.00
60. 00 06000 LABORATORY	5, 238, 373		5, 238, 37	3 0	5, 238, 373	60.00
60.01 06001 BLOOD LABORATORY	0			0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	1, 222, 664	0	1, 222, 66	4 0	1, 222, 664	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 223, 163	0	2, 223, 16	3 0	2, 223, 163	66.00
67.00 06700 OCCUPATI ONAL THERAPY	686, 251	0	686, 25	1 0	686, 251	67.00
68.00 06800 SPEECH PATHOLOGY	376, 465	0	376, 46	5 0	376, 465	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 366, 112		1, 366, 11	2 0	1, 366, 112	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 054, 366		3, 054, 36	6 0	3, 054, 366	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 524, 045		2, 524, 04	5 0	2, 524, 045	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 865, 805		3, 865, 80		3, 865, 805	73.00
OUTPATIENT SERVICE COST CENTERS		•				
88.00 08800 RURAL HEALTH CLINIC	1,047,630		1,047,63	0 0	1, 047, 630	88.00
90. 00 09000 CLINIC	3, 409, 299		3, 409, 29	9 0	3, 409, 299	90.00
90. 01 09001 WOUND CLINC	440, 634		440, 63		440, 634	90.01
91.00 09100 EMERGENCY	4, 578, 867		4, 578, 86	7 0	4, 578, 867	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 150, 448		1, 150, 44		1, 150, 448	92.00
OTHER REIMBURSABLE COST CENTERS		I		-		
101.00 10100 HOME HEALTH AGENCY	2,949,067		2, 949, 06	7	2, 949, 067	101.00
SPECIAL PURPOSE COST CENTERS	_/ /			•	_/ /	1
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	1, 438, 794		1, 438, 79	4	1, 438, 794	
200.00 Subtotal (see instructions)	60, 252, 786					
201.00 Less Observation Beds	1, 150, 448		1, 150, 44		1, 150, 448	
202.00 Total (see instructions)	59, 102, 338					
	1 07,102,000		1 07,102,00		1 02,000	1-0-100

	Financial Systems MAR ATION OF RATIO OF COSTS TO CHARGES	GARET MARY COMM	Provider C	CN: 15-1329	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 2:4	pared:
				e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	<u>Charges</u> Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	5, 070, 866		5, 070, 86			30.00
	03100 I NTENSI VE CARE UNI T	535, 951		535, 95			31.00
43.00	04300 NURSERY	2, 510, 093		2, 510, 09	93		43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	3, 548, 227	12, 780, 042			0.000000	
	05200 DELIVERY ROOM & LABOR ROOM	229, 345	33, 285			0.00000	
	05400 RADI OLOGY-DI AGNOSTI C	1, 501, 901	52, 329, 779			0.00000	
	06000 LABORATORY	2, 960, 502	22, 846, 572	25, 807, 07		0.000000	
	06001 BLOOD LABORATORY	0	0		0 0. 000000	0.00000	
	06500 RESPI RATORY THERAPY	3, 343, 178	1, 087, 126			0.00000	
66.00	06600 PHYSI CAL THERAPY	205, 785	3, 845, 919			0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	127, 856	1, 189, 511	1, 317, 36		0.000000	
68.00	06800 SPEECH PATHOLOGY	74, 803	462, 294	537, 09		0.000000	
	06900 ELECTROCARDI OLOGY	456, 393	3, 974, 552	4, 430, 94		0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 219, 157	4, 396, 777	7, 615, 93		0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENT	1, 466, 042	1, 083, 121	2, 549, 16		0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 524, 938	8, 334, 116	11, 859, 05	0. 325979	0.00000	73.00
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · ·					
	08800 RURAL HEALTH CLINIC	0	684, 001	684, 00		0.000000	
	09000 CLINIC	138, 198	5, 652, 725	5, 790, 92		0.00000	
	09001 WOUND CLINC	23, 934	1, 723, 831	1, 747, 76		0.000000	
	09100 EMERGENCY	303, 970	6, 927, 507	7, 231, 47		0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	19, 763	823, 818	843, 58	1. 363767	0.00000	92.00
	OTHER REIMBURSABLE COST CENTERS	r		r	- 1		
101.00	10100 HOME HEALTH AGENCY	0	2, 076, 932	2, 076, 93	32		101.00
	SPECIAL PURPOSE COST CENTERS	1					
	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	1, 889, 646				116.00
200.00		29, 260, 902	132, 141, 554	161, 402, 45	56		200. 00
201.00							201.00
202.00	Total (see instructions)	29, 260, 902	132, 141, 554	161, 402, 45	6		202.00

Heal th	Fi nan	ici a	I Syst	ems		
COMPLIE			DATIO		COCTC	TO

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1329 Period: From 01/01/2216 Worksheet C Part I Date/Time Prepared: To 12/31/2016 Cost Center Description PPS Inpatient Ratio Title XIX Hospital Cost INPATIENT ROUTINE SERVICE COST CENTERS 00 30.00 30.00 30.00 0.00 03300 JAULTS & PEDIATRICS 30.00 30.00 30.00 1.00 03100 (INTENSIVE CARE UNIT 43.00 43.00 43.00 ANCILLARY SERVICE COST CENTERS 0.0000000 50.00 50.00 50.00 50.00 OS200 (PELOTING ROOM 0.000000 0.000000 50.00 50.00 50.00 50.00 OS200 (PELOTING ROOM 0.000000 0.000000 50.00 <	Health Financial Systems M	ARGARET MARY COMML	JNI TY HOSPI TAL	In Lieu of Form CMS-2552-10			
Cost Center Description PPS Inpatient Ratio In 00 11.00 11.00 11.00 30.00 30.00 Q3000 ADULTS & PEDIATRICS 30.00 31.00 31.00 31.00 Q3000 NURSERY 43.00 43.00 43.00 ANCI LLARY SERVICE COST CENTERS 50.00 50.00 50.00 50.00 Q5000 DELIVERY NOOM & LABOR ROOM 0.000000 50.00 54.00 D5400 RADI LDGY-DI ARNOSTI C 0.000000 60.00 60.00 Q6000 LABORATORY 0.000000 60.00 65.00 Q65000 RESPI RATORY THERAPY 0.000000 66.00 66.00 Q6600 PHYSI CAL THERAPY 0.000000 66.00 66.00 Q6600 SPECEH PATHOLOGY 0.000000 67.00 67.00 Q6700 QCUPATI ONAL THERAPY 0.000000 67.00 68.00 Q6800 SPECEH PATHOLOGY 0.000000 67.00 72.00 Q7200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 71.00 72.00 Q7200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 Q7300 DRUGS CHARGED TO PATIENTS 0.000000 72.00 73.00 Q7300 DRUGS CHARGED TO PATIENTS 0.000000 7	COMPUTATION OF RATIO OF COSTS TO CHARGES			From 01/01/2016 To 12/31/2016	Part I Date/Time Pre 5/25/2017 2:4		
Ratio 11.00 30.00 03000 ADULTS & PEDIATRI CS 30.00 30.00 03000 INTESSIVE CARE UNIT 30.00 43.00 043000 INTESSIVE CARE UNIT 43.00 43.00 05000 OPERATING ROOM 0.000000 50.00 05000 OPERATING ROOM 0.000000 52.00 052000 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 052000 IBLOOD LABORATORY 0.000000 60.01 06001 BLOOD LABORATORY 0.000000 60.00 06000 PHYSICAL HERAPY 0.000000 65.00 06500 OPERATINERAPY 0.000000 66.00 06600 PHYSICAL HERAPY 0.000000 66.00 06600 PHYSICAL HERAPY 0.000000 67.00 06700 OCUPATIONAL THERAPY 0.000000 68.00 06800 SPECH PATHOLOGY 0.000000 71.00 0100 LAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 70.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 </td <td></td> <td></td> <td>Title XIX</td> <td>Hospi tal</td> <td>Cost</td> <td></td>			Title XIX	Hospi tal	Cost		
11.00 30.00 03000 ADULTS & PEDLATRICS 30.00 31.00 03000 INTENSIVE CARE UNIT 31.00 30.00 05000 PEDLATRICS 31.00 30.00 0000 FERNICE COST CENTERS 31.00 30.00 05200 DELIVERY SERVICE COST CENTERS 30.000 50.00 05000 OPERATING ROOM 0.000000 52.00 52.00 DS200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 52.00 DS2000 LABORATORY 0.000000 60.01 65.00 OBCOD (LABORATORY 0.000000 60.01 65.00 OBCOD RESPIRATORY 0.000000 65.00 66.00 OBCOD RESPIRATORY THERAPY 0.000000 66.00 66.00 OBCOD SPECEL ATRORY THERAPY 0.000000 67.00 67.00 OSF000 SPECHATHORY THERAPY 0.000000 67.00 68.00 OBCOD CLEVATIONAL THERAPY 0.000000 71.00 71.00 71.00 OTION MEDICAL SUPPLIES CHARGED TO PATIENTS	Cost Center Description						
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 DELEVERY ROOM 0.000000 52.00 05200 DELIVERY ROOM 0.000000 54.00 05400 RADIOLOGY-DI AGNOSTI C 0.000000 60.01 06001 BL00D LABORATORY 0.000000 60.00 60.01 06000 PHYSI CAL THERAPY 0.000000 60.01 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 066000 PHYSI CAL THERAPY 0.000000 67.00 67.00 06700 OCUPATIONAL THERAPY 0.000000 68.00 68.00 06800 SPEECH PATHOLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 72.00 07200 IMEL, DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 72.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
30.00 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 31.00 04300 INTENSIVE CARE UNIT 31.00 30.00 ADULTS & PEDIATRICS 31.00 ANCILLARY SERVICE COST CENTERS 30.00 50.00 50.00 50.00 50.00 05000 OPERATING ROOM 0.000000 51.00 05000 OPERATING ROOM 0.000000 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 60.01 06000 LABORATORY 0.000000 60.01 60.01 06000 RESPI RATORY THERAPY 0.000000 60.01 65.00 06600 PHYSI CAL THERAPY 0.000000 66.00 66.00 06600 SPEECH PATHOLY THERAPY 0.000000 66.00 67.00 06000 SPEECH PATHOLOGY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 72.00 07200 RUSS CHARGET TO PATIENTS 0.0000000 90.00		11.00					
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50.00 05000 OPERATING ROOM 0.000000 52.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 64.00 05400 RADI LOGY-DI AGNOSTI C 0.000000 60.01 60.00 06000 LABORATORY 0.000000 60.01 60.01 06000 LABORATORY 0.000000 60.01 61.00 06500 RESPIRATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 65.00 66.00 06600 SPEECH PATHORY THERAPY 0.000000 66.00 67.00 06700 0CUPATI INT ATHERAPY 0.000000 68.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 72.00 73.00 73.00 09300 CLINIC 0.000000 90.01 90000 90.00 90.00 90.00 90.00 90.01 990001 WOUND CLINC 0.000000 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>43.00</td></t<>						43.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 54.00 05400 RADIOLOCY-DI AGNOSTI C 0.000000 54.00 60.00 A6000 LABORATORY 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 66.01 06000 HENORATORY 0.000000 60.01 65.00 06500 RESPIRATORY THERAPY 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 66.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 6000 LASCALT HERAPY 0.000000 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 08800 RURAL HEALTH CLINIC 0.000000 90.00 00.01 09001 WUND CLINC 0.000000 90.00 91.00 09100 BURRGENCY 0.000000 90.01 92.00 082607 RURAL HE							
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 60.00 06000 LABORATORY 0.000000 60.01 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 066000 PHYSI CAL THERAPY 0.000000 65.00 66.00 066000 PHYSI CAL THERAPY 0.000000 65.00 66.00 066000 PHYSI CAL THERAPY 0.000000 65.00 68.00 064000 SPEECH PATHOLOGY 0.000000 67.00 68.00 064000 ELCTROCARDI OLOGY 0.000000 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 DRUGS CHARGED TO PATIENT 0.000000 73.00 70.00 OBS00 RURAL HEALTH CLINIC 0.000000 90.00 90.00 09000 CLINIC 0.000000 90.00 91.00 O9100 EMERGENCY 0.000000 90.00 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0.000000 90.00 <							
60.00 06000 LABORATORY 0.000000 60.01 60.01 06001 BLOD LABORATORY 0.000000 60.01 65.00 06500 RESPIRATORY THERAPY 0.000000 66.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 69.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07200 INPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 RURAL HEALTH CLINIC 0.000000 73.00 90.01 09001 WOUND CLINC 0.000000 90.01 91.00 99001 BERCHALTH AGENCY 0.000000 90.01 91.00 99001 BEN							
60.01 06001 BLOOD LABORATORY 0.000000 60.01 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06000 PHYSI CAL THERAPY 0.000000 67.00 67.00 06200 SPEECH PATHOLOGY 0.000000 67.00 68.00 06400 SPEECH PATHOLOGY 0.000000 68.00 69.00 OC4000 SPEECH PATHOLOGY 0.000000 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 72.00 73.00 D7300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 00 09000 CLINI C 0.000000 90.00 90.00 09000 CLINI C 0.000000 90.00 91.00 09100 MERGENCY 0.000000 90.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 90.01 91.00 09100 MERGENCY 0.000000 90.01 92.00 OTHER REI MBURSABLE COS							
65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 0CCUPATI ONAL THERAPY 0.000000 68.00 68.00 06600 SPECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 0007300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 01000 DUTPATI ENT SERVICE COST CENTERS 0.000000 73.00 90.00 09000 CLI NI C 0.000000 90.00 90.01 09001 WOUND CLI NC 0.000000 90.00 91.000 90000 CLI NI C 0.000000 90.00 92.000 095ERVATION BEDS (NON-DI STI NCT PART) 0.000000 90.00 92.000 07100 HEMERSABLE COST CENTERS 101.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 OT300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 001PATI ENT SERVICE COST CENTERS 0.000000 88.00 90.00 90001 CLINC 0.000000 90.00 90.01 09001 WOUND CLINC 0.000000 90.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 OTIO MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENT 0.000000 73.00 00100 DUTPATIENT SERVICE COST CENTERS 0.000000 73.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 90.01 90.01 09000 CLINIC 0.000000 90.01 91.00 09100 EMERGENCY 0.000000 90.01 92.00 OB2ERVATION BEDS (NON-DI STINCT PART) 0.000000 91.00 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0.000000 91.00 92.00 OB2ERVATION BEDS (NON-DI STINCT PART) 0.000000 91.00 91.00 INTER ET MBURSABLE COST CENTERS 101.00 101.00 113.00 11300 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 72.00 O7200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 73.00 007300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 0UTPATI ENT SERVICE COST CENTERS 0.000000 73.00 00.00 09000 CLINC 0.000000 90.00 09000 CLINC 0.000000 90.01 09000 CLINC 0.000000 91.00 09100 EMERGENCY 0.000000 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0.000000 91.00 09100 EMERGENCY 0.000000 92.00 01100 HOME HEALTH AGENCY 101.00 101.00 101.00 91.00 113.00 11300 INTEREST EXPENSE 113.00 113.00 11300 INTEREST EXPENSE 113.00 11600 11600 HOSPI CE 200.00 200.00<							
69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENT 0.000000 72.00 00000 OUTPATIENT SERVICE COST CENTERS 0.000000 72.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 90.01 09000 CLINIC 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 90.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 91.00 92.00 09200 DESEVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 01100 HOME HEALTH AGENCY 10.0000 101.00 113.00 113.00 113.00 113.00							
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 73.00 73.00 00000 CLINIC 0.000000 88.00 90.00 O9000 CLINIC 0.000000 90.00 90.01 09001 WOUND CLINC 0.000000 90.00 91.00 09010 EMERGENCY 0.000000 90.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 011000 HOME REIMBURSABLE COST CENTERS 101.00 92.00 113.00 11300 INTEREST EXPENSE 113.00 113.00 113.00 114.00 INFERST EXPENSE 113.00 1160 116.00 200.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00							
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 73.00 73.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 90.00 09000 CLINIC 0.000000 90.00 90.10 OP0100 EMERGENCY 0.000000 90.01 91.00 09100 EMERGENCY 0.000000 90.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 92.00 0THER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 101.00 10100 HOME HEALTH AGENCY 101.00 11300 1NTEREST EXPENSE 113.00 113.00 11300 INTEREST EXPENSE 113.00 11300 10600 HOSPICE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00							
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 88.00 88.00 90.00 09000 CLINIC 0.000000 90.00 90.10 09001 WUND CLINC 0.000000 90.01 91.00 09100 EMERGENCY 0.000000 91.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 0THER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 101.00 10100 HOME HEALTH AGENCY 101.00 101.00 11300 1NTEREST EXPENSE 113.00 113.00 11300 INTEREST EXPENSE 113.00 11300 11600 405PI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 201.00							
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 90.00 09000 CLINIC 0.000000 90.00 90.01 09001 WOUND CLINC 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 90.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 0THER REIMBURSABLE COST CENTERS 0.000000 92.00 92.00 000000 92.00 011.00 10100 HOME HEALTH AGENCY 0.000000 92.00 92.00 011300 INTEREST EXPENSE 101.00 113.00 11300 117EREST EXPENSE 113.00 116.00 11600 HOSPI CE 116.00 200.00 200.00 200.00 201.00 Less Observation Beds 201.00 201.00 201.00 201.00							
88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 90.00 09000 CLINIC 0.000000 90.00 90.01 09001 WOUND CLINC 0.000000 90.01 91.00 09100 EMERGENCY 0.000000 90.01 92.00 095200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 0THER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 101.00 101000 HOME HEALTH AGENCY 101.00 101.00 10100 HOME HEALTH AGENCY 101.00 113.00 113000 INTEREST EXPENSE 113.00 113.00 113.00 113.00 116.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00 201.00		0. 000000				73.00	
90.00 09000 CLINIC 0.000000 90.00 90.01 09001 WOUND CLINC 0.000000 90.01 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 01.00 HOME HEALTH AGENCY 0.000000 92.00 01.00 HOME HEALTH AGENCY 101.00 10100 101.00 HOME HEALTH AGENCY 101.00 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPICE 116.00 200.00 200.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00							
90.01 09001 WOUND CLINC 0.000000 90.01 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 0THER REIMBURSABLE COST CENTERS 92.00 92.00 101.00 10100 HOME HEALTH AGENCY 101.00 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 114600 116.00 11600 HOSPICE 116.00 11600 200.00 Subtotal (see instructions) 200.00 201.00 201.00							
91.00 09100 EMERGENCY 0.000000 91.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 92.00 0THER REIMBURSABLE COST CENTERS 0.000000 92.00 92.00 92.00 101.00 10100 HOME HEALTH AGENCY 0.000000 101.00 101.00 SPECIAL PURPOSE COST CENTERS 101.00 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPICE 116.00 200.00 200.00 200.00 200.00 200.00 201.00 Less Observation Beds 200.00 201.00 <							
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 11300 Experimental (see instructions) 116.00 200.00 201.00 2							
OTHER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 INTEREST EXPENSE 113.00 11300 HORENTEX 116.00 116.00 10600 HOSPICE 200.00 200.00 200.00 201.00 Less 0bservation 201.00							
101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 116.00 116.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00		0. 000000				92.00	
SPECIAL PURPOSE COST CENTERS 113.00 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00							
113.00 INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						101.00	
116.00 HOSPICE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00		1					
200.00Subtotal (see instructions)200.00201.00Less Observation Beds201.00							
201.00 Less Observation Beds 201.00							
202.00 lotal (see instructions) 202.00							
	202.00 Total (see instructions)					202.00	

Health Financial Systems MAF	RGARET MARY COM	MUNITY HOSPITA	L	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT/	AL COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016		
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1		1	- 1		
50.00 05000 OPERATING ROOM	234, 794				15, 774	
52.00 05200 DELIVERY ROOM & LABOR ROOM	80, 870					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 132, 820					
60. 00 06000 LABORATORY	261, 271	25, 807, 074			14, 926	
60.01 06001 BLOOD LABORATORY	0	0	0.00000		0	60.01
65. 00 06500 RESPI RATORY THERAPY	154, 658					
66. 00 06600 PHYSI CAL THERAPY	304, 960				8, 740	
67.00 06700 OCCUPATI ONAL THERAPY	64, 251	1, 317, 367				
68.00 06800 SPEECH PATHOLOGY	56, 158					
69. 00 06900 ELECTROCARDI OLOGY	139, 368					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	66, 988					
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	223, 792					
73.00 07300 DRUGS CHARGED TO PATIENTS	88, 177	11, 859, 054	0.00743	1, 739, 501	12, 933	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	49, 511				0	
90. 00 09000 CLINIC	761, 414					
90. 01 09001 WOUND CLINC	38, 933	1, 747, 765			318	
91.00 09100 EMERGENCY	542, 589					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	156, 004		1		0	1 121 00
200.00 Total (lines 50-199)	4, 356, 558	149, 318, 968		9, 671, 027	243, 885	200.00

Health Financial Systems MA	RGARET MARY COMMUN	NITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider CO	CN: 15-1329	Period:	Worksheet D	
THROUGH COSTS				From 01/01/2016 To 12/31/2016		narod
				10 12/31/2010	5/25/2017 2:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physi ci an	Nursi ng	Allied Healt	h All Other	Total Cost	
	Anesthetist	School		Medi cal	(sum of col 1	
	Cost			Educati on	through col.	
				Cost	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
	0	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	60.01 65.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY	0	0		0 0		67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0			0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS				<u> </u>		10100
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 WOUND CLINC	0	0		0 0	0	90.01
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
200.00 Total (lines 50-199)	0	0		0 0	0	200.00
						-

Health Financial Systems MA	RGARET MARY COM	MUNITY HOSPITA	L	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Period:	Worksheet D		
THROUGH COSTS				From 01/01/2016	Part IV		
				Го 12/31/2016	Date/Time Pre 5/25/2017 2:4		
		Title	XVIII	Hospi tal	Cost	<u> 2 piii</u>	
Cost Center Description	Total	Total Charges			I npati ent		
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program		
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges		
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷	0		
	4)			col. 7)			
	6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS	1						
50.00 05000 OPERATING ROOM	0	16, 328, 269			1, 096, 967		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	262, 630			6, 739		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	53, 831, 680			837, 609		
60. 00 06000 LABORATORY	0	25, 807, 074	0.00000		1, 474, 353	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0.00000		0	60.01	
65. 00 06500 RESPI RATORY THERAPY	0	4, 430, 304	0.00000	0. 000000	1, 939, 660	65.00	
66. 00 06600 PHYSI CAL THERAPY	0	4,051,704	0.00000	0. 000000	116, 121	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	1, 317, 367	0.00000		79, 098	67.00	
68.00 06800 SPEECH PATHOLOGY	0	537, 097	0.00000	0. 000000	63, 129	68.00	
69. 00 06900 ELECTROCARDI OLOGY	0	4, 430, 945	0.00000	0. 000000	278, 662		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7, 615, 934	0.00000	0. 000000	1, 222, 392	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	2, 549, 163			658, 525	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	11, 859, 054	0.00000	0. 000000	1, 739, 501	73.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	684, 001	0.00000	0. 000000	0	88.00	
90. 00 09000 CLINIC	0	5, 790, 923	0.00000	0. 000000	91, 895	90.00	
90.01 09001 WOUND CLINC	0	1, 747, 765	0.00000		14, 282		
91. 00 09100 EMERGENCY	0	7, 231, 477	0.00000	0. 000000	52, 094		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	843, 581	0.00000	0. 000000	0	92.00	
200.00 Total (lines 50-199)	0	149, 318, 968			9, 671, 027	200.00	

Health Financial Systems MA	RGARET MARY COMM	MUNITY HOSPITA	L	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-1329	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2016 To 12/31/2016		anarad
				10 12/31/2010	5/25/2017 2:4	42 pm
		Title	e XVIII	Hospi tal	Cost	<u> </u>
Cost Center Description	Inpatient	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS	1 1		1			
50.00 05000 OPERATING ROOM	0	0		0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
60. 00 06000 LABORATORY	0	0		0		60.00
60.01 06001 BLOOD LABORATORY	0	0		0		60.01
65. 00 06500 RESPI RATORY THERAPY	0	0		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
OUTPATIENT SERVICE COST CENTERS						4
88.00 08800 RURAL HEALTH CLINIC	0	0		0		88.00
90. 00 09000 CLINIC	0	0		0		90.00
90. 01 09001 WOUND CLINC	0	0		0		90.01
91.00 09100 EMERGENCY	0	0		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92.00
200.00 Total (lines 50-199)	0	0	1	0		200.00

Health Financial Systems MAI	RGARET MARY CON	MUNITY HOSPITA	L	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C		Period: From 01/01/2016 To 12/31/2016		
		Title	× XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 194658		2, 855, 73		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 428097	0	5, 27	6 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 221851	0	18, 104, 13	0 4, 202	0	54.00
60. 00 06000 LABORATORY	0. 202982	0	6, 323, 56	3 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0. 275977	0	354, 59	6 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 548698	0	1, 185, 20	4 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 520926	0	233, 90	3 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 700926	0	20, 24	9 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 308312	0	1, 570, 72	9 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 401049	0	1, 259, 78	3 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 990147	0	348, 30	3 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 325979	0	2, 962, 45	1 936	0	73.00
OUTPATIENT SERVICE COST CENTERS			•			1
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
90. 00 09000 CLINIC	0. 588732	0	1, 877, 69	8 0	0	90.00
90. 01 09001 WOUND CLINC	0. 252113	0	824, 76	8 117	0	90.01
91.00 09100 EMERGENCY	0. 633186	0	1, 753, 82	5 1, 723	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 363767	0	521, 39		0	92.00
200.00 Subtotal (see instructions)		0	40, 201, 61	0 6, 978	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00 Net Charges (line 200 +/- line 201)		0	40, 201, 61	0 6, 978	0	202.00

Health Financial Systems MA		RGARET MARY COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-		
APPORTI	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider CC			Worksheet D Part V Date/Time Pro 5/25/2017 2:4	
		1		XVIII	Hospi tal	Cost	
		Cos					
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.					
		(see inst.)	(see inst.)				
		6.00	7.00				_
	ANCILLARY SERVICE COST CENTERS		-				
	05000 OPERATING ROOM	555, 892					50.00
	05200 DELIVERY ROOM & LABOR ROOM	7, 535					52.00
	05400 RADI OLOGY-DI AGNOSTI C	4, 016, 419					54.00
	06000 LABORATORY	1, 283, 569	0				60.00
	06001 BLOOD LABORATORY	0	0				60.01
	06500 RESPI RATORY THERAPY	97, 860					65.00
	06600 PHYSI CAL THERAPY	650, 319					66.00
	06700 OCCUPATI ONAL THERAPY	121, 846					67.00
	06800 SPEECH PATHOLOGY	14, 193					68.00
	06900 ELECTROCARDI OLOGY	484, 275					69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	505, 235					71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	344, 871					72.00
	07300 DRUGS CHARGED TO PATIENTS	965, 697	305				73.00
	OUTPATIENT SERVICE COST CENTERS	1					
	08800 RURAL HEALTH CLINIC	0	-				88.00
	09000 CLINIC	1, 105, 461					90.00
	09001 WOUND CLINC	207, 935					90.01
	09100 EMERGENCY	1, 110, 497					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	711, 064					92.00
200.00	Subtotal (see instructions)	12, 182, 668	2, 357				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	12, 182, 668	2, 357				202.00

MARGARET MARY COMMUNITY HOSPITAL

Heal th	Financial Systems MARGARET MARY COMMU	JNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1329	Peri od:	Worksheet D-1	
			From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 2:43	
		Title XVIII	Hospi tal	Cost	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				-
1.00	Inpatient days (including private room days and swing-bed da	ys, excluding newborn)		5, 059	1.00
2.00	Inpatient days (including private room days, excluding swing			5, 059	2.00
3.00	Private room days (excluding swing-bed and observation bed d	ays). If you have only p	rivate room days,	0	3.00
	do not complete this line.				
4.00 5.00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private r		or 21 of the east	4, 259 0	4.00
5.00	reporting period	com days) thi ough becenic	ier st ut the cust	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)	5.7			
7.00	Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	7.00
0.00	reporting period		01 6 11		
8.00	Total swing-bed NF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable	to the Program (excludin	a swina-bed and	1, 771	9.00
	newborn days)		.g =g ==== =	.,	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.00
	through December 31 of the cost reporting period (see instru				
11.00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		room days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12.00
.2.00	through December 31 of the cost reporting period		dajo)		
13.00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	ite room days)	0	13.00
	after December 31 of the cost reporting period (if calendar				
	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	days)	0	
15.00 16.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
10.00	SWING BED ADJUSTMENT				10.00
17.00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost		17.00
	reporting period	C			
18.00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost		18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to servic	as through December 21 a	f the cost	0.00	19.00
19.00	reporting period	es through becember 31 c	in the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	0.00	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instructio			7, 275, 157	
22.00	Swing-bed cost applicable to SNF type services through Decem 5 x line 17)	ber 31 of the cost repor	ting period (line	0	22.00
23.00	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reporti	na period (line 6	0	23.00
201.00	x line 18)		ng por loa (i nio c		20100
24.00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ing period (line	0	24.00
	7 x line 19)				
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	ig period (line 8	0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 275, 157	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	/			
28.00	General inpatient routine service charges (excluding swing-b	ed and observation bed o	harges)	0	
29.00	Private room charges (excluding swing-bed charges)			0	
30.00 31.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	· Lipo 29)		0 0. 000000	30.00 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	- 1116 20)		0.000000	
33.00	Average semi-private room per diem charge (line 2) : The 3)			0.00	
	Average per diem private room charge differential (line 32 m	inus line 33)(see instru	icti ons)	0.00	
35.00	Average per diem private room cost differential (line 34 x l	ine 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and private record	lifformartial (1)		36.00
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost c	inferential (line	7, 275, 157	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	JUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (se			1, 438. 06	
	Program general inpatient routine service cost (line 9 x lin			2, 546, 804	
	Medically necessary private room cost applicable to the Prog Total Program general inpatient routine service cost (line 3	, , ,		0 2, 546, 804	
т. UU	In the service cost (TITIE Service cost (TITIE S	7 TING 40)		2, 340, 004	1 41.00

	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1329 P	eriod: rom 01/01/2016	Worksheet D-1	1
					0 12/31/2016		
			Title	XVIII	Hospi tal	5/25/2017 2:4 Cost	ŧ∠ pi
	Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	-
00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42
~~	Intensive Care Type Inpatient Hospital Units		200	2 425 40	144	254 120	1 42
00 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	703, 423	290	2, 425. 60	146	354, 138	43
00	BURN INTENSIVE CARE UNIT						44
00	SURGI CAL I NTENSI VE CARE UNI T						46
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)	-		1.00 3,278,638	48
00	Total Program inpatient costs (sum of lines			ons)		6, 179, 580	
	PASS THROUGH COST ADJUSTMENTS						
00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50
00) Dess through sects appliable to Drogram inc	ationt anaillan	n convioso (f	rom Wkot D o	m of Donto II	0	F1
. 00	Pass through costs applicable to Program inp and IV)	attent andiriar	y services (i	IOM WKSL. D, S	uni of Parts II	0	51
. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52
. 00	Total Program inpatient operating cost exclu	ding capital re	elated, non-ph	ysician anesth	etist, and	0	
	medical education costs (line 49 minus line	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
00	Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0	
00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	0	57
. 00	Bonus payment (see instructions)					0	
00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the	0.00	59
00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	dated by the	market basket		0.00	60
. 00	If line 53/54 is less than the lower of line				the amount by	0	
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see	instructions)					
. 00 . 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (soo instru	ictions)			0	
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	1 03
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64
~~	instructions)(title XVIII only)						
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reporting	period (See	0	65
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l onlv). For	0	66
	CAH (see instructions)		- p			-	
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67
00	(line 12 x line 19)	a casts after D	locombor 21 of	the cost rope	cting pariod	0	1 40
. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)		ecember 31 01	the cost repo	ting period	0	68
. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER N						1
. 00	Skilled nursing facility/other nursing facil						70
. 00 . 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line			<i>∠</i>)			71
. 00	Medically necessary private room cost applic		n (line 14 x l	ine 35)			73
. 00	Total Program general inpatient routine serv						74
. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B, P	art II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
00	Program capital-related costs (line 73 + line						77
00	Inpatient routine service cost (line 74 minu	s line 77)					78
00	Aggregate charges to beneficiaries for exces	• •					79
00	Total Program routine service costs for comp		ost limitatio	n (line 78 min	us line 79)		80
00 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81
00	Reasonable inpatient routine service cost fill tation (83
00	Program inpatient ancillary services (see in		-				84
00	Utilization review - physician compensation	(see instructio					85
. 00	Total Program inpatient operating costs (sum		rough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASE Total observation bed days (see instructions					800	87
			1 :			1, 438. 06	
. 00	Adjusted general inpatient routine cost per	arem (rrne z/ ÷	· IIne Z)			1,430.00	

Health Financial Systems MAR	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C	Provider CCN: 15-1329		Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
					5/25/2017 2:4	2 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	986, 534	7, 275, 157	0. 13560	3 1, 150, 448	156, 004	90.00
91.00 Nursing School cost	C	7, 275, 157	0.0000	0 1, 150, 448	0	91.00
92.00 Allied health cost	C	7, 275, 157	0. 00000	0 1, 150, 448	0	92.00
93.00 All other Medical Education	C	7, 275, 157	0. 00000	0 1, 150, 448	0	93.00

MARGARET MARY COMMUNITY HOSPITAL

eal th	Financial Systems MARGARET MARY COMMUN	NI TY HOSPI TAL	In Lieu	u of Form CMS-2	2552-
OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1329	Peri od:	Worksheet D-1	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	nare
			10 12/31/2010	5/25/2017 2:4	
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
	INPATIENT DAYS			F 050	
	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			5, 059 5, 059	
	Private room days (excluding swing-bed and observation bed da		arivato room dave	5, 039	3.
. 00	do not complete this line.	iys). If you have only p	Si i vate i udin udys,	0	3.
. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		4, 259	4.
. 00	Total swing-bed SNF type inpatient days (including private ro		per 31 of the cost	0	
	reporting period			-	
. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after Decembei	r 31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)				
. 00	Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	er 31 of the cost	0	7.
	reporting period				
. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)				
. 00	Total inpatient days including private room days applicable t	o the Program (excludin	ng swing-bed and	88	9.
0. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including privato	room dave)	0	10.
0.00	through December 31 of the cost reporting period (see instruc		room days)	0	10.
1.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.
	December 31 of the cost reporting period (if calendar year, e			0	
	Swing-bed NF type inpatient days applicable to titles V or XI		ate room days)	0	12.
	through December 31 of the cost reporting period	3 (31	5 /		
3.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	ate room days)	0	13.
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr	am (excluding swing-bea	d days)	0	
	Total nursery days (title V or XIX only)			977	
	Nursery days (title V or XIX only)			0	16.
	SWING BED ADJUSTMENT	an thurse December 21	-£ +b+		1 1 7
7.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	or the cost		17.
B. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	os after December 21 et	f the cost		18.
5.00	reporting period	es al ter becember 31 of			10.
9.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 (of the cost	0.00	19
	reporting period				
D. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0.00	20.
	reporting period				
	Total general inpatient routine service cost (see instruction			7, 275, 157	
2.00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost repo	rting period (line	0	22.
	5 x line 17)				
	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23.
	x line 18)	24 . C. I.L		0	
4.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost repor	ting period (line	0	24.
5 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost concrti	na period (line o	0	25.
	x line 20)	Si di the cost reputti	ig period (TTTTE 8	0	20
5.00	Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26))	7, 275, 157	
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT		·1	, , , ,	
3. 00	General inpatient routine service charges (excluding swing-be	d and observation bed o	charges)	0	28
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
1	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	, ,	uctions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35)	and private near act	differential (1:	0	36
7.00	General inpatient routine service cost net of swing-bed cost	and private room cost of	an rerential (line	7, 275, 157	37
	27 minus line 36) PART II - HOSPITAL AND SURPROVIDERS ONLY				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	LISTMENTS			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			1, 438. 06	38
	Program general inpatient routine service cost (line 9 x line			1, 438, 08	
	Medically necessary private room cost applicable to the Progr	-		120, 347	40.
). 00	Medically necessary private room cost appricable to the Proof				

MPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	1
				From 01/01/2016 To 12/31/2016		epare
					5/25/2017 2:4	42 pr
Cost Conton Decorintion	Title XIX Hospital		Cost			
Cost Center Description	Total Inpati ent	Total Inpati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
	Cost	Days	÷ col. 2)		col. 4)	
	1.00	2.00	3.00	4.00	5.00	1
.00 NURSERY (title V & XIX only)	1, 206, 149	977				42
Intensive Care Type Inpatient Hospital Units						
. OO INTENSIVE CARE UNIT	703, 423	290	2, 425. 6	0 1	2, 426	43
. OO CORONARY CARE UNIT						44
. OO BURN INTENSIVE CARE UNIT						45
. 00 SURGI CAL I NTENSI VE CARE UNI T						46
. 00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1.00	-
.00 Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			105, 055	5 48
.00 Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		234, 030) 49
PASS THROUGH COST ADJUSTMENTS						
.00 Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sur	n of Parts I and	0	50
.00 Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	0	51
and IV) .00 Total Program excludable cost (sum of lines	50 and 51)				C	52
.00 Total Program inpatient operating cost exclu		lated non-nh	vsician anosth	botist and		
medical education costs (line 49 minus line		nated, non ph			0	/ 33
TARGET AMOUNT AND LIMIT COMPUTATION	/					
.00 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	ing cost and ta	rget amount (line 56 minus	line 53)	0	57
.00 Bonus payment (see instructions)					0	
.00 Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	ompounded by the	0.00) 59
market basket	aget report up	datad by the	mankat baakat		0.00	
.00 Lesser of lines 53/54 or 55 from prior year .00 If line 53/54 is less than the lower of line				the amount by	0.00 0	
which operating costs (line 53) are less that					0	0
amount (line 56), otherwise enter zero (see		3 (11163 54 X	00), 01 1/0 01	the target		
.00 Relief payment (see instructions)					o	62
.00 Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63
PROGRAM INPATIENT ROUTINE SWING BED COST	•					
.00 Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost reporti	ng period (See	0	64
instructions)(title XVIII only)					_	
.00 Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportino	g period (See	0	65
instructions)(title XVIII only) .00 Total Medicare swing-bed SNF inpatient routi	no coste (lino	44 plus lips	4E) (+; + ~ V)/		C	66
CAH (see instructions)	ne costs (inne	o4 prus rine	b)(title xvii	i oniy). Foi	0	/ 00
.00 Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	eportina period	C	67
(line 12 x line 19)	j			510		
.00 Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	orting period	C	68
(line 13 x line 20)						
.00 Total title V or XIX swing-bed NF inpatient					0) 69
PART III - SKILLED NURSING FACILITY, OTHER N						1 70
.00 Skilled nursing facility/other nursing facil	2		• •			70
.00 Adjusted general inpatient routine service c .00 Program routine service cost (line 9 x line		ine io - iiile	<u>~)</u>			72
.00 Medically necessary private room cost applic		(line 14 x l	ine 35)			73
.00 Total Program general inpatient routine serv	U	•				74
.00 Capital -related cost allocated to inpatient	•			Part II, column		75
26, line 45)						
.00 Per diem capital-related costs (line 75 ÷ li						76
.00 Program capital-related costs (line 9 x line	· · · · · · · · · · · · · · · · · · ·					77
.00 Inpatient routine service cost (line 74 minu	,		>			78
00 Aggregate charges to beneficiaries for exces	• •		· · · · · · · · · · · · · · · · · · ·			79
00 Total Program routine service costs for comp		UST LIMITATIO	n (iine /8 mir	ius i i ne 79)		80
.00 Inpatient routine service cost per diem limi .00 Inpatient routine service cost limitation (I)				81
.00 Reasonable inpatient routine service cost frim tation (i						82
.00 Program inpatient ancillary services (see in						84
.00 Utilization review - physician compensation		ns)				85
.00 Total Program inpatient operating costs (sum						86
PART IV - COMPUTATION OF OBSERVATION BED PAS						
.00 Total observation bed days (see instructions					800	87
.00 Adjusted general inpatient routine cost per		line 2)			1, 438. 06	
to Aujusted general inpatrent routine cost per		,				

Health Financial Systems MAR	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	986, 534	7, 275, 157	0. 13560	3 1, 150, 448	156, 004	90.00
91.00 Nursing School cost	0	7, 275, 157	0.00000	0 1, 150, 448	0	91.00
92.00 Allied health cost	0	7, 275, 157	0.00000	0 1, 150, 448	0	92.00
93.00 All other Medical Education	0	7, 275, 157	0.00000	0 1, 150, 448	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Title XVIII Ratio of Cos To Charges	Program Charges	5/25/2017 2:4 Cost Inpatient Program Costs (col. 1 x	epared:
	Ratio of Cos To Charges	To 12/31/2016 Hospi tal I npati ent Program Charges	5/25/2017 2:4 Cost Inpatient Program Costs (col. 1 x	
	Ratio of Cos To Charges	Hospital Inpatient Program Charges	5/25/2017 2:4 Cost Inpatient Program Costs (col. 1 x	
	Ratio of Cos To Charges	t Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x	
	To Charges	Program Charges	Program Costs (col. 1 x	
INPATIENT ROUTINE SERVICE COST CENTERS		Charges	(col. 1 x	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	3		
INPATIENT ROUTINE SERVICE COST CENTERS	1.00			
INPATIENT ROUTINE SERVICE COST CENTERS	1.00		col. 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS		1, 769, 741		30,00
31. 00 03100 I NTENSI VE CARE UNI T		271, 348		31.00
43. 00 04300 NURSERY		271, 340		43.00
ANCI LLARY SERVICE COST CENTERS				10.00
50. 00 05000 OPERATI NG ROOM	0. 1946	58 1, 096, 967	213, 533	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 4280	97 6,739	9, 624	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 2218	51 837, 609	185, 824	54.00
60. 00 06000 LABORATORY	0. 2029	82 1, 474, 353	299, 267	60.00
60. 01 06001 BLOOD LABORATORY	0. 0000		0	
65. 00 06500 RESPI RATORY THERAPY	0. 2759			
66. 00 06600 PHYSI CAL THERAPY	0. 5486		63, 715	
67.00 06700 OCCUPATI ONAL THERAPY	0. 5209			
68.00 06800 SPEECH PATHOLOGY	0. 7009			
69. 00 06900 ELECTROCARDI OLOGY	0. 3083			
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 4010			
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 9901			
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0. 3259	79 1, 739, 501	567, 041	73.00
88. 00 08800 RURAL HEALTH CLINIC	0.0000	00	0	88.00
90. 00 09000 CLINIC	0. 5887		-	
90. 01 09001 WOUND CLINC	0. 2521			
91. 00 09100 EMERGENCY	0. 6331			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 3637		0	
200.00 Total (sum of lines 50-94 and 96-98)		9, 671, 027	3, 278, 638	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)	0		201.00
202.00 Net Charges (line 200 minus line 201)	-	9, 671, 027		202.00

Health Financial Systems MARGARET MARY COMMU	JNI TY HOSPI TAI	L	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC	CN: 15-1329	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Pre	
				5/25/2017 2:4	i2 pm
		e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
		1 00	2.00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			93, 240		30.00
31. 00 03100 INTENSIVE CARE UNIT			2, 166		31.00
43. 00 04300 NURSERY			2,100		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM		0. 1946	58 8, 073	1, 571	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		1. 4280			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2218			
60. 00 06000 LABORATORY		0. 2029			
60. 01 06001 BLOOD LABORATORY		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0.2759		7, 769	
66. 00 06600 PHYSI CAL THERAPY		0. 5486	98 1, 347	739	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 52092	26 512	267	67.00
68.00 06800 SPEECH PATHOLOGY		0. 70092	26 3, 815	2, 674	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 3083	1, 982	611	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.4010	49 86, 479	34, 682	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 9901		3, 303	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3259	79 43, 765	14, 266	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		1. 5316		0	
90. 00 09000 CLINIC		0. 5887		0	
90. 01 09001 WOUND CLINC		0. 2521		0	
91.00 09100 EMERGENCY		0. 6331		288	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.3637		0	
200.00 Total (sum of lines 50-94 and 96-98)	<u> </u>		253, 664	105, 055	
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			253, 664		202.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Period: From 01/01/2016		nor!
			To 12/31/2016	5/25/2017 2:4	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			10 105 005	1 1 0
00 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	ctions)		12, 185, 025 0	1.0 2.0
00	PPS payments	,		0	3.0
00	Outlier payment (see instructions)			0	4.0
00 00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	ictions)		0.000	5. C
00	Sum of line 3 plus line 4 divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0	8.0
00 . 00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, col. 13, line 200		0	9. C
	Total cost (sum of lines 1 and 10) (see instructions)			12, 185, 025	
	COMPUTATION OF LESSER OF COST OR CHARGES			, ,	
00	Reasonable charges				110 /
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	12.0 13.0
	Total reasonable charges (sum of lines 12 and 13)			0	
	Customary charges				
	Aggregate amount actually collected from patients liable for		U U	0	15. 16.
00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(1 3	on a chargebasis	0	10.
00	Ratio of line 15 to line 16 (not to exceed 1.000000)	(-)		0.000000	17.
	Total customary charges (see instructions)			0	18.
00	Excess of customary charges over reasonable cost (complete or instructions)	nly if line 18 exceeds l	ine 11) (see	0	19.
00	Excess of reasonable cost over customary charges (complete or	nly if line 11 exceeds l	ine 18) (see	0	20.
	instructions)				
	Lesser of cost or charges (line 11 minus line 20) (for CAH se Interns and residents (see instructions)	e instructions)		12, 306, 875 0	21.0
	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	23.
00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24.
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			123, 545	25.
	Deductibles and Coinsurance relating to amount on line 24 (for	or CAH, see instructions	5)	6, 784, 073	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			5, 399, 257	
00	instructions) Direct graduate modical education normants (from What E.4.	ing EQ)		0	28.
	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36)			0	20.
	Subtotal (sum of lines 27 through 29)			5, 399, 257	30.
	Primary payer payments			14, 970	
	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	(FS)		5, 384, 287	32.
	Composite rate ESRD (from Wkst. 1-5, line 11)	020)		0	33.
	Allowable bad debts (see instructions)			1,094,342	
	Adjusted reimbursable bad debts (see instructions)	-muetione)		711, 322	
	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		689, 750 6, 095, 609	36. 37.
	MSP-LCC reconciliation amount from PS&R			0	38.
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.
	Pioneer ACO demonstration payment adjustment (see instruction Partial or full credits received from manufacturers for repla		uctions)	0	39. 39.
	RECOVERY OF ACCELERATED DEPRECIATION	acca devices (see instit		0	39.
00	Subtotal (see instructions)			6,095,609	40.
	Sequestration adjustment (see instructions)			121, 912	
	Interim payments Tentative settlement (for contractors use only)			6, 320, 996 0	41.0
	Balance due provider/program (see instructions)			-347, 299	
	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	
	§115. 2				1

9115.2TO 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)093.0094.00Total (sum of lines 91 and 93)094.00

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1329	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	pare
		Titlo	XVIII	Hospi tal	5/25/2017 2: 4	2 pm
		Inpatien			Cost 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		4, 773, 6		6, 320, 996	1.
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER	08/04/2016	388, 10	00	0	3.
02				0	0	3
03				0	0	3
04 05				0	0	3
05	Provider to Program			0	0	3
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		388, 10		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5, 161, 7 ⁻	13	6, 320, 996	4
	TO BE COMPLETED BY CONTRACTOR					
00	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)2	TENTATI VE TO PROVIDER			0	0	5
)2)3				0	0	
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		389, 80	70	0	6
02	SETTLEMENT TO PROVIDER		507, 00	0	347, 299	
00	Total Medicare program liability (see instructions)		5, 551, 52	20	5, 973, 697	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		C)	1.00	2.00	

Heal th	Financial Systems MARGARET MARY COMM	UNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1329	Period: From 01/01/2016		
			To 12/31/2016	Date/Time Pre 5/25/2017 2:43	
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO DE CONDUETED DV CONTRACTOR FOR NONCTANDARD COCT DEDORTE			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION)N			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst		ie 14	1, 693	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12		1, 917	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			443	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		4, 549	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			161, 402, 456	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3			2, 590, 384	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I	0	7.00
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	n (see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)			0	
	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ins)	0	32.00

	Financial Systems MARGARET MARY CC ATION OF REIMBURSEMENT SETTLEMENT	DMMUNITY HOSPITAL Provider CCN: 15-1329	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 01/01/2016	Part V	
			To 12/31/2016	Date/Time Pre	
		Title XVIII	Hospi tal	5/25/2017 2:4 Cost	z pili
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDI	CARE PART A SERVICES - COS	T REI MBURSEMENT	(170 500	1.0
1.00	Inpatient services	weti ana)		6, 179, 580	1.0
2.00 3.00	Nursing and Allied Health Managed Care payment (see instr Organ acquisition	uctions)		0	2.0 3.0
4.00	Subtotal (sum of lines 1 through 3)			6, 179, 580	
f. 00 5. 00	Primary payer payments			0, 179, 580	5.0
5.00	Total cost (line 4 less line 5). For CAH (see instruction	(a		6, 241, 376	
5.00	COMPUTATION OF LESSER OF COST OR CHARGES	(3)	ļ	0, 241, 370	0.0
	Reasonabl e charges				
7.00	Routi ne servi ce charges			0	7.0
3. 00	Ancillary service charges			0	8.0
9.00	Organ acquisition charges, net of revenue			0	9.0
10.00	Total reasonable charges			0	10.0
	Customary charges				
11.00	Aggregate amount actually collected from patients liable	1 5	5		
12.00	Amounts that would have been realized from patients liabl		on a charge basis	0	12.0
13.00	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	13.0
14.00	Total customary charges (see instructions)			0.000000	14.0
15.00	Excess of customary charges over reasonable cost (complet	e only if line 14 exceeds l	ine 6) (see	0	
10.00	instructions)	e only if the it exceeds i		0	15.0
16.00	Excess of reasonable cost over customary charges (complet	e only if line 6 exceeds li	ne 14) (see	0	16.0
	i nstructi ons)	, , , , , , , , , , , , , , , , , , ,			
17.00	Cost of physicians' services in a teaching hospital (see	instructions)		0	17.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Workshee	et E-4, line 49)		0	
19.00	Cost of covered services (sum of lines 6, 17 and 18)			6, 241, 376	
	Deductibles (exclude professional component)			615, 636	
21.00	Excess reasonable cost (from line 16)				
22.00 23.00	Subtotal (line 19 minus line 20 and 21) Coinsurance			5, 625, 740 644	
24.00	Subtotal (line 22 minus line 23)			5, 625, 096	
25.00	Allowable bad debts (exclude bad debts for professional s	ervices) (see instructions)		61, 107	
26.00	Adjusted reimbursable bad debts (see instructions)			39, 720	
27.00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		25, 866	
28.00	Subtotal (sum of lines 24 and 25, or line 26)			5, 664, 816	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.0
9.50	Pioneer ACO demonstration payment adjustment (see instruc	tions)		0	29.5
29.99	Recovery of Accel erated Depreciation	-		0	29.9
30.00	Subtotal (see instructions)			5, 664, 816	
30. 01	Sequestration adjustment (see instructions)			113, 296	
31.00				5, 161, 713	
32.00	Tentative settlement (for contractor use only)			0	32.0
33.00	Balance due provider/program (line 30 minus lines 30.01,			389, 807	33.0
34.00	Protested amounts (nonallowable cost report items) in acc	ordance with CMS Pub. 15-2,	chapter 1,	0	34.0

LCUL	Financial Systems MARGARET MARY COMMUN ATION OF REIMBURSEMENT SETTLEMENT	NITY HOSPITAL Provider CCN: 15-1329	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 01/01/2016 To 12/31/2016		
		Title XIX	Hospi tal	Cost	rz pi
		•	I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR	XIX SERVICES		
~ ~	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		234, 030	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)		234, 030	0	
00	Inpatient primary payer payments		201,000	Ŭ	5.
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		234,030	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges				
00	Routine service charges		95, 406		8
00	Ancillary service charges		253, 664	0	
. 00	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation		0	0	11
. 00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		349, 070	0	12
. 00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13
. 00	basis	services on a charge	0	0	13
. 00	Amounts that would have been realized from patients liable fo	r payment for services	on 0	0	14
	a charge basis had such payment been made in accordance with	1 5	011 0	Ū	
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15
. 00	Total customary charges (see instructions)		349, 070	0	16
. 00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	115, 040	0	17
	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds li	ne 0	0	18
00	16) (see instructions)		0	0	10
. 00 . 00	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	19
	Cost of covered services (enter the lesser of line 4 or line		234, 030	0	
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21
. 00	Other than outlier payments		0	0	22
. 00	Outlier payments		0	0	
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		25
. 00	Routine and Ancillary service other pass through costs		0	0	26
	Subtotal (sum of lines 22 through 26)		0	0	27
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28
. 00	Titles V or XIX (sum of lines 21 and 27)		234, 030	0	29
~~~	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 20
. 00	Excess of reasonable cost (from line 18)	<b>`</b>	0	0	
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6 Deductibles		234, 030 0	0	
	Coi nsurance		0	0	33
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	Ū	35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	id 33)	234, 030	0	36
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-	0	0	
. 00	Subtotal (line 36 ± line 37)		234, 030	0	38
	Direct graduate medical education payments (from Wkst. E-4)		0		39
0. 00	Total amount payable to the provider (sum of lines 38 and 39)		234, 030	0	
. 00	Interim payments		292, 589	0	41
2.00	Balance due provider/program (line 40 minus line 41)		-58, 559	0	
3.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	F	Period: From 01/01/2016 To 12/31/2016		nore
ר I y)					5/25/2017 2:4	12 pm
		General Fund	Specific Purpose Fund		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
00	Cash on hand in banks	5, 283, 380	) (	0 0	0	1.
00	Temporary investments	0		0 0	0	
00	Notes receivable	0	) (	0 0	0	3
00	Accounts receivable	10, 935, 461	(	o c	0	4
00	Other receivable	0	(	0 0	0	5
00	Allowances for uncollectible notes and accounts receivable	0	) (	0 C	0	
00	Inventory	1, 104, 045		0 0	0	
00	Prepai d expenses	1, 357, 408		0 0	0	
00	Other current assets	381, 134			0	
. 00 . 00	Due from other funds	19, 061, 428			0	
. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	19,001,420	·	<u> </u>	0	- ' '
. 00	Land	2, 553, 658	1 (	0 0	0	12
. 00	Land improvements	468, 364		0 0	0	
	Accumul ated depreciation	-392, 788		0 0	0	
	Bui I di ngs	76,061,360		0 0	0	
. 00	Accumulated depreciation	-40, 012, 438	i (	0 0	0	16
7.00	Leasehold improvements	0	(	0 0	0	17
8.00	Accumulated depreciation	0	(	0 0	0	18
	Fixed equipment	6, 341, 285		0 C	0	19
	Accumulated depreciation	-5, 992, 465		0 0	0	
	Automobiles and trucks	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Major movable equipment	52,060,884		) 0	0	
	Accumulated depreciation	-31, 966, 697		0 0	0	
	Minor equipment depreciable	0			0	
1	Accumulated depreciation HIT designated Assets	0			0	
1	Accumulated depreciation	0			0	
1	Mi nor equi pment-nondepreci abl e	0		0 0	0	
	Total fixed assets (sum of lines 12-29)	59, 121, 163		0 0	0	
	OTHER ASSETS		1			
1.00	Investments	0	) (	0 0	0	31
2.00	Deposits on Leases	0	(	0 0	0	32
3.00	Due from owners/officers	0	(	0 0	0	33
	Other assets	77, 271, 070		0 0	0	
	Total other assets (sum of lines 31-34)	77, 271, 070		0 0	0	
		155, 453, 661	(	0 0	0	36
	CURRENT LI ABI LI TI ES	2 014 0/0	<u>,</u>			1 22
	Accounts payable Salaries, wages, and fees payable	2,014,860			0	
	Payrol I taxes payable	7, 761, 684			0	
	Notes and Loans payable (short term)	1, 759, 928			0	
	Deferred i ncome	1, 739, 920			0	
	Accel erated payments	0		, ,	, v	42
	Due to other funds	Ő	) (	0 0	0	
	Other current liabilities	1, 898, 894		0 0	0	
	Total current liabilities (sum of lines 37 thru 44)	13, 435, 366		0 0	0	45
	LONG TERM LIABILITIES					1
5.00	Mortgage payable	0	) (	0 0	0	46
7.00	Notes payable	0	(	o c	0	47
	Unsecured Loans	0	(	ס כ	0	
	Other long term liabilities	27, 395, 272		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	27, 395, 272		0 0	0	
. 00	Total liabilities (sum of lines 45 and 50)	40, 830, 638	(	0 0	0	51
	CAPITAL ACCOUNTS			1		4
	General fund balance	114, 623, 023				52
	Specific purpose fund		(	0	1	53
	Donor created - endowment fund balance - restricted			0	l	54
	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0	l	55
	Plant fund balance - invested in plant			0	0	
	Plant fund balance - reserve for plant improvement,				0	
3 00 i	i fant fand barance feserve for prant filiprovement,		1		. 0	1 50
3. 00	replacement, and expansion			1	1	
3.00 9.00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	114, 623, 023	(	0 0	0	59

	I Financial Systems MAR MENT OF CHANGES IN FUND BALANCES	GARET MARY COMM	Provider CC		Perio	d:	u of Form CMS Worksheet G		002 10
						01/01/2016 12/31/2016			
		General	Fund	Speci al	Purpos	e Fund	Endowment Fund		
		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		104, 500, 043 10, 122, 980 114, 623, 023 0 114, 623, 023 0 114, 623, 023 0 114, 623, 023		0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0		0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 16.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund					
1 00		6.00	7.00	8.00					1 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 18. 00 19. 00	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	000	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

STATE	I FINANCIAL SYSTEMS MARGARET MARY COMMU NENT OF PATIENT REVENUES AND OPERATING EXPENSES	NITY HOSPITAL Provider CCN	15-1329	Peri od:	u of Form CMS-2552- Worksheet G-2		
OTATE			. 10 1027	From 01/01/2016 To 12/31/2016	Parts I & II	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		7, 580, 9	59	7, 580, 959	1.00	
2.00	SUBPROVI DER – I PF					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		7 500 0	- 0	7 500 050	9.00	
10.00	Total general inpatient care services (sum of lines 1-9)		7, 580, 9	59	7, 580, 959	10.00	
11 00	Intensive Care Type Inpatient Hospital Services		E2E 0	E 1	535, 951	111 00	
11.00 12.00	CORONARY CARE UNIT		535, 9	01	535, 951	11.00 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)					14.00	
16.00		Flipoc	535, 9	E 1	535, 951	16.00	
10.00	11-15)	i i i i i i i i i i i i i i i i i i i	030, 9	51	555, 951	10.00	
17.00	Total inpatient routine care services (sum of lines 10 and 10	5)	8, 116, 9 [.]	10	8, 116, 910	17.00	
18.00	Ancillary services		20, 658, 12		133, 019, 793		
19.00	5		485, 8		16, 299, 175		
20.00			100, 0	0 0	0,2,7,1,0	20.00	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0		
22.00				2, 076, 932	2,076,932		
23.00					, ,	23.00	
24.00	СМНС					24.00	
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00	
26.00	HOSPI CE			0 1, 889, 646	1, 889, 646		
27.00	PHYSI CI AN REV			0 15, 242, 093	15, 242, 093		
27.01	PRO FEES			0 10, 524, 475	10, 524, 475		
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	3 to Wkst.	29, 260, 90		187, 169, 024		
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)			87, 282, 815		29.00	
30.00	ADD (SPECIFY)			0		30.00	
31.00				0		31.00	
32.00				0		32.00	
33.00				0		33.00	
34.00				0		34.00	
35.00				0		35.00	
36.00	Total additions (sum of lines 30-35)			0		36.00	
37.00	DEDUCT (SPECIFY)			0		37.00	
38.00				0		38.00	
39.00				0		39.00	
40.00				0		40.00	
41.00				0		41.00	
42.00	Total deductions (sum of lines 37-41)			0		42.00	
43.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer		87, 282, 815		43.00	
	to Wkst. G-3, line 4)						

	· · · · · · · · · · · · · · · · · · ·	MMUNITY HOSPITAL		u of Form CMS-2		
STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-1329	Peri od:	Worksheet G-3		
			From 01/01/2016 To 12/31/2016	Date/Time Pre	nared	
					5/25/2017 2:42 pm	
				1.00 187,169,024		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)				1.00	
2.00					2.00	
3.00					3.00	
4.00				87, 282, 815 4, 008, 646	4.00	
5.00					5.00	
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc			0	6.00	
7.00					7.00	
8.00					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	
	Revenue from rental of living quarters			0	15.00	
	Revenue from sale of medical and surgical supplies to oth	er than patients		0	16.00	
	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	
	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 I NCOME			6, 082, 567		
24.01	TEMP REST CONTRIBUTIONS			31, 767	24.01	
25.00	Total other income (sum of lines 6-24)			6, 114, 334		
26.00	Total (line 5 plus line 25)			10, 122, 980		
	OTHER EXPENSES (SPECIFY)			0	27.00	
28.00	Total other expenses (sum of line 27 and subscripts)	2)		0	28.00	
29.00	Net income (or loss) for the period (line 26 minus line 2	8)	l	10, 122, 980	29.00	

	Financial Systems		GARET MARY COM				u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED HOME HEALT	TH AGENCY COSTS	5	Provider C		eriod: rom 01/01/2016	Worksheet H	
				HHA CCN:	15-7143 T	o 12/31/2016	Date/Time Pre 5/25/2017 2:4	pared: 2 pm
						Home Health	PPS	2 pm
		Sal ari es	Employee	Transportatio	Contracted/Pu	Agency I Other Costs	Total (sum of	
			Benefits	n (see	rchased		cols. 1 thru	
		1.00	2.00	instructions) 3.00	Servi ces 4.00	5.00	5) 6.00	
	GENERAL SERVICE COST CENTERS	1			1			
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable			0		0	0	2.00
3.00	Equipment Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	411, 001	0	0	0	213, 315	624, 316	5.00
6.00	Skilled Nursing Care	490, 025	0	0	0	0	490, 025	6.00
7.00	Physical Therapy	434, 918		0		-	434, 918	1
8.00 9.00	Occupational Therapy Speech Pathology	143, 548 2, 953	0	0	-		143, 548 2, 953	
10.00	Medical Social Services	13, 087	0	0	0	-	13, 087	10.00
11.00 12.00	Home Health Aide Supplies (see instructions)	35, 251	0	0	0	-	35, 251 0	
13.00	Drugs	0	0	0		-	0	
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0	0	0	0	14.00
15.00	HOME Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respi ratory Therapy	0	0	0	-	-	0	
17.00 18.00	Private Duty Nursing Clinic	0	0	0	0	-	0	
19.00	Health Promotion Activities	0	0	0	0	-	0	
20.00	Day Care Program	0	0	0	0	-	0	
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0	0	0	-	0	
23.00	All Others (specify)	0	0	0	0	-	0	
23.50 24.00	Telemedicine Total (sum of lines 1–23)	0 1, 530, 783	0	0	0		0 1, 744, 098	
21100		Recl assi fi cat		Adjustments	Net Expenses	210/010	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	21100
		i on	Trial Balance (col. 6 +		for Allocation			
			col . 7)		(col . 8 +			
		7.00	8.00	9.00	<u>col. 9)</u> 10.00	-		-
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00			
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable	0	О	0	0			2.00
2 00	Equipment		0	0				2 00
3.00 4.00	Plant Operation & Maintenance Transportation	0	0	0	0			3.00 4.00
5.00	Administrative and General	0	624, 316	0	624, 316			5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	490, 025	0	490, 025			6.00
7.00	Physical Therapy	0	434, 918	0	434, 918			7.00
8.00 9.00	Occupational Therapy Speech Pathology	0	143, 548 2, 953	0	143, 548 2, 953			8.00 9.00
10.00	Medical Social Services	0	13, 087	0	13, 087			10.00
11.00	Home Heal th Ai de	0	35, 251	0	35, 251			11.00
12.00 13.00	Supplies (see instructions) Drugs	0	0	0	-			12.00 13.00
14.00	DME	0	-	0				14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0				16.00
17.00 18.00	Private Duty Nursing Clinic	0	0	0	0			17.00 18.00
	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	-			20.00
21.00 22.00	Home Delivered Meals Program Homemaker Service	0 0	0	0	0			21.00 22.00
23.00	All Others (specify)	0	Ő	0	0			23.00
	Telemedicine Total (sum of lines 1–23)	0	0 1, 744, 098	0 0				23.50 24.00
27.00	1 (Sun Of THES 1-23)	1 0	1, 744, 070	0	1 1, 744, 090	I		27.00

HHA CCR:         15-7143         From 0/101/2016         Part I S22/201           Image: Second		u of Form CMS				GARET MARY COMM		h Financial Systems	
Example in the second	H-1	Worksheet H- Part I			Provider CO		E COST	ALLOCATION - HHA GENERAL SERVIC	COST A
Capit C	Prepared: 2:42 pm	Date/Time Pr 5/25/2017 2:	o 12/31/2016	15-7143 T	HHA CCN:				
Image: Capital Related Costs         Plant Operation & Transportation of Number All Costs of Costs (Cols. Costs)         Plant Operation & Transportation of Number All Costs of Costs (Cols. Costs)           0         GENERAL SERVICE COST CENTERS         0         1.00         2.00         3.00         4.00         4A.00           1.00         Capital Related - Bidg. & If (Cons. Costs)         0         0         0         0         4.00         4A.00           2.00         Capital Related - Movable Equipment         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		PPS							
For Cost All location (From Wkst. H, col. 10)         Fixtures (col. 0)         Equipment (col. 0)         Operation & Meintenance         Operation & Meintenance         (col. 0)           0         1.00         2.00         3.00         4.00         44.00           1.00         Capital Related - Bldg. & Fixtures         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			Agency I		ated Costs	Capital Rela			
For Cost All location (From Wkst. H, col. 10)         Fixtures (col. 0)         Equipment (col. 0)         Operation & Meintenance         Operation & Meintenance         (col. 0)           0         1.00         2.00         3.00         4.00         44.00           1.00         Capital Related - Bldg. & Fixtures         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		Subtotal	Transportatio	Dlant	Movablia	Pl dac 8	Not Exponence		
CENERAL SERVICE COST CENTERS           1.00         1.00         2.00         3.00         4.00         44.00           1.00         Capital Related - Bldg. & Fixtures         0         0         0         0         44.00           2.00         Capital Related - Movable Equipment         0         0         0         0         0         0         0           3.00         Plant Operation & Maintenance         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		(col s. 0-4)							
H. col. 10)         O         1.00         2.00         3.00         4.00         4A.00           1.00         Capital Related - Bldg. & Fixtures         0         0         0         0         0         4.00         4A.00           2.00         Capital Related - Movable Equipment         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         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>Mai ntenance</td><td></td><td></td><td></td><td></td><td></td></t<>				Mai ntenance					
CENERAL SERVICE COST CENTERS         Image: Construct on the service of the ser									
1.00       Capital Related - Bldg. & O       0       0         Fixtures       Capital Related - Movable       0       0       0         2.00       Capital Related - Movable       0       0       0       0         3.00       Plant Operation & Maintenance       0       0       0       0       0         3.00       Plant Operation & Maintenance       0       0       0       0       0       0         6.00       Skilled Nursing Care       490.025       0       0       0       0       43         7.00       Physical Therapy       143,548       0       0       0       0       43         9.00       Speech Pathology       2,953       0       0       0       0       14         9.00       Speech Pathology       2,953       0       0       0       0       0       1         10.00       Hold cal Social Services       13,087       0       0       0       0       0       1         11.00       Home Healt Nide       35,251       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		4A. 00	4.00	3.00	2.00	1.00	0	CENEDAL SEDVICE COST CENTERS	
2.00         Capital Related - Movable Equipment         0         0         0           3.00         Plant Operation & Maintenance         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         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>0 1.0</td><td></td><td></td><td></td><td></td><td>0</td><td>0</td><td></td><td>1.00</td></t<>	0 1.0					0	0		1.00
Equipment         cquipment         cquipment         cquipment         cquipment           4.00         Transportation & Maintenance         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	0 2.0				0				2 00
4.00       Transportation       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	0 2.0				0		0		2.00
5.00         Administrative and General         624,316         0         0         0         62           HHA REIMBURSABLE SERVICES	0 3.0			-	0	0	0		
HHA RELMURSABLE SERVICES           6.00         Killed Nursing Care         490,025         0         0         0         0         43           7.00         Physical Therapy         434,918         0         0         0         0         43           8.00         Occupational Therapy         143,548         0         0         0         0         43           8.00         Occupational Therapy         143,548         0         0         0         0         143           9.00         Specch Pathology         2,953         0         0         0         0         0         140           10.00         Mee Healt h Aide         35,251         0         0         0         0         0         33           11.00         Home Healt h Aide         35,251         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         <	4.0 ,316 5.0	624, 31	-	-	0	0	624, 316		
7.00       Physical Therapy       434,918       0       0       0       0       43         8.00       Occupational Therapy       143,548       0       0       0       0       14         9.00       Speech Pathology       2,953       0       0       0       0       14         10.00       Medical Social Services       13,087       0       0       0       0       14         11.00       Home Healt hA ide       35,251       0       0       0       0       0       0       3         12.00       Supplies (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 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
8.00       Occupational Therapy       143,548       0       0       0       143         9.00       Speech Pathology       2,953       0       0       0       0       14         9.00       Speech Pathology       2,953       0       0       0       0       14         9.00       Home Health Aide       35,251       0       0       0       0       3         12.00       Supplies (see instructions)       0       0       0       0       0       0       3         13.00       Drugs       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       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>490, 02 434, 91</td><td>-</td><td>-</td><td>-</td><td>-</td><td></td><td>5</td><td></td></t<>		490, 02 434, 91	-	-	-	-		5	
10.00       Medical Social Services       13.087       0       0       0       1         11.00       Home Health Aide       35,251       0       0       0       0       3         12.00       Supplies (see instructions)       0       0       0       0       0       0       3         13.00       Drugs       0       0       0       0       0       0       0       0       0       3         14.00       DME       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       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>, 548 8. 0</td> <td>143, 54</td> <td>0</td> <td>C</td> <td>0</td> <td>0</td> <td>143, 548</td> <td>Occupational Therapy</td> <td>8.00</td>	, 548 8. 0	143, 54	0	C	0	0	143, 548	Occupational Therapy	8.00
11.00       Home Heal th Ai de       35,251       0       0       0       0       3         12.00       Supplies (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<	, 953 9. 0 , 087 10. 0	2, 95 13, 08		C	0	0			
13.00       Drugs       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	, 251 11. 0	35, 25	0	C	0	0		Home Health Aide	
14.00       DME [®] 0       0       0       0       0         HHA NONREIMBURSABLE SERVICES         5.00       Home Dial ysis Ai de Services       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       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>0 12.0 0 13.0</td><td></td><td>0</td><td>C</td><td>0</td><td>0</td><td>-</td><td></td><td></td></td<>	0 12.0 0 13.0		0	C	0	0	-		
15.00       Home Dialysis Aide Services       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	0 13.0			-	0	0	-	5	
16.00       Respiratory Therapy       0       0       0       0         17.00       Private Duty Nursing       0       0       0       0         18.00       Clinic       0       0       0       0       0         18.00       Clinic       0       0       0       0       0       0         19.00       Health Promotion Activities       0       0       0       0       0       0         20.00       Day Care Program       0       0       0       0       0       0         21.00       Homemaker Service       0       0       0       0       0       0         23.00       All Others (specify)       0       0       0       0       0       0         24.00       Total (sum of lines 1-23)       1, 744, 098       0       0       0       0       1, 74         24.00       Total (sum of lines 1-23)       1, 744, 098       0       0       0       1, 74         25.00       Capital Related - Bldg. & Fixtures       5.00       6.00       6.00       1, 74         2.00       Capital Related - Movable Equipment       5.00       6.00       6.00       1, 74      <					0				15 00
18.00       Clinic       0       0       0       0       0         19.00       Health Promotion Activities       0       0       0       0       0       0         20.00       Day Care Program       0       0       0       0       0       0         21.00       Home Delivered Meals Program       0       0       0       0       0       0         22.00       Homemaker Service       0       0       0       0       0       0         23.00       All Others (specify)       0       0       0       0       0       0         24.00       Total (sum of lines 1-23)       1, 744, 098       0       0       0       0       0       0       0       1, 74         24.00       Total (sum of lines 1-23)       1, 744, 098       0       0       0       0       1, 74         24.00       Capital Related - Bldg. & Fixtures       5.00       6.00       6.00       0       0       1, 74         3.00       Plant Operation & Maintenance       6.24, 316       4A + 5)       5.00       6.00       4.00       1, 74       1, 74       1, 74       1, 74       1, 74       1, 74       1, 74	0 15.0 0 16.0		-		-	-	-		
19.00       Heal th Promotion Activities       0       0       0       0       0         20.00       Day Care Program       0       0       0       0       0       0         21.00       Home Delivered Meals Program       0       0       0       0       0       0         22.00       Homemaker Service       0       0       0       0       0       0         23.00       All Others (specify)       0       0       0       0       0       0         23.00       Telemedicine       0       0       0       0       0       0       0         24.00       Total (sum of lines 1-23)       1,744,098       0       0       0       0       1,744         24.00       Total (sum of lines 1-23)       1,744,098       0       0       0       1,744         24.00       Total (sum of lines 1-23)       1,744,098       0       0       0       1,744         25.00       General       60.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00	0 17.0		0	C	0	0	0	Private Duty Nursing	
20.00         Day Care Program         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	0 18.0 0 19.0				0	0	0		
22.00       Homemaker Service       0       0       0       0       0         23.00       All Others (specify)       0       0       0       0       0       0         23.00       Telemedicine       0       0       0       0       0       0       0       0       0         23.00       Telemedicine       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       1,74         24.00       Total (sum of lines 1-23)       1,744,098       O       0       0       0       1,74       14       14       15       1       16       1,74       14       15       16       16       16       16       16       16       16       16       16       16       16       16       16       16       16       16       16       16       16       16       16       16       16	0 20.0		0	C	0	0	0	Day Care Program	20.00
23.00       All Others (specify)       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       1,744,098       0       0       0       0       0       1,744       0       0       0       0       0       1,744       0       0       0       0       0       1,744       0       0       0       0       0       1,744       0       0       0       0       1,744       0       1,744       4A + 5)       5.00       6.00       6.00       0       0       0       1,744       4A + 5)       5.00       6.00       6.00       0       0       0       1,744       4A + 5)       5.00       6.00       6.00       0       0       0       1,744       4A + 5)       5.00       6.00       0       0 <td>0 21.0</td> <td></td> <td>0</td> <td>C</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>	0 21.0		0	C	0	0	0		
24.00       Total (sum of lines 1-23)       1,744,098       0       0       0       0       1,74         Administrativ       Total (cols.       e & General       4A + 5)       5.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00       6.00	0 22.0		0	C	0	0	0		
Administrativ e & GeneralTotal (col s. (4A + 5)66.0065.006.006.0066.00767777777777777777777777777777777777777777777777777777777777777777777777777777777777777777777777777777777777777777777777777777 <td>0 23.5</td> <td></td> <td>-</td> <td></td> <td>-</td> <td>0</td> <td>0</td> <td></td> <td></td>	0 23.5		-		-	0	0		
5.006.00GENERAL SERVICE COST CENTERS1.00Capital Related - Bidg. & Fixtures2.00Capital Related - Movable Equipment3.00Plant Operation & Maintenance 4.004.00Transportation Strative and General5.00Administrative and General HHA REI MBURSABLE SERVICES6.00Skilled Nursing Care Physical Therapy2.00Occupational Therapy8.00Occupational Therapy8.00Occupational Therapy80,033223,581	, 098 24.0	1, 744, 09			0	Total (cols.		Total (sum of Trifles T-23)	24.00
GENERAL SERVICE COST CENTERS         1.00       Capital Related - Bldg. & Fixtures         2.00       Capital Related - Movable Equipment         3.00       Plant Operation & Maintenance         4.00       Transportation         5.00       Administrative and General         624, 316         HHA REI MBURSABLE SERVICES         6.00       Skilled Nursing Care         273, 205       763, 230         7.00       Physical Therapy         242, 482       677, 400         8.00       Occupational Therapy         80, 033       223, 581			-						
Fixtures2.00Capital Related - Movable Equipment3.00Plant Operation & Maintenance4.00Transportation5.00Administrative and General6.00Skilled Nursing Care7.00Physical Therapy242, 482677, 4008.00Occupational Therapy80, 033223, 581						0.00	5.00	GENERAL SERVICE COST CENTERS	
2. 00Capital Related - Movable Equipment3. 00Plant Operation & Maintenance4. 00Transportation5. 00Administrative and General6. 00Skilled Nursing Care273, 205763, 2307. 00Physical Therapy242, 482677, 4008. 00Occupational Therapy80, 003223, 581	1.0								1.00
3.00Plant Operation & Maintenance4.00Transportation5.00Administrative and General624, 316HHA REIMBURSABLE SERVICES6.00Skilled Nursing Care7.00Physical Therapy242, 482677, 4008.00Occupational Therapy80, 033223, 581	2.0								2.00
4.00       Transportation       624, 316         5.00       Administrative and General       624, 316         HHA REIMBURSABLE SERVICES       600         6.00       Skilled Nursing Care       273, 205         7.00       Physical Therapy       242, 482         6.00       Occupational Therapy       80, 033         223, 581       677, 400	2.0								2 00
5.00         Administrative and General         624,316           HHA REIMBURSABLE SERVICES	3.0 4.0								
6.00         Skilled Nursing Care         273, 205         763, 230           7.00         Physical Therapy         242, 482         677, 400           8.00         Occupational Therapy         80, 033         223, 581	5.0						624, 316		5.00
7.00         Physical Therapy         242, 482         677, 400           8.00         Occupational Therapy         80, 033         223, 581	6.0					763, 230	273, 205		6.00
	7.0					677, 400	242, 482	Physi cal Therapy	7.00
9. UU ISpeech Pathology IIII, 646I 4. 599I	8. 0 9. 0					223, 581 4, 599	80,033	Speech Pathology	8.00 9.00
10.00 Medical Social Services 7,296 20,383	10.0					20, 383	7, 296	Medical Social Services	10.00
11. 00         Home Health Aide         19, 654         54, 905           12. 00         Supplies (see instructions)         0         0	11.0								
13.00 Drugs 0 0	13.0					0	0	Drugs	13.00
14. 00 DME 0 0	14.0					0	0		14.00
15.00 Home Dialysis Aide Services 0 0	15.0					0	0	Home Dialysis Aide Services	15.00
16.00   Respiratory Therapy   0   0     17.00   Private Duty Nursing   0   0	16.0					-			
17.00         Private Duty Nursing         0         0           18.00         Clinic         0         0	17.0 18.0					-	0		
19.00 Health Promotion Activities 0 0	19.0					-	0	Health Promotion Activities	19.00
20.00     Day Care Program     0     0       21.00     Home Delivered Meals Program     0     0	20.0 21.0					-	0		
22.00 Homemaker Service 0 0	22.0					0	0	Homemaker Service	22.00
23.00     All Others (specify)     0     0       23.50     Tel emedicine     0     0	23.0 23.5					-	0		
24. 00 Total (sum of lines 1-23) 1, 744, 098	23.5					-			

COST A	<u>Financial Systems</u> LLOCATION - HHA STATISTICAL BAS		GARET MART COM	MUNITY HOSPITA Provider C		Peri od:	u of Form CMS-: Worksheet H-1	
				HHA CCN:	15-7143	From 01/01/2016 To 12/31/2016	Part II	pared:
						Home Health	PPS	•
		Capital Rel	ated Costs			Agency I		
		BIdgs &	Movabl e	Plant	Transportati	o Reconciliatio	Administrativ	1
		Fixtures	Equi pment	Operation &	n (MILEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance (SQUARE FEET)			(ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS		2.00	2.00		200	2.00	
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		0			0		2.00
2 00	Equipment		0					2 00
3.00 4.00	Plant Operation & Maintenance Transportation (see	0	0	0		0		3.00
4.00	i nstructi ons)	0	0	0		0		4.00
5.00	Administrative and General	0	0	0		0 -624, 316	1, 119, 782	5.00
	HHA REIMBURSABLE SERVICES		-				, , , -	
6.00	Skilled Nursing Care	0	0	0		0 0		•
7.00	Physical Therapy	0	0	0		0 0	434, 918	•
8.00	Occupational Therapy	0	0	0		0 0	143, 548	•
9.00	Speech Pathology	0	0	0		0 0	2, 953	
10. 00 11. 00	Medical Social Services Home Health Aide	0	0	0		0 0	13, 087 35, 251	
12.00	Supplies (see instructions)	0	0				35, 251	•
12.00	Drugs	0	0	0		0	0	
14.00	DME	0	0	0		0 0	-	
	HHA NONREI MBURSABLE SERVI CES							1
	Home Dialysis Aide Services	0	0			0 0		
16.00	Respiratory Therapy	0	0	0		0 0	-	
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	
19.00 20.00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	
	Home Delivered Meals Program	0	0	0		0 0		
22.00	Homemaker Service	0	0	0		0 0	0	
	All Others (specify)	0	0	0		0 0	0	
	Tel emedi ci ne	0	0	0		0 0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0		0 -624, 316	1, 119, 782	24.00
25.00	Cost To Be Allocated (per	0	0	0		0	624, 316	25.00
	Worksheet H-1, Part I)							
2/ 02	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0.00000		0. 557534	

Heal tl	n Financial Systems	MAR	GARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
ALLOC	ATION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	TERS	Provider CO	CN: 15-1329 15-7143	Period: From 01/01/2016 To 12/31/2016		pared:
						Home Health	PPS	2 pm
				CAPI TAL REL	ATED COSTS	Agency I		
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FLXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	EMPLOYEE BENEFI TS DEPARTMENT	
1.00		0	1.00	1.01	2.00	2.01	4.00	1.00
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ \end{array}$	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	0 763, 230 677, 400 223, 581 4, 599 20, 383 54, 905 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	47, 456 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0	471, 230 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ \end{array}$
	Cost Center Description	Subtotal	ADMI NI STRATI V E & GENERAL	OPERATI ON OF PLANT	OPERATION O PLANT -OFFSITE	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	
		4A	5.00	7.00	7.01	7.02	8.00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 15.00\\ 16.00\\ 19.50\\ 20.00\\ 21.00\\ \end{array}$	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	606, 564 763, 230 677, 400 223, 581 4, 599 20, 383 54, 905 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	114, 537 144, 122 127, 913 42, 219 868 3, 849 10, 368 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			29       16, 599         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         29       16, 599	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ \end{array}$

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

ALLOC	ATION OF GENERAL SERVICE COSTS	FO HHA COST CEN	TERS	Provider C HHA CCN:	CN: 15-1329 15-7143	Period: From 01/01/2016 To 12/31/2016		pared.
						Home Health	PPS	2 pm
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI N	Agency I CENTRAL 0 SERVI CES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 21. \ 00\\ \end{array}$	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	52, 747 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0       24         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       24		$\begin{array}{c} 2,00\\ 3,00\\ 4,00\\ 5,00\\ 6,00\\ 7,00\\ 8,00\\ 9,00\\ 10,00\\ 11,00\\ 12,00\\ 13,00\\ 14,00\\ 15,00\\ 16,00\\ 17,00\\ 18,00\\ 19,00\\ 19,50\end{array}$
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 21.\ 00\\ 21.\ 00\\ 21.\ 00\\ \end{array}$	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	875, 630 907, 352 805, 313 265, 800 5, 467 24, 232 65, 273 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		875, 6           907, 3           805, 3           265, 8           5, 4           24, 2           65, 2	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	1, 290, 536 1, 145, 403 378, 049 7, 776 34, 465 92, 838 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ \end{array}$

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

Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS T		GARET MARY COMM TERS STATISTICA			Period:	u of Form CMS-2 Worksheet H-2	
BASIS	U TITA COST CEN		HHA CCN:		From 01/01/2016 To 12/31/2016	Part II	pared:
					Home Health	PPS	•
		CAPI TAL RELA	TED COSTS		Agency I		
						Deservitientie	-
Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	NEW MVBLE EQUI P OFFSI T (SQUARE FEET)	DEPARTMENT (GROSS SALARI ES)	Reconciliatio n	
1.00 Administrative and Constal	<u>1.00</u> 3,415	1.01 219	2.00	2.01	4.00	5A 0	1 00
<ul> <li>1.00 Administrative and General</li> <li>2.00 Skilled Nursing Care</li> <li>3.00 Physical Therapy</li> <li>4.00 Occupational Therapy</li> <li>5.00 Speech Pathology</li> <li>6.00 Medical Social Services</li> <li>7.00 Home Health Aide</li> <li>8.00 Supplies (see instructions)</li> <li>9.00 Drugs</li> <li>10.00 DME</li> <li>11.00 Home Dialysis Aide Services</li> <li>12.00 Respiratory Therapy</li> <li>13.00 Private Duty Nursing</li> <li>14.00 Clinic</li> <li>15.00 Health Promotion Activities</li> <li>16.00 Day Care Program</li> <li>17.00 Home Dialvered Meals Program</li> <li>18.00 Homemaker Service</li> <li>19.00 All Others (specify)</li> <li>19.50 Telemedicine</li> <li>20.00 Total (sum of lines 1-19)</li> <li>21.00 Unit cost to be allocated</li> <li>22.00 Unit cost multiplier</li> </ul>	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21 50 2. 28310 OPERATI ON OF PLANT -	0 0 0 0 0 0 0 0 0 0 0 0 0 0	HOUSEKEEPI NG (SQUARE	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
	(ACCUM. COST)	(SQUARE FEET)	-OFFSI TE (SQUARE FEET)	HOSPI TAL & OFFS (SQUARE FEET)	(POUNDS OF LAUNDRY)	FEET)	
1.00 Administrative and General	5.00 606,564	7.00	7.01 219	7.02	8.00 5 0	<u>9.00</u> 3,415	1.00
<ul> <li>Administrative and ceneral</li> <li>Skilled Nursing Care</li> <li>O Skilled Nursing Care</li> <li>O Physical Therapy</li> <li>O Occupational Therapy</li> <li>So Speech Pathology</li> <li>Medical Social Services</li> <li>Home Heal th Ai de</li> <li>Supplies (see instructions)</li> <li>O Drugs</li> <li>D Drugs</li> <li>O Private Duty Nursing</li> <li>O Clinic</li> <li>O Pay Care Program</li> <li>O Day Care Program</li> <li>O Home Delivered Meals Program</li> <li>O Home Service</li> <li>O All Others (specify)</li> <li>Telemedicine</li> <li>O Total (sum of lines 1-19)</li> <li>O Total cost multiplier</li> </ul>	763, 230 677, 400 223, 581 4, 599 20, 383 54, 905 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	219 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 41 16, 59	0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         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>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td><td>$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 20.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$</td></t<>	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 20.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$

Heal th	Financial Systems	MAR	GARET MARY CON	IMUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	TERS STATISTIC	CAL Provider CO	CN: 15-1329	Period:	Worksheet H-2	
BASI S				HHA CCN:	15-7143	From 01/01/2016 To 12/31/2016	Part II Date/Time Pre	nared
				TILIX CON.	13 / 143		5/25/2017 2:4	
						Home Health	PPS	
						Agency I		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MEALS	(HOURS OF	ADMI NI STRATI O	SERVICES &	(100%	RECORDS &	
		SERVED)	SERVI CE)		SUPPLY	PHARMACY)	LIBRARY	
				(HOURS OF SERVICE)	(COSTED REQUIS.)		(TIME SPENT)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	10.00	11.00	13.00	35, 08		10.00	1.00
2.00	Skilled Nursing Care	0	0	0	00, 00	0 0	0	2.00
3.00	Physical Therapy	0	0	0		0 0	0	3.00
4.00	Occupational Therapy	0	0	0		0 0	0	4.00
5.00	Speech Pathology	0	0	0		0 0	0	5.00
6.00	Medical Social Services	0	0	0		0 0	0	6.00
7.00	Home Health Aide	0	0	0		0 0	0	7.00
8.00	Supplies (see instructions)	0	0	0		0 0	0	8.00
9.00	Drugs	0	0	0		0 0	0	9.00
10.00	DME	0	0	0		0 0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0		0 0	0	11.00
12.00	Respiratory Therapy	0	0	0		0 0	0	1.2.00
13.00	Private Duty Nursing	0	0	0		0 0	0	
14.00	Clinic	0	0	0		0 0	0	1 11 00
15.00	Health Promotion Activities	0	0	0		0 0	0	1 101 00
16.00	Day Care Program	0	0	0		0 0	0	1 .0.00
17.00	Home Delivered Meals Program	0	0	0		0 0	0	1
18.00	Homemaker Service	0	0	0		0 0	0	18.00
19.00	All Others (specify)	0	0	0		0 0	0	19.00
19.50	Tel emedi ci ne	0	0	0		0 0	0	1
20.00 21.00	Total (sum of lines 1-19) Total cost to be allocated	0	0	0	35, 08	24 0	0	20.00
	Unit cost multiplier	0. 000000	0. 000000	0. 000000			0	
22.00		0.000000	0.000000	0.00000	0.00000	0.000000	0.00000	22.00

Heal th	Financial Systems	MAR	GARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	TS		Provider C	CN: 15-1329	Period: From 01/01/2016	Worksheet H-3 Part I	
				HHA CCN:	15-7143	To 12/31/2016		pared: 2 pm
				Titl€	e XVIII	Home Health	PPS	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Agency I Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
		0	<u>Part I)</u> 1.00	Part II) 2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION						-	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care Physical Therapy	2.00 3.00	1, 290, 536	0	1, 290, 53		233.75	1.00 2.00
2.00 3.00	Occupational Therapy	4.00	1, 145, 403 378, 049				314. 41 316. 89	
4.00	Speech Pathol ogy	5.00	7, 776	C			131.80	
5.00	Medical Social Services	6.00	34, 465	-	34, 40		1, 914. 72	
6.00	Home Health Aide	7.00	92, 838		92, 83	38 692	134. 16	6.00
7.00	Total (sum of lines 1-6)		2, 949, 067	C				7.00
					Program Visi	ts		
					P	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					to	Deducti bl es		
					Deducti bl es			
		0	1.00	2.00	Coi nsurance 3.00	4.00	5.00	
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	5.00	
8.00	Skilled Nursing Care		17140	C	20	96		8.00
8.01	Skilled Nursing Care		50031	C	1	0		8.01
8.02	Skilled Nursing Care		50034	C		0		8. 02
8.03	Skilled Nursing Care		50035	C		0		8.03
8. 04 8. 05	Skilled Nursing Care Skilled Nursing Care		50042 99915	C	2,65	0		8.04 8.05
9.00	Physical Therapy		17140			18		9.00
9.01	Physical Therapy		50031	C	_	0		9.01
9.02	Physical Therapy		50034	C		0		9.02
9.03	Physical Therapy		50035	C		0		9.03
9.04	Physical Therapy		50042	C		0		9.04
9. 05 10. 00	Physical Therapy Occupational Therapy		99915 17140	C	1, 8: 1 ⁻			9.05 10.00
10.00	Occupational Therapy		50031	C	1	0		10.00
10.02	Occupational Therapy		50034	C		0		10.02
10.03	Occupational Therapy		50035	C		0		10.03
10.04	Occupational Therapy		50042	C		0		10.04
10. 05 11. 00	Occupational Therapy		99915 17140	C		32 9		10.05 11.00
11.00	Speech Pathology Speech Pathology		50031	C		0		11.00
11.02			50034	C		0		11.02
11.03	Speech Pathology		50035	C		0		11.03
11.04	Speech Pathology		50042	C		0		11.04
11.05	Speech Pathology		99915	C		5		11.05
12.00	Medical Social Services		17140	C		3		12.00
12. 01 12. 02	Medical Social Services Medical Social Services		50031 50034	C		0 0		12.01 12.02
12.02	Medical Social Services		50034 50035	C		0		12.02
12.03	Medical Social Services		50042	C		0		12.03
12.05	Medical Social Services		99915	C		8		12.05
13.00	Home Health Aide		17140	C	1.	15		13.00
13.01	Home Health Aide		50031	C		0		13.01
13.02	Home Health Aide		50034	C		0		13.02
13.03 13.04	Home Health Aide Home Health Aide		50035 50042	C		0		13.03 13.04
13.04 13.05	Home Health Aide		50042 99915			52		13.04
	Total (sum of lines 8-13)		,,,,,	C				14.00
	1 (	1				- I I	I	

	Financial Systems		GARET MARY COM				u of Form CMS-2	
APPORT	IONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-1329	Period: From 01/01/2016	Worksheet H-3 Part I	
				HHA CCN:	15-7143	To 12/31/2016	Date/Time Pre	pared:
				Title	e XVIII	Home Health	5/25/2017 2:4 PPS	2 pm
						Agency I		
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA		Ratio (col. 3	
		H-2 Part I,	Costs (from	Ancillary	Costs (col s.		÷ col. 4)	
		col. 28, line	Wkst. H-2, Part I)	Costs (from Part II)	1 + 2)	Records)		
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput							
15.00	Cost of Medical Supplies	8.00				0 0		
16.00	Cost of Drugs	9.00				0 0	0. 000000	16.00
			Program Visits		Cost of Services			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles & Coinsurance	Coi nsurance	
		6.00	Coi nsurance 7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION							
	Cost Per Visit Computation	-			1			
1.00 2.00	Skilled Nursing Care Physical Therapy	0	, · · ·			0 689, 796 0 643, 912		1.00 2.00
2.00	Occupational Therapy		2,048			0 843, 912		2.00
4.00	Speech Pathology	0	14			0 1,845		4.00
5.00	Medical Social Services	0	11			0 21,062		5.00
6.00	Home Health Aide	0	367			0 49, 237		6.00
7.00	Total (sum of lines 1-6)	0	6, 037			0 1, 610, 563		7.00
	Cost Center Description	( 00	7.00	0.00	0.00	10.00	11.00	
	Limitation Cost Computation	6.00	7.00	8.00	9.00	10.00	11.00	
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
8. 04 8. 05	Skilled Nursing Care Skilled Nursing Care							8.04 8.05
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
9.04	Physical Therapy							9.04
9. 05 10. 00	Physical Therapy Occupational Therapy							9.05 10.00
10.00	Occupational Therapy							10.00
10.02	Occupational Therapy							10.02
10.03								10.03
10.04	Occupational Therapy							10.04
10. 05 11. 00	Occupational Therapy Speech Pathology							10.05 11.00
11.00	Speech Pathology							11.00
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
11.04	Speech Pathology							11.04
11.05	Speech Pathology							11.05
12.00	Medical Social Services							12.00
	Medical Social Services							12.01
12.01	Medical Social Services							12.02 12.03
12.02	Medical Social Services	1						12.03
	Medical Social Services Medical Social Services				1		1	
12. 02 12. 03								12.05
12. 02 12. 03 12. 04 12. 05 13. 00	Medical Social Services Medical Social Services Home Health Aide							13.00
12. 02 12. 03 12. 04 12. 05 13. 00 13. 01	Medical Social Services Medical Social Services Home Health Aide Home Health Aide							13. 00 13. 01
12.02 12.03 12.04 12.05 13.00 13.01 13.02	Medical Social Services Medical Social Services Home Health Aide Home Health Aide Home Health Aide							13.00 13.01 13.02
12. 02 12. 03 12. 04 12. 05 13. 00 13. 01 13. 02 13. 03	Medical Social Services Medical Social Services Home Health Aide Home Health Aide Home Health Aide Home Health Aide							13.00 13.01 13.02 13.03
12. 02 12. 03 12. 04 12. 05 13. 00 13. 01 13. 02 13. 03 13. 04	Medical Social Services Medical Social Services Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide							13.00 13.01 13.02 13.03 13.04
12. 02 12. 03 12. 04 12. 05 13. 00 13. 01 13. 02 13. 03	Medical Social Services Medical Social Services Home Health Aide Home Health Aide Home Health Aide Home Health Aide							13.00 13.01 13.02 13.03

PORT	IONMENT OF PATIENT SERVICE COST	ΓS		Provider C	CN: 15-1329	Period: From 01/01/2016	Worksheet H-3 Part I	3
				HHA CCN:	15-7143	To 12/31/2016		eparec 12 pm
				Title	XVIII	Home Health Agency I	PPS	
		Prog	ram Covered Cha	arges	Cost of Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to Deductibles &	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles &	Subject to Deductibles & Coinsurance	
		6.00	Coi nsurance 7. 00	8.00	9.00	Coi nsurance	11.00	
. 00	Supplies and Drugs Cost Comput Cost of Medical Supplies	ations 0	0	0		0 0		15.0
00	Cost of Drugs		0					
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						-
	PART I - COMPUTATION OF LESSER		PROGRAM COST, A	AGGREGATE OF TH	HE PROGRAM L	IMITATION COST,	OR BENEFICIARY	
	COST LIMITATION							-
00	Cost Per Visit Computation Skilled Nursing Care	689, 796						1.0
00	Physical Therapy	643, 912						2.
00	Occupational Therapy	204, 711						3.
00 00	Speech Pathology Medical Social Services	1, 845 21, 062						4.
00	Home Heal th Aide	49, 237						6.
00	Total (sum of lines 1-6)	1, 610, 563						7.
	Cost Center Description							-
	Limitation Cost Computation	12.00						
00	Skilled Nursing Care							8.
01	Skilled Nursing Care							8.
02	Skilled Nursing Care							8.0
03 04	Skilled Nursing Care Skilled Nursing Care							8. 8.
04 05	Skilled Nursing Care							8.
00	Physical Therapy							9.
01	Physi cal Therapy							9.
02	Physical Therapy							9.
03	Physical Therapy							9.
04 05	Physical Therapy Physical Therapy							9. 9.
. 00	Occupational Therapy							10.
. 01	Occupational Therapy							10.
. 02	Occupational Therapy							10.
. 03	1 13							10.
. 04 . 05	Occupational Therapy							10.
. 00	Occupational Therapy Speech Pathology							11.
. 01	Speech Pathology							11.
. 02	Speech Pathology							11.
. 03	Speech Pathology							11.
. 04	Speech Pathology							11.
. 05 . 00	Speech Pathology Medical Social Services							11.
. 00	Medical Social Services							12.
. 02	Medical Social Services							12.
. 03	Medical Social Services							12.
	Medical Social Services							12.
. 04	Medical Social Services							12.
. 04 . 05	Home Health Aide	1						13.
. 04 . 05 . 00	Home Health Aide Home Health Aide							
2. 04 2. 05 3. 00 3. 01	Home Health Aide Home Health Aide Home Health Aide							
2. 04 2. 05 3. 00 3. 01 3. 02 3. 03	Home Health Aide Home Health Aide Home Health Aide							13. 13.
2. 03 2. 04 2. 05 3. 00 3. 01 3. 02 3. 03 3. 04 3. 05	Home Health Aide Home Health Aide							13. 13. 13. 13.

Health Financial Systems	MAR	GARET MARY CON	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provi der C	CN: 15-1329	Period: From 01/01/2016	Worksheet H-3 Part II	
			HHA CCN:	15-7143	To 12/31/2016		pared: 2 pm
			Title	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNI SHED I	BY SHARED HOSP	ITAL DEPARTME	INTS		
1.00 Physical Therapy	66.00	0. 548698	0		0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 520926	0		0 col. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0. 700926	0		0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	0. 401049	0		0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 325979	0		0 col. 2, line 1	6.00	5.00

ALCUL	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-1329		riod:	Worksheet H-4	
		HHA CCN:	15-7143	To	om 01/01/2016 12/31/2016		par 2 pi
		Title	XVIII	ł	Home Health Agency I	PPS	
				_	Par		
			Part A	C	Not Subject to Deductibles &	Subject to Deductibles & Coinsurance	
			1.00		Coi nsurance		
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	COMARY CHARGE	1.00		2.00	3.00	
	Reasonable Cost of Part A & Part B Services						1
00	Reasonable cost of services (see instructions)			0	0	0	1 1
00	Total charges			0	0	0	2
	Customary Charges		1	_	-	-	
00	Amount actually collected from patients liable for payment for on a charge basis (from your records)	or services		0	0	0	3
00	Amount that would have been realized from patients liable for	r payment		0	0	0	4
	for services on a charge basis had such payment been made in	accordance					
20	with 42 CFR §413.13(b)		0,0000	000	0,000000	0,000000	
)0 )0	Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions)		0.0000	00	0.000000	0.000000	
00	Excess of total customary charges over total reasonable cost	(complete		0	0	0	
-	only if line 6 exceeds line 1)				Ĵ	Ū	
00	Excess of reasonable cost over customary charges (complete or 1 exceeds line 6)	nlyifline		0	0	0	8
0	Primary payer amounts			0	о	0	
			1		Part A	Part B	
					Servi ces	Comidiana	
				-		Servi ces	-
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				1.00	2.00	F
00	Total reasonable cost (see instructions)						10
00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				1.00	2.00 0 1,035,856	1
00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers				1.00	2.00 0 1,035,856 4,099	1
00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes				1.00	2.00 0 1,035,856 4,099 11,731	1   1   1
00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes				1.00	2.00 0 1,035,856 4,099 11,731 2,050	1 1 1 1
00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers	5			1.00	2.00 0 1,035,856 4,099 11,731 2,050 1,170	1 1 1 1 1 1
00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes	5			1.00	2.00 0 1,035,856 4,099 11,731 2,050	1 1: 1: 1: 1: 1: 1: 1:
00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments	5			1.00	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0	1 1 1 1 1 1 1 1 1 1 1
00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments	5			1.00	2.00 1,035,856 4,099 11,731 2,050 1,170 0 0 0 0 0 0 0 0 0	1 1 1 1 1 1 1 1 1 1 1 1 1
00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments				1.00	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1 1 1 1 1 1 1 1 1 1 1 1 20
00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins				1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 1,035,856 4,099 11,731 2,050 1,170 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 2 2
00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21)				1.00	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0 0 0 0 1,054,906	11 11 11 11 11 11 11 11 11 11 11 11 20 22 22
00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)				1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0 0 0 0 0 0 0 0 0 0 0 0 0	11 12 12 14 14 14 14 14 15 16 15 16 17 17 20 20 22 22 22 22 22 22
00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21)				1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0 0 0 0 1,054,906	11 12 12 14 14 14 14 14 14 15 16 15 16 15 20 22 22 22 22 22 24
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)				1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0 0 0 0 1,054,906 0 1,054,906	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	surance)			1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0 0 0 0 0 0 1,054,906 0 1,054,906 0 0 1,054,906 0 0 0 0 0 0 0 0 0 0 0 0 0	111 12 14 14 14 14 14 14 14 14 14 14 14 14 14
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from dual eligible beneficiaries (see i	surance) nstructi ons;	)		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0 0 0 1,054,906 0 1,054,906 0 1,054,906	111 121 121 121 121 121 121 121 121 121
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus line	surance) nstructi ons;	)		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0 0 0 1,054,906 0 1,054,906 1,054,906 1,054,906	111 121 131 144 151 144 151 146 151 146 151 146 151 146 151 146 151 146 151 146 151 146 151 146 151 146 151 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 155 146 146 155 146 146 155 146 155 146 155 146 155 146 155 146 146 155 146 146 155 146 146 155 146 146 155 146 146 146 146 146 146 146 146 146 146
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	surance) nstructions; ne 27)	)		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0 0 0 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0	$ \begin{array}{c} 11\\ 12\\ 13\\ 14\\ 15\\ 16\\ 16\\ 20\\ 21\\ 22\\ 22\\ 24\\ 25\\ 26\\ 26\\ 26\\ 26\\ 30\\ \end{array} $
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus line	surance) nstructions; ne 27)	)		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0 0 0 1,054,906 0 1,054,906 1,054,906 1,054,906	111 12 13 14 15 16 15 16 15 16 15 16 20 21 22 22 22 22 22 22 22 22 22 22 22 22
.00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00           .00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	surance) nstructions; ne 27)	)		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0 0 0 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 0 0 0 0 0 0 0 0 0 0 0 0	111 12 12 14 14 14 14 14 14 14 14 14 14 14 14 14
. 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Qutlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Interim payments (see instructions)	surance) nstructions; ne 27)	)		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0 0 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906	111 121 121 121 121 121 121 121 121 121
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments DATE B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Subtotal (see instructions) Sequestration adjustment (see instructions) Tentative settlement (for contractor use only)	surance) nstructions, ne 27) ns)	)		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0 0 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 0 1,054,906 0 0 0 1,054,906 0 0 0 0 0 0 0 0 0 0 0 0 0	111 121 131 141 151 16 177 18 199 200 211 222 24 299 200 211 222 24 299 200 211 222 24 200 211 222 24 200 211 222 24 200 211 222 200 211 222 200 211 222 200 211 222 200 211 222 200 211 222 200 201 201
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Qutlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Interim payments (see instructions)	surance) nstructions; ne 27) ns) and 33)			1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 0 1,035,856 4,099 11,731 2,050 1,170 0 0 0 1,054,906 0 1,054,906 1,054,906 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 1,054,906 0 0 1,054,906 0 0 0 1,054,906 0 0 0 0 0 0 0 0 0 0 0 0 0	11111111111111111111111111111111111111

	SIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider C	CN: 15-1329		eriod:	Worksheet H-5	
PR(	DGRAM BENEFI CI ARI ES	HHA CCN:	15-7143		rom 01/01/2016 o 12/31/2016	Date/Time Prep 5/25/2017 2:42	
					Home Health Agency I	PPS	
		I npati en	t Part A		Par	t B	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
00	Total interim payments paid to provider	1.00	2.00	0	3.00	4.00 1,033,808	1
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0		0	2
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3
1	Program to Provider					0	
)1 )2				0		0	3
03				0		0	3
)4 )5				0		0	
10	Provider to Program			0		0	
0				0		0	
51				0		0	
52 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) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		1, 033, 808	4
0	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		[				
00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						Ę
1				0		0	Į
)2				0		0	5
)3	Provider to Program			0		0	5
50				0		0	Ę
51				0		0	5
52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0		0	5
0	5. 50-5. 98) Determined net settlement amount (balance due) based on			0		0	6
	the cost report. (1)						
)1 )2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0		0	
)2 )0	Total Medicare program liability (see instructions)			0		1, 033, 808	-
			·		Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)		1.00	2.00	

	Financial Systems M/ IS OF HOSPITAL-BASED HOSPICE COSTS	ARGARET MARY COMMU	Provider C		Per	ri od:	u of Form CMS-2 Worksheet O	2002-
			Hospi ce CCI			om 01/01/2016 12/31/2016		
						Hospi ce I	5/25/2017 2.4	2 pm
		SALARI ES	OTHER	SUBTOTAL (col. 1 plu col. 2)		RECLASSI FI - CATI ONS	SUBTOTAL	
		1.00	2.00	3.00		4.00	5.00	
	GENERAL SERVICE COST CENTERS	- <b>I</b>				1		
. 00	CAP REL COSTS-BLDG & FIXT*		0		0	0	0	1.0
. 00	CAP REL COSTS-MVBLE EQUIP*		0		0	0	0	2.0
. 00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		0	0	0	3.0
. 00	ADMI NI STRATI VE & GENERAL*	154, 942	152, 000			0	306, 942	4. (
. 00	PLANT OPERATION & MAINTENANCE*	0	11, 472	11, 4		0	11, 472	5.0
00	LAUNDRY & LINEN SERVICE*	0	0		0	0	0	6.0
. 00	HOUSEKEEPI NG*	0	0		0	0	0	
00	DI ETARY*	0	0		0	0	0	8.0
. 00	NURSI NG ADMI NI STRATI ON*	0	0		0	0	0	9. (
0. 00	ROUTINE MEDICAL SUPPLIES*	0	0		0	0	0	10. (
1.00	MEDICAL RECORDS*	0	0		0	0	0	11. (
2.00	STAFF TRANSPORTATION*	0	60, 611	60, 6		0	60, 611	
3.00	VOLUNTEER SERVICE COORDINATION*	0	0		0	0	0	
4.00	PHARMACY*	0	123, 211	123, 2		0	123, 211	
5.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	0		0	0	0	
6.00	OTHER GENERAL SERVICE (DELETED)*	0	0		0	0	0	
7.00	PATI ENT/RESI DENTI AL CARE SERVI CES							17.0
- 00	DI RECT PATI ENT CARE SERVICE COST CENTERS					0	0	0.5
5.00	INPATIENT CARE-CONTRACTED**	0	0		0	0	0	25.0
	PHYSICIAN SERVICES**	0	0		0	0	0	26.
7.00	NURSE PRACTITIONER** REGISTERED NURSE**	257.007	0	257.0	0	0	0	27.
3.00 9.00	LPN/LVN**	257, 097	0	257,0		0	257,097	
9.00 D.00	PHYSICAL THERAPY**	43, 261 0	0	43, 2	0	0	43, 261 0	
1.00	OCCUPATIONAL THERAPY**	0	0		0	0	0	
2.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		0	0	0	32.0
3.00	MEDICAL SOCIAL SERVICES**	59, 769	0	59, 7	60	0	59, 769	
4.00	SPIRITUAL COUNSELING**	27, 742	0	27,7		0	27, 742	
	DI ETARY COUNSELING**	27,742	0	27,7	0	0	27,742	
5.00	COUNSELING - OTHER**	0	0		0	0	0	
7.00	HOSPICE AIDE & HOMEMAKER SERVICES**	117, 026	0	117, 0	-	0	117, 026	
3.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	117,0	0	0	0	
9.00	PATI ENT TRANSPORTATI ON**	0	0		0	0	0	
). 00	I MAGI NG SERVI CES**	0	0		0	0	0	
1.00	LABS & DI AGNOSTI CS**	0	0		0	o	0	41.
	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0		0	0	0	
3.00	OUTPATI ENT SERVI CES**	0	0		0	0	0	43.
1.00	PALLIATIVE RADIATION THERAPY**	0	0		0	0	0	44.
5.00	PALLIATIVE CHEMOTHERAPY**	0	0		0	0	0	45.
5.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		0	0	0	46.0
	NONREIMBURSABLE COST CENTERS							
0. 00	BEREAVEMENT PROGRAM *	0	0		0	0	0	60.
1.00	VOLUNTEER PROGRAM *	0	0		0	0	0	61.0
. 00	FUNDRAI SI NG*	0	0		0	0	0	62.
. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		0	0	0	63.
. 00	PALLIATIVE CARE PROGRAM*	0	0		0	0	0	64.
. 00	OTHER PHYSICIAN SERVICES*	0	0		0	0	0	65.
. 00	RESI DENTI AL CARE*	0	0		0	0	0	66.
	ADVERTI SI NG*	0	0		0	0	0	
. 00	TELEHEALTH/TELEMONI TORI NG*	0	0		0	0	0	
. 00	THRIFT STORE*	0	0		0	0	0	
	NURSING FACILITY ROOM & BOARD*	0	0		0	0	0	
	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		0	0	0	
0 00	TOTAL	659, 837	347, 294	1,007,1	31	0	1,007,131	1100

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

NALYS	Financial Systems M IS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN:	15-1329	Period:	Worksheet 0	
			Hospi ce CCN:	15-1551	From 01/01/2016 To 12/31/2016	Date/Time Pr	
					Hospi ce I	5/25/2017 2:	42 pr
		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)				
		6.00	7.00				
00	GENERAL SERVICE COST CENTERS						1
00 00	CAP REL COSTS-BLDG & FIXT* CAP REL COSTS-MVBLE EQUIP*	0	0				1
00	EMPLOYEE BENEFITS DEPARTMENT*		0				
00	ADMI NI STRATI VE & GENERAL*		306, 942				4
00	PLANT OPERATION & MAINTENANCE*	0	11, 472				5
00	LAUNDRY & LINEN SERVICE*	0	0				6
00	HOUSEKEEPI NG*	0	0				7
00	DI ETARY*	0	0				8
00	NURSING ADMINISTRATION*	0	0				9
. 00	ROUTINE MEDICAL SUPPLIES*	0	0				10
. 00	MEDI CAL RECORDS*	0	0				11
. 00	STAFF TRANSPORTATION*	0	60, 611				12
. 00	VOLUNTEER SERVICE COORDINATION*	0	0				13
. 00	PHARMACY*	0	123, 211				14
	PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	0				15
5.00	OTHER GENERAL SERVICE (DELETED)*	0	0				16
7.00	PATI ENT/RESI DENTI AL CARE SERVI CES DI RECT PATI ENT CARE SERVI CE COST CENTERS						17
. 00	INPATIENT CARE-CONTRACTED**	0	0				25
. 00	PHYSICIAN SERVICES**		0				26
. 00	NURSE PRACTI TI ONER**		0				27
. 00	REGI STERED NURSE**	0	257, 097				28
0.00	LPN/LVN**	0	43, 261				29
. 00	PHYSICAL THERAPY**	0	0				30
I. 00	OCCUPATIONAL THERAPY**	0	0				31
2.00	SPEECH/LANGUAGE PATHOLOGY**	0	0				32
3.00	MEDICAL SOCIAL SERVICES**	0	59, 769				33
1.00	SPI RI TUAL COUNSELI NG**	0	27, 742				34
5.00	DI ETARY COUNSELI NG**	0	0				35
. 00	COUNSELING - OTHER**	0	0				36
7.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	117, 026				37
3.00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	0				38
2.00	PATIENT TRANSPORTATION**	0	0				39
. 00	I MAGI NG SERVI CES** LABS & DI AGNOSTI CS**	0	0				40
. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0				42
3. 00	OUTPATIENT SERVICES**		0				42
. 00	PALLIATIVE RADIATION THERAPY**		0				44
5.00	PALLIATIVE CHEMOTHERAPY**	0	0				45
. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0				46
	NONREI MBURSABLE COST CENTERS	- 1	1				
0. 00	BEREAVEMENT PROGRAM *	0	0				60
	VOLUNTEER PROGRAM *	0	0				61
. 00	FUNDRAI SI NG*	0	0				62
. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63
. 00	PALLIATIVE CARE PROGRAM*	0	0				64
	OTHER PHYSI CI AN SERVI CES*	0	0				65
	RESIDENTIAL CARE*	0	0				66
	ADVERTI SI NG*	0	0				67
. 00		0	0				68
	THRIFT STORE*	0	0				69
	NURSING FACILITY ROOM & BOARD*	0	0				70
	OTHER NONREIMBURSABLE (SPECIFY)* TOTAL		1, 007, 131				100
	sfer the amounts in column 7 to Wkst. 0-5,	U					100

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

	J	ARGARET MARY COMM			-	u of Form CMS-2	
	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSP	PICE ROUTINE HOME	Provider C	CN: 15-1329	Period:	Worksheet 0-2	
CARE			Hospi ce CCI	N: 15-1551	From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATI ONS		
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
	INPATIENT CARE-CONTRACTED						25.00
	PHYSI CI AN SERVI CES	0	0		0 0	0	26.00
27.00	NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00	REGI STERED NURSE	256, 527	0	256, 52	27 0	256, 527	28.00
29.00	LPN/LVN	43, 165	0	43, 10	65 0	43, 165	29.00
30.00	PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0		0 0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	59, 636	0	59, 6	36 0	59, 636	33.00
34.00	SPI RI TUAL COUNSELI NG	27, 680	0	27,6	80 0	27,680	34.00
35.00	DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00	COUNSELING - OTHER	0	0		0 0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	116, 766	0	116, 70	66 0	116, 766	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0		0 0	0	39.00
40.00	I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0		0 0	0	41.00
42 00	MEDICAL SUPPLIES-NON-ROUTINE		0		0 0	0	42 00

41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00		
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	0	0	0	42.00		
43.00	OUTPATI ENT SERVI CES	0	0	0	0	0	43.00		
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00		
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00		
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00		
100.00	TOTAL *	503, 774	0	503, 774	0	503, 774	100.00		
* Tran	* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.								

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED			25.00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTI TI ONER	0	0	27.00
28.00	REGI STERED NURSE	0	256, 527	28.00
29.00	LPN/LVN	0	43, 165	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	59, 636	33.00
34.00	SPI RI TUAL COUNSELI NG	0	27, 680	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	116, 766	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	503, 774	100.00
* Trans	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 51		

Health Financial Systems MAF	GARET MARY COMM			Inlie	u of Form CMS-:	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC		Provider CC		Period:	Worksheet 0-3	
RESPITE CARE				From 01/01/2016		
		Hospi ce CCN	: 15-1551	To 12/31/2016		
				Hospi ce I	5/25/2017 2:4	2 pili
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
	SHEMIN ES	OTTIER	(col. 1 +	CATIONS	OUDIONAL	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED	0	0		0 0	0	25.00
26.00 PHYSICIAN SERVICES	0	0		0 0	0	26.00
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	166	0		66 0	166	28.00
29.00 LPN/LVN	28	0		28 0	28	29.00
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31. 00 OCCUPATI ONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	39	0		39 0	39	33.00
34.00 SPIRITUAL COUNSELING	18	0		18 0	18	34.00
35.00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	76	0		76 0	76	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00 PATIENT TRANSPORTATION	0	0		0 0	0	39.00
40.00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.00
43.00 OUTPATIENT SERVICES	0	0		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100.00 TOTAL *	327	0	3	27 0	327	100.00

 45.00
 PALLIATIVE CHEMOTHERAPY
 0

 46.00
 OTHER PATIENT CARE SERVICES (SPECIFY)
 0

 100.00
 TOTAL *
 327

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

	ADJUSTMENTS	TOTAL (col. 5		
		± col. 6)	-	
	6.00	7.00		
DIRECT PATIENT CARE SERVICE COST CENTERS			1	
25.00 INPATIENT CARE-CONTRACTED	0	0		25.00
26.00 PHYSICIAN SERVICES	0	0		26.00
27.00 NURSE PRACTITIONER	0	0		27.00
28.00 REGI STERED NURSE	0	166		28.00
29.00 LPN/LVN	0	28		29.00
30. 00 PHYSI CAL THERAPY	0	0		30.00
31. 00 OCCUPATI ONAL THERAPY	0	0		31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00 MEDICAL SOCIAL SERVICES	0	39		33.00
34.00 SPIRITUAL COUNSELING	0	18		34.00
35.00 DI ETARY COUNSELI NG	0	0		35.00
36.00 COUNSELING - OTHER	0	0		36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	76		37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00 PATIENT TRANSPORTATION	0	0		39.00
40.00 I MAGI NG SERVI CES	0	0		40.00
41.00 LABS & DIAGNOSTICS	0	0		41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		42.00
43.00 OUTPATIENT SERVICES	0	0		43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00 TOTAL *	0	327		100.00
* Transfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 52			

	ARGARET MARY COMM				u of Form CMS-2	
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSP	I CE GENERAL	Provider CCN		Period: From 01/01/2016	Worksheet 0-4	ļ
INPATIENT CARE		Hospi ce CCN:		To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED	0	0		0 0	0	
26. 00 PHYSI CI AN SERVI CES	0	0		0 0	0	
27.00 NURSE PRACTITIONER	0	0		0 0	0	
28.00 REGI STERED NURSE	404	0	40		404	
29.00 LPN/LVN	68	0	6	68 0	68	
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	94	0	ç	94 0	94	33.00
34.00 SPI RI TUAL COUNSELI NG	44	0	4	14 0	44	34.00
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE ALDE & HOMEMAKER SERVICES	184	0	18	34 0	184	37.00
38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN						38.00
39.00 PATIENT TRANSPORTATION	0	0		0 0	0	39.00
40.00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.00
43.00 OUTPATIENT SERVICES	0	0		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45. 00 PALLI ATI VE CHEMOTHERAPY	o o	0		0 0	0	
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	
100. 00 TOTAL *	794	0	79	94 0		100.00

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

	· · · · · · · · · · · · · · · · · · ·			
		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTI TI ONER	0	0	27.00
28.00	REGI STERED NURSE	0	404	28.00
29.00	LPN/LVN	0	68	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	94	33.00
34.00	SPI RI TUAL COUNSELI NG	0	44	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	184	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38.00
39.00	PATI ENT TRANSPORTATI ON	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
	TOTAL *	0	794	100.00
-	sfer the amount in column 7 to Wkst. 0-5, col	umn 1 line 53		

Heal th	Financial Systems MARGARET MARY COMM	UNITY HOSPITA	L	In Lie	u of Form CMS-:	2552-10
COST A	ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-1329	Peri od:	Worksheet 0-5	
EXPENS	SES FOR ALLOCATION	Hospi ce CC	N: 15-1551	From 01/01/2016 To 12/31/2016		
				Hospi ce I	372372017 2.4	
	Descriptions		HOSPI CE	GENERAL	TOTAL	
			DI RECT	SERVI CE	EXPENSES (sum	
				EXPENSES FROM		
				) WKST B PART I	2)	
				(see	,	
				instructions)		
			1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 203, 122	203, 122	3.00
4.00	ADMI NI STRATI VE & GENERAL		306, 9	42 228, 532	535, 474	4.00
5.00	PLANT OPERATION & MAINTENANCE		11, 4	72 0	11, 472	5.00
6.00	LAUNDRY & LINEN SERVICE			0 0	0	6.00
7.00	HOUSEKEEPING			0 0	0	7.00
8.00	DI ETARY			0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON			0 0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES			0 9	9	10.00
11.00	MEDI CAL RECORDS			0 0	0	11.00
12.00	STAFF TRANSPORTATION		60, 6	11	60, 611	12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00	PHARMACY		123, 2	11 0	123, 211	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES			0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)			0 0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES			0	0	17.00
	LEVEL OF CARE		•		•	1
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		503, 7	74	503, 774	51.00
52.00	HOSPICE INPATIENT RESPITE CARE		3	27	327	52.00
53.00	HOSPICE GENERAL INPATIENT CARE		7	94	794	53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	61.00
62.00	FUNDRAI SI NG			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	65.00
66.00	RESI DENTI AL CARE			0	0	66.00
67.00	ADVERTI SI NG			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	68.00
69.00	THRI FT STORE			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)			0	0	71.00
99.00	NEGATI VE COST CENTER			0	0	99.00
100.00	) TOTAL		1, 007, 1	31 431, 663	1, 438, 794	100. 00

	2	RGARET MARY COM				u of Form CMS-2	
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI	ERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2016 To 12/31/2016		pared:
					Hospi ce I	0/20/2011 2.1	2 pm
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBI		SUBTOTAL	
		EXPENSES	& FIX	EQUI P	BENEFI TS		
					DEPARTMENT		
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	203, 122	0		0 203, 122		3.00
4.00	ADMI NI STRATI VE & GENERAL	535, 474	0		0 0	535, 474	4.00
5.00	PLANT OPERATION & MAINTENANCE	11, 472	0		0 0	11, 472	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	0	0		0 0	0	7.00
8.00	DI ETARY	0	0		0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0		0 0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	9	0		0 0	9	10.00
11.00	MEDI CAL RECORDS	0	0		0 0	0	11.00
12.00	STAFF TRANSPORTATION	60, 611	0		0 0	60, 611	
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	
14.00	PHARMACY	123, 211	0		0 0	123, 211	
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0		0 0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	Ŭ	0		0	0	17.00
	LEVEL OF CARE				0		
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	503, 774			202, 213		
52.00	HOSPI CE I NPATI ENT RESPI TE CARE	327	0		0 291	618	
53.00	HOSPICE GENERAL INPATIENT CARE	794	0		0 618		
00100	NONREI MBURSABLE COST CENTERS				010	.,	00100
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62.00	FUNDRAI SI NG	0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	l o	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	
65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	
69.00	THRI FT_STORE	0	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0		Ŭ Ŭ	0	70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0	Ω		0 0	0	
99.00	NEGATI VE COST CENTER	0	0		0 0		99.00
	TOTAL	1, 438, 794	0		0 203, 122	1, 438, 794	
100.00	1.0.00	1, 400, 794	0	I	200, 122	1 1, 430, 794	1.00.00

Heal th	Financial Systems M	ARGARET MARY COM	MUNITY HOSPITA	٨L	In L	ieu of Form CMS	-2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C Hospice CC	CN: 15-1329 N: 15-1551	Period: From 01/01/20 To 12/31/20		repared:
				_	Hospi ce I		
	Descriptions	ADMI NI STRATI V E & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVIO	HOUSEKEEPI N	G DI ETARY	
		4,00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS		0.00	0.00	7100	0100	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL	535, 474					4.00
5.00	PLANT OPERATION & MAINTENANCE	6, 800	18, 272				5.00
6.00	LAUNDRY & LINEN SERVICE	0,000	10, 272		0		6.00
7.00	HOUSEKEEPI NG	0			0	0	7.00
8.00	DI ETARY	0					0 8.00
9.00	NURSI NG ADMI NI STRATI ON	0				0	9.00
9.00		0				0	10.00
	ROUTINE MEDICAL SUPPLIES	5				0	
11.00	MEDICAL RECORDS	0					11.00
12.00	STAFF TRANSPORTATION	35, 929	C			0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	C			0	13.00
14.00	PHARMACY	73, 038	C			0	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0	C			0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	C			0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	C			0	17.00
	LEVEL OF CARE			1	-	-	
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	418, 499					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	366	5, 847		0	0	0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	837	12, 425	b l	0	0	0 53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	C			0	60.00
61.00	VOLUNTEER PROGRAM	0	C			0	61.00
62.00	FUNDRAI SI NG	0	C			0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	C			0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	C			0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	C			0	65.00
66.00	RESI DENTI AL CARE	0	C		0	0	0 66.00
67.00	ADVERTI SI NG	0	C			0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	C			0	68.00
69.00	THRI FT STORE	0	C			0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
	OTHER NONREI MBURSABLE (SPECIFY)	0	C		0	0	0 71.00
	NEGATI VE COST CENTER	0	Ċ		0	0	0 99.00
	TOTAL	535, 474	18, 272		0	0	0 100.00
	1			1	i.	i.	

	Financial Systems ALLOCATION - HOSPITAL-BASED HOSPICE GENERA	MARGARET MARY COMM	Provi der C		P	eriod:	u of Form CMS-: Worksheet 0-6	
0001 7	LEGGATION - HOSTITAL-DASED HOSTICE GENERA	L SERVICE COSTS		GN. 13-1327		rom 01/01/2016	Part I	,
			Hospi ce CCI	N: 15-1551	T		Date/Time Pre	pared:
						Hospice I	5/25/2017 2:4	2 pm
	Descriptions	NURSI NG	ROUT I NE	MEDI CAL		STAFF	VOLUNTEER	
		ADMI NI STRATI O	MEDI CAL	RECORDS		TRANSPORTATI 0	SERVI CE	
		N	SUPPLI ES			Ν	COORDI NATI ON	
		9.00	10.00	11.00		12.00	13.00	
	GENERAL SERVICE COST CENTERS			-				
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMI NI STRATI VE & GENERAL							4.00
5.00	PLANT OPERATION & MAINTENANCE							5.00
6.00	LAUNDRY & LINEN SERVICE							6.00
7.00	HOUSEKEEPI NG							7.00
8.00	DI ETARY							8.00
9.00	NURSING ADMINISTRATION	0						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	14					10.00
11.00	MEDI CAL RECORDS	0			0			11.00
12.00	STAFF TRANSPORTATION	0				96, 540		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0				0	0	13.00
14.00	PHARMACY	0				0	0	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0				0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0				0	0	16.00
17.00	. ,							17.00
	LEVEL OF CARE	I		1		1		
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	0	0	1 50. OC
51.00	HOSPICE ROUTINE HOME CARE	0	14		0		0	51.00
52.00	HOSPI CE I NPATI ENT RESPI TE CARE	0	0		0		0	52.00
53.00		0	0		0		0	
	NONREIMBURSABLE COST CENTERS	łłł_		1		1		
60.00		0				0	0	60.00
61.00	VOLUNTEER PROGRAM	0				0	0	61.00
62.00	FUNDRAI SI NG	0				0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0				0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0				0	0	65.00
66.00	RESI DENTI AL CARE	0				0	0	66.00
67.00		0				0	0	67.00
68.00		0				0	0	
69.00		0				o	0	
	NURSING FACILITY ROOM & BOARD							70.00
	OTHER NONREI MBURSABLE (SPECIFY)	0				о	0	
	NEGATI VE COST CENTER	0	0		0	0	0	
	TOTAL	o	14		0	-	0	100.00

COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C Hospice CC	CN: 15-1329 N: 15-1551	Period: From 01/01/2016 To 12/31/2016	Worksheet 0-0 Part I Date/Time Pro 5/25/2017 2:4	epared:
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN ADMI NI STRATI V E SERVI CES	OTHER GENERA SERVI CE (DELETED)	AL PATI ENT/ RESI DENTI AL CARE SERVI CES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00							13.00
	PHARMACY	196, 249					14.00
	PHYSICIAN ADMINISTRATIVE SERVICES	0	C				15.00
	OTHER GENERAL SERVICE (DELETED)	0			0		16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES				0		17.00
	LEVEL OF CARE	0		J			
50.00	HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE	105 272			0	1 415 002	
	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	195, 373 282			0 0 0	1, 415, 982 7, 251	
	HOSPICE INPATIENT RESPITE CARE	594			0 0 0 0	15, 561	
55.00	NONREI MBURSABLE COST CENTERS	574	U	<u>′</u>	0 0	15, 50	53.00
60 00	BEREAVEMENT PROGRAM	0			0	(	60.00
	VOLUNTEER PROGRAM	0			0	(	
	FUNDRAI SI NG	0			0	(	
	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	(	
	PALLIATIVE CARE PROGRAM	0			0	(	
	OTHER PHYSICIAN SERVICES	0			0	(	
	RESI DENTI AL CARE	0	C		0 0	(	
	ADVERTI SI NG	0			0	(	
	TELEHEALTH/TELEMONI TORI NG	0			0	(	
	THRI FT STORE	0		1	0	(	
	NURSING FACILITY ROOM & BOARD	1				(	
	OTHER NONREI MBURSABLE (SPECIFY)	0	C		0 0	(	
	NEGATI VE COST CENTER	0	C		0 0	C	99.00
	TOTAL	196, 249	C		0 0	1, 438, 794	100 00

Heal th	Financial Systems	MARGARET MARY CON	IMUNI TY HOSPI TA	L	In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENE	ERAL SERVICE COSTS	Provider CO	CN: 15-1329	Peri od:	Worksheet 0-6	
STATI S	TI CAL BASI S		lloopi oo CCI	. 1E 1EE1	From 01/01/2016		norod.
			Hospi ce CCI	N: 15-1551	To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
					Hospi ce I	0/20/2011 2.1	2 pm
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	RECONCILIATIO	ADMI NI STRATI V	
		& FIX	EQUI P	<b>BENEFITS</b>	Ν	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
			VALUE)	(GROSS		COSTS)	
				SALARI ES)			
	Γ	1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS		1	1			
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	659, 83			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0		0 -535, 474	903, 320	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	11, 472	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	0	0		0 0	0	7.00
8.00	DI ETARY	0	0		0 0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0 0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0 0	9	10.00
11.00	MEDI CAL RECORDS	0	0		0 0	0	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	60, 611	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.00
14.00	PHARMACY	0	0		0 0	123, 211	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	-		0 0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE				-	-	
50.00	HOSPICE CONTINUOUS HOME CARE			151.00	0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			656, 88		705, 987	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0		94		618	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	2,00	06 0	1, 412	53.00
(0.00	NONREI MBURSABLE COST CENTERS		0		0	0	40.00
60.00	BEREAVEMENT PROGRAM	0			0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62.00 63.00	FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	62.00 63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	65.00
66. 00		0	0		0 0	0	66.00
67.00	RESI DENTI AL CARE ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
69.00	THRIFT STORE	0	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0		0 0	0	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)				0 0	0	1
	NEGATIVE COST CENTER					0	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, P	Part I)	0	203, 12	22	535, 474	
	UNIT COST MULTIPLIER	0. 000000	0. 000000			0. 592784	1
		1 0.00000		0.00700		0.0.2701	1.511.00

Heal th	Financial Systems MAI	RGARET MARY COMM	IUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI	ERVICE COSTS	Provider C	CN: 15-1329	Period:	Worksheet 0-6	)
STATI S	TI CAL BASI S		Hospice (C)	N: 15-1551	From 01/01/2016 To 12/31/2016		nared
			nospi ce cci	N. 15-1551	10 12/31/2010	5/25/2017 2:4	
-					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI N	G DI ETARY	NURSI NG	
	·	OPERATION & I	LINEN SERVICE	(SQUARE FEET	) (IN-FACILITY	ADMI NI STRATI O	
		MAI NTENANCE	(IN-FACILITY		DAYS)	Ν	
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
						HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	1		1			
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL	10.05/					4.00
5.00	PLANT OPERATION & MAINTENANCE	18, 256					5.00
6.00	LAUNDRY & LINEN SERVICE	0	74		- ,		6.00
7.00	HOUSEKEEPING	0		18, 2			7.00
8.00		0			0 74		8.00
9.00	NURSI NG ADMI NI STRATI ON	0			0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0			0	0	10.00
11.00	MEDI CAL RECORDS	0			0	0	11.00
12.00	STAFF TRANSPORTATION	0			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00		0			0	0	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0			0	0	15.00
16.00 17.00	OTHER GENERAL SERVICE (DELETED)	0			0	0	16.00 17.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	U			0		17.00
50.00	HOSPICE CONTINUOUS HOME CARE			1	-	0	50.00
50.00	HOSPICE CONTINUOUS HOME CARE					0	51.00
52.00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	5, 842	23	5,6	74 23	0	52.00
52.00	HOSPICE GENERAL INPATIENT CARE	12, 414	51			0	53.00
55.00	NONREI MBURSABLE COST CENTERS	12, 414	51	12, 50	52 51	0	33.00
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES	0			0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0 0	0	71.00
		1		1			•
99.00	NEGATI VE COST CENTER						99.00
	NEGATIVE COST CENTER COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	18, 272	0		0 0	0	99.00 100.00

Heal th	Financial Systems MAR	GARET MARY COMML	JNI TY HOSPI TA	L	In Lie	u of Form CMS-:	2552-10
COST A	NLLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provider C		Period: From 01/01/2016	Worksheet 0-6 Part II	)
			Hospi ce CC	N: 15-1551	To 12/31/2016		
					Hospi ce I	5/25/2017 2:4	z pili
	Cost Center Descriptions	ROUTINE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATIO	SERVI CE	(CHARGES)	
		SUPPLI ES	(PATI ENT	N	COORDI NATI ON		
		(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS)			SERVICE)		
-		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS			1			
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00 7.00	LAUNDRY & LINEN SERVICE						6.00 7.00
7.00 8.00	HOUSEKEEPI NG DI ETARY						8.00
8.00 9.00	NURSI NG ADMI NI STRATI ON						9.00
9.00 10.00	ROUTINE MEDICAL SUPPLIES	11, 183					10.00
11.00	MEDICAL RECORDS	11, 103	1, 163				11.00
12.00	STAFF TRANSPORTATION		1, 103	96, 45	5		12.00
13.00	VOLUNTEER SERVICE COORDINATION				0 0		13.00
14.00	PHARMACY				0 0	13, 217	
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES					0	
16.00	OTHER GENERAL SERVICE (DELETED)					0	
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES				о 0	0	17.00
	LEVEL OF CARE			1			1
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	11, 133	1, 113	96, 02		13, 158	•
52.00	HOSPICE INPATIENT RESPITE CARE	16	16		8 0	19	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	34	34	29	3 0	40	53.00
	NONREIMBURSABLE COST CENTERS						1
60.00	BEREAVEMENT PROGRAM				0 0	0	60.00
61.00	VOLUNTEER PROGRAM				0 0	0	61.00
62.00	FUNDRAI SI NG				0 0	0	
63.00	HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS				0 0	0	
64.00	PALLIATIVE CARE PROGRAM				0 0	0	
65.00	OTHER PHYSICIAN SERVICES				0 0	0	
66.00	RESI DENTI AL CARE				0 0	0	
67.00	ADVERTI SI NG				0 0	0	
68.00	TELEHEALTH/TELEMONI TORI NG				0 0	0	
69.00	THRIFT STORE				0 0	0	
70.00	NURSING FACILITY ROOM & BOARD					-	70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)				0 0	0	
99.00	NEGATIVE COST CENTER	1.4	~	04 54		104 040	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	14 0. 001252	0 0. 000000			196, 249	
101.00	UNIT COST MULTIPLIER	0.001252	0.000000	1. 00088	0.00000	14.848226	101.00

Heal th	Financial Systems MAR	RGARET MARY CON	IMUNITY HOSPITA	L	In Lieu	u of Form CMS	-2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provider C	CN: 15-1329	Period:	Worksheet 0-	-6
STATI S	ITI CALI BASI S		Hospi ce CC	N: 15-1551	From 01/01/2016 To 12/31/2016	Part II Date/Time Pr	enared.
			nospi ce co	N. 15-1551	10 12/31/2010	5/25/2017 2:	
			_		Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL				
		ADMI NI STRATI V	SERVI CE	RESI DENTI AL			
		E SERVICES	(DELETED)	CARE SERVICE			
		(PATI ENT	(SPECI FY	(IN-FACILIT	Y		
		DAYS) 15.00	BASIS)	DAYS)			
	GENERAL SERVICE COST CENTERS	15.00	16.00	17.00			-
1.00	CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	CAP REL COSTS-BEDG & TTXT						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	11, 458					15.00
16.00	OTHER GENERAL SERVICE (DELETED)		0				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				74		17.00
F0 00	LEVEL OF CARE	0	0	1			
50.00 51.00	HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE	11, 384					50.00 51.00
52.00	HOSPICE INPATIENT RESPITE CARE	23			23		51.00
53.00	HOSPICE GENERAL INPATIENT CARE	51	0		23 51		53.00
55.00	NONREI MBURSABLE COST CENTERS	51		۰ ۱	51		
60,00	BEREAVEMENT PROGRAM		0				60.00
61.00	VOLUNTEER PROGRAM		0				61.00
62.00	FUNDRAI SI NG		0	)			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0	)			63.00
64.00	PALLIATIVE CARE PROGRAM		0				64.00
65.00	OTHER PHYSICIAN SERVICES		0				65.00
66.00	RESI DENTI AL CARE	0	0		0		66.00
67.00	ADVERTI SI NG		0				67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0				68.00
69.00	THRI FT STORE		0				69.00
70.00	NURSING FACILITY ROOM & BOARD	_	-				70.00
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0	0		0		71.00
99.00	NEGATIVE COST CENTER	_			0		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I) UNIT COST MULTIPLIER	0. 000000	0. 000000		0		100. 00 101. 00
101.00	UNIT COST MULTIPLIER	0.00000	J 0. 000000	U. 0000			101.00

	n Financial Systems M. TIONMENT OF HOSPITAL-BASED HOSPICE SHARED SE	ARGARET MARY COM RVICE COSTS BY	Provider C		Peri od:	u of Form CMS-: Worksheet 0-7	
	OF CARE			N: 15-1551	From 01/01/2016 To 12/31/2016		pared:
					Hospi ce I		
				Charges by	/ LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	НСНС	HRHC	HI RC	
		0	1.00	2.00	3.00	4.00	
1 00	ANCI LLARY SERVICE COST CENTERS		0 546/00			-	
1.00 2.00 3.00	PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY	66.00 67.00 68.00	0. 548698 0. 520926 0. 700926		0 0 0 0 0 0	0 0 0	1.00 2.00 3.00
4.00 5.00 6.00	DRUGS CHARGED TO PATI ENTS DURABLE MEDI CAL EQUI P-RENTED LABORATORY	73.00 96.00 60.00	0. 325979 0. 202982		0 0 0 0	0	4.00 5.00 6.00
5.01 7.00 3.00 9.00 10.00	BLOOD LABORATORY MEDICAL SUPPLIES CHARGED TO PATIENTS OTHER OUTPATIENT SERVICE COST CENTER RADIOLOGY-THERAPEUTIC OTHER ANCILLARY SERVICE COST CENTERS Totals (sum of lines 1-11)	60. 01 71. 00 93. 00 55. 00 76. 00	0. 000000 0. 401049		0 0 0 0	0 0	6.01 7.00 8.00 9.00 10.00
1.00		Charges by LOC (from Provider Records)		Shared Serv	ice Costs by LOC		11.00
	Cost Center Descriptions	HGI P 5. 00	HCHC (col. 1 x col. 2) 6.00	HRHC (col. x col. 3) 7.00	1 HIRC (col. 1 x col. 4) 8.00	HGIP (col. 1 x col. 5) 9.00	
	ANCILLARY SERVICE COST CENTERS	5.00	0.00	7.00	0.00	7.00	
. 00 . 00 . 00 . 00	PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY DRUGS CHARGED TO PATIENTS	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0 0 0	0 0 0 0	1.00 2.00 3.00 4.00
5.00 5.00 5.01 7.00	DURABLE MEDI CAL EQUI P-RENTED LABORATORY BLOOD LABORATORY MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	000000000000000000000000000000000000000	0 0 0		0 0 0 0 0 0	0 0 0	5.00 6.00 6.01 7.00
3.00 9.00 10.00 11.00	OTHER OUTPATIENT SERVICE COST CENTER RADIOLOGY-THERAPEUTIC OTHER ANCILLARY SERVICE COST CENTERS Totals (sum of lines 1-11)		0		0 0	0	8.00 9.00 10.00 11.00

LCUL	ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provider CC	CN: 15-1329		riod: om 01/01/2016	Worksheet 0-8	
		Hospi ce CCN	l: 15-1551	То		Date/Time Prep 5/25/2017 2:42	
					Hospi ce I		
			TITLE XVIII MEDICARE	I	TITLE XIX MEDICAID	TOTAL	
			1.00		2.00	3.00	
	HOSPI CE CONTI NUOUS HOME CARE						
00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	-7, col. 6,				0	1.
	line 11)						
00	Total unduplicated days (Wkst. S-9, col. 4, line 10)					0	2.
00	Total average cost per diem (line 1 divided by line 2)					0.00	3.
00	Unduplicated program days (Wkst. S-9 col. as appropriate, lin	ne 10)		0	0		4.
00	Program cost (line 3 times line 4)			0	0		5.
	HOSPICE ROUTINE HOME CARE						
00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	-7, col. 7,				1, 415, 982	6
	line 11)						
00	Total unduplicated days (Wkst. S-9, col. 4, line 11)					11, 133	7
00	Total average cost per diem (line 6 divided by line 7)					127.19	8
00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ine 11)	10, 7	93	71		9
. 00	Program cost (line 8 times line 9)		1, 372, 7	62	9, 030		10
	HOSPICE INPATIENT RESPITE CARE						
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	-7, col. 8,				7, 251	11
	line 11)						
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)					16	12
. 00	Total average cost per diem (line 11 divided by line 12)					453.19	13
. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ine 12)		7	0		14
. 00	Program cost (line 13 times line 14)		3, 1	72	0		15
	HOSPI CE GENERAL I NPATI ENT CARE						
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	-7, col. 9,				15, 561	16
	line 11)						
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)					34	17
00	Total average cost per diem (line 16 divided by line 17)					457.68	18
. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ine 13)		17	0		19
. 00	Program cost (line 18 times line 19)		7,7	81	0		20
	TOTAL HOSPICE CARE						
00	Total cost (sum of line 1 + line 6 + line 11 + line 16)					1, 438, 794	21
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 14)					11, 183	22
. 00	Average cost per diem (line 21 divided by line 22)					128.66	23

		GARLI WART COW	MUNITY HOSPITA				u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1329	Pe	eriod: rom 01/01/2016	Worksheet M-1	
			Component	CCN: 15-8511	To		Date/Time Pre 5/25/2017 2:4	
						RHC I	Cost	
		Compensati on	Other Costs		1	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)		i ons	Trial Balance	
							(col. 3 +	
		1.00	2.00	2.00		4.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00		4.00	5.00	
1.00	Physician	168, 451	0	168, 4	51	0	168, 451	1.00
2.00	Physician Assistant	116, 733	0	100/ 1		0	116, 733	2.00
3.00	Nurse Practitioner	7, 664	0	7,6		0	7, 664	3.00
4.00	Visiting Nurse	7,004	0	7,0	04	0	7, 004 0	4.00
5.00	Other Nurse	41, 602	0	41, 6	-	0	41, 602	5.00
6.00	Clinical Psychologist	41,002	0	41,0	02	0	41,002	6.00
7.00	Clinical Social Worker	0	0		0	0	0	7.00
8.00	Laboratory Techni ci an	0	0		0	0	0	8.00
8.00 9.00		69, 705	0	69, 7	~	0	-	9.00
	Other Facility Health Care Staff Costs		0			0	69, 705	
10.00	Subtotal (sum of lines 1 through 9)	404, 155	0	404, 1		0	404, 155	10.00
11.00	Physician Services Under Agreement	0	0		0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		~	0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	0	14.00
15.00	Medical Supplies	0	0		0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0		0	0	0	16.00
	Depreciation-Medical Equipment	0	0		0	0	0	17.00
18.00	Professional Liability Insurance	0	0		0	0	0	18.00
19.00	Other Health Care Costs	0	0		0	0	0	19.00
	Allowable GME Costs							20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of	404, 155	0	404, 1	55	0	404, 155	22.00
	lines 10, 14, and 21)							
23.00	COSTS OTHER THAN RHC/FQHC SERVICES Pharmacy	0	0	1	0	0	0	23.00
23.00	Dental	0	0		0	0	0	23.00
24.00	Optometry	0	0		0	0	0	24.00
25.00	Tel eheal th	0	0		0	0	0	25.00
		0	0		0	0	0	
25.02	Chronic Care Management	0	0		0	0	-	25.02
26.00	All other nonreimbursable costs	0	0		0	0	0	26.00
27.00	Nonallowable GME costs		0		~	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	28.00
	through 27) FACILITY OVERHEAD							
29.00	Facility Costs	0	80, 821	80, 8	21	0	80, 821	29.00
30.00	Administrative Costs	0 174, 073	00, 021	174.0		0	80, 821 174, 073	30.00
30.00	Total Facility Overhead (sum of lines 29 and	174,073	80, 821	254, 8		0	254, 894	30.00
51.00	30)	174,073	8U, 82 I	254, 8	74	0	∠54, 8 <b>9</b> 4	31.00
32.00	Total facility costs (sum of lines 22, 28	578, 228	80, 821	659, 0	10	0	659, 049	32.00
JZ. UU	TOTAL FACTORY COSTS (SUII OF TIMES 22, 20	J/U, ZZO	00, 021	0.57,0	+7	0	037,049	JZ. 00

	Financial Systems MAR	GARET MARY CON		CN: 15-1329	Peri od:	u of Form CMS- Worksheet M-	
				CCN: 15-8511	From 01/01/2016 To 12/31/2016		epared:
					RHC I	Cost	42 pili
		Adjustments	Net Expenses			0001	
		5	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS		1	1			
1. 00	Physi ci an	0					1.00
2.00	Physician Assistant	0		1			2.00
3.00	Nurse Practitioner	0		1			3.00
4.00	Visiting Nurse	0	-				4.00
5.00	Other Nurse	0					5.00
6.00	Clinical Psychologist	0	-				6.00
7.00	Clinical Social Worker	0	-				7.00
8.00	Laboratory Techni ci an	0					8.00
9.00	Other Facility Health Care Staff Costs	0					9.00
10.00	Subtotal (sum of lines 1 through 9)	0					10.00
11.00	Physician Services Under Agreement	0					11.00
12.00	Physician Supervision Under Agreement	0	-				12.00
	Other Costs Under Agreement	0					13.00
14.00	Subtotal (sum of lines 11 through 13)	0					14.00
	Medical Supplies	0					15.00
	Transportation (Health Care Staff)	0					16.00
17.00	Depreciation-Medical Equipment	0					17.00
	Professional Liability Insurance	0	-				18.00
	Other Health Care Costs	0	C	D			19.00
	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	-	1			21.00
22.00	Total Cost of Health Care Services (sum of	0	404, 155				22.00
	lines 10, 14, and 21)						-
22 00	COSTS OTHER THAN RHC/FQHC SERVICES	0					
23.00	Pharmacy Dental	0					23.00
24.00		0	-				24.00
25.00	Optometry Telehealth	0	-				25.00
	Chronic Care Management	0					25.01
26.02	All other nonreimbursable costs	0	-				26.00
27.00	Nonallowable GME costs	0					20.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0					27.00
20.00	through 27)	0					20.00
	FACILITY OVERHEAD			1			
29.00	Facility Costs	0	80, 821				29.00
30.00	Administrative Costs	0		1			30.00
31.00	Total Facility Overhead (sum of lines 29 and	0					31.00
	30)	0	20.,07				
32.00	Total facility costs (sum of lines 22, 28	0	659, 049				32.00
	and 31)						1

	· · · · · · · · ·	MARGARET MARY CON				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQH	C SERVICES	Provider C		Period: From 01/01/2016	Worksheet M-2	
			Component		To 12/31/2016	Date/Time Pre	pared:
						5/25/2017 2:4	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)		col. 2 or	
		1.00	0.00		1 x col. 3)	col . 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
1 00	Positions	0.(0	0.400	1.00			1 00
1.00	Physi ci an	0.62					1.00
2.00	Physician Assistant	0.85					2.00
3.00	Nurse Practitioner	0.07					3.00
4.00	Subtotal (sum of lines 1 through 3)	1.54			4, 536		4.00
5.00	Visiting Nurse	0.00				0	5.00
5.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7.02
0 00	only)	1 54	4 246			4 524	8.00
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.54	4, 246			4, 536	8.00
9.00	Physician Services Under Agreements		0			0	9.00
9.00	Physicial services under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPITAL-BAS	ED RHC/EOHC SE	RVLCES		1.00	
10.00	Total costs of health care services (from					404, 155	10.00
11.00	Total nonreimbursable costs (from Wkst. M-						11.00
12.00	Cost of all services (excluding overhead)		,			404, 155	
13.00	Ratio of hospital -based RHC/FQHC services					1.000000	
4.00	Total hospital-based RHC/FQHC overhead - (			ine 31)		254, 894	
15.00	Parent provider overhead allocated to faci					388, 581	
16.00	Total overhead (sum of lines 14 and 15)		,			643, 475	
17.00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					643, 475	
18.00						,	
	Overhead applicable to hospital-based RHC/	'FQHC services (I	ine 13 x line	18)		643, 475	19,00

ALCUL	Financial Systems MARGARET MARY COMMUN ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1329	Peri od:	Worksheet M-3	8
			From 01/01/2016		
		Component CCN: 15-8511	To 12/31/2016	Date/Time Pre 5/25/2017 2:4	
		Title XVIII	RHC I	Cost	
		· · · · ·			
				1.00	
00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (fro	www.kst M 2 Lipo 20)		1,047,630	1 1.
00	Cost of vaccines and their administration (from Wkst. M-4, li			1, 047, 830	
00	Total allowable cost excluding vaccine (line 1 minus line 2)	ne is)		934, 568	
00	Total Visits (from Wkst. M-2, column 5, line 8)			4, 536	
00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		1,000	
00	Total adjusted visits (line 4 plus line 5)			4, 536	
00	Adjusted cost per visit (line 3 divided by line 6)			206.03	7
			Calculation	of Limit (1)	
			Prior to	On or After	
			January 1	January 1	
			1.00	2.00	
	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	80. 44	81.32	
00	Rate for Program covered visits (see instructions)		206.03	206.03	9
	CALCULATION OF SETTLEMENT				-
	Program covered visits excluding mental health services (from contractor records) 0			906	
	Program cost excluding costs for mental health services (line 9 x line 10) 0		186, 663		
	Program covered visits for mental health services (from contr		0	0	
	Program covered cost from mental health services (line 9 x li		0	0	
	Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instruction		0	0	14
	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	186, 663	
	Total program charges (see instructions) (from contractor's re		0	127, 115	
	Total program preventive charges (see instructions)(from prov			4, 298	
	Total program preventive costs ((line 16.02/line 16.01) times	,		6, 311	
	Total Program non-preventive costs ((line 16 minus lines 16.0			129, 096	
	(Titles V and XIX see instructions.)			,	
6. 05	Total program cost (see instructions)		0	135, 407	16
7.00	Primary payer amounts			0	17
3. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		18, 982	18
	records)				
9.00	Beneficiary coinsurance for RHC/FQHC services (see instructio	ons) (from contractor		20, 767	19
0. 00	records) Net Medicare cost excluding vaccines (see instructions)			135, 407	20
	Program cost of vaccines and their administration (from Wkst.	$M_{-4}$ line 16)		61, 317	
	Total reimbursable Program cost (line 20 plus line 21)	w 4, The Toy		196, 724	
	Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	25
	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	25
5.00	Net reimbursable amount (see instructions)			196, 724	26
	Sequestration adjustment (see instructions)			3, 934	
	Interim payments			130, 929	
	Tentative settlement (for contractor use only)			0	
	Balance due component/program (line 26 minus lines 26.01, 27,			61, 861	
0.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II		0	30

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10			
		Peri od:	Worksheet M-4		
VACCIN	E COST		From 01/01/2016 To 12/31/2016		
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		404, 155		1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,	1, 788		3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	5	22, 702		4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu		24, 490		5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22			6.00
7.00	Total overhead (from Wkst. M-2, line 19)		643, 475		7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6)	tal direct cost (line 5	0. 060596	0. 047326	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	38, 992	30, 453	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their)		63, 482		
101.00	lines 5 and 9)		00,102		101.00
11.00	Total number of pneumococcal and influenza vaccine injections		89	230	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1		713.28	215. 57	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	50	119	13.00
14 00	beneficiaries	hair) administration	35, 664	25, 653	14 00
14.00	Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)	neir) administration	35, 004	20, 003	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (the			113, 062	15.00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3				
16.00	Total Program cost of pneumococcal and influenza vaccine and			61, 317	16.00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Heal th	Financial Systems MARGARET MARY CO	MMUNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
			Peri od:		
	ES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8511	From 01/01/2016 To 12/31/2016		pared:
			RHC I	Cost	<u> </u>
				t B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			130, 929	1.00
2.00	Interim payments payable on individual bills, either subm	itted or to be submitted to		0	2.00
2.00	the contractor for services rendered in the cost reporting period. If none, write			Ű	2.00
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount based on subsequent				3.00
	revision of the interim rate for the cost reporting period				
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50	·····			0	3.50
3.51				0	3.51
3.52				Ő	3.52
3.53				0	3.53
3.54				Ő	3.54
3.99					
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trai		2	0 130, 929	3.99 4.00
1.00	27)			100, 727	1.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after d	esk review. Also show date o	of		5.00
0.00	each payment. If none, write "NONE" or enter a zero. (1)				0.00
	Program to Provider				
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
	Provider to Program		u	-	
5.50				0	5.50
5.51				0	5.51
5.52				Ő	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			_	6.00
6.01	SETTLEMENT TO PROVIDER			61, 861	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			192, 790	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
			NUIIDEI		
		0	1.00	2.00	