near th Financi	ai systems	WARGARET WARY COMMON	II IY HUSPITAL	III L	_1 eu 01 F01111 CWS-2552-10
This report is	s required by law (42 USC 1395g;	42 CFR 413.20(b)). Fai	lure to report can	result in all inte	rim FORM APPROVED
payments made	since the beginning of the cost	reporting period being	deemed overpaymen	ts (42 USC 1395g).	OMB NO. 0938-0050 EXPIRES 05-31-2019
HOSPITAL AND I	HOSPITAL HEALTH CARE COMPLEX COS T SUMMARY	T REPORT CERTIFICATION	Provider CCN: 15-13	329 Period: From 01/01/20 To 12/31/20	
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed co	st report		Date: 5/17.	/2018 Time: 8:02 am
use only	2. [] Manually submitted cost 3. [0] If this is an amended r 4. [F] Medicare Utilization. E	eport enter the number	of times the provi	der resubmitted thi	s cost report
Contractor use only	(1) As Submitted 7.	Date Received: Contractor No. [N] Initial Report fo [N] Final Report for	or this Provider CCI this Provider CCN		endor Code: 4 column 1 is 4: Enter times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARGARET MARY COMMUNITY HOSPITAL (15-1329) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 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.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)	
	Officer or Administrator of Provider(s)
Ti tl e	t.
Date	

	Title	XVIII			
Title V	Part A	Part B	HIT	Title XIX	
1. 00	2. 00	3. 00	4. 00	5. 00	
0	280, 623	-388, 002	0	70, 398	1.00
0	0	0		0	2.00
0	0	0		0	3.00
0	0	0		0	5.00
0				0	6.00
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	1.00 0 0 0 0 0 0	Title V Part A 1.00 2.00 0 280,623 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 0 280,623 -388,002 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 30,790 0 280,623 -357,211	Title V Part A Part B HIT 1.00 2.00 3.00 4.00 0 280,623 -388,002 0	Title V Part A Part B HIT Title XIX 1.00 2.00 3.00 4.00 5.00 0 280,623 -388,002 0 70,398 0

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1329 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/17/2018 8:01 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 321 MITCHELL 1.00 PO Box: 1.00 2.00 City: BATESVILLE State: IN Zi p Code: 47006-County: RIPLEY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 MARGARET MARY COMMUNITY 151329 99915 01/07/1966 N 0 O 3.00 HOSPI TAI 4.00 Subprovi der - IPF 4.00 Subprovi der - IRF 5.00 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital-Based HHA MARGARET MARY COMMUNITY 157143 99915 03/01/1985 N Ρ Ν 12.00 HOSPI TAI 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce MARGARET MARY COMMUNITY 151551 99915 12/31/2003 14.00 14.00 HOSPI TAL 15.00 Hospital -Based Health Clinic - RHC MARGARET MARY COMMUNITY 158511 99915 09/03/2013 N 0 Ν 15.00 HOSPI TAL Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2017 12/31/2017 20.00 Type of Control (see instructions) 21.00 2 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22 01 Did this hospital receive interim uncompensated care payments for this cost reporting 22 01 Ν Ν period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes 22.02 N Ν 22.02 or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν 22.03 Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" for ves or "N" for no In-State In-State Out-of Medicai d Other Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d paid days el i gi bl e unpai d days 1.00 3.00 4.00 5.00 6.00 2.00 24.00 If this provider is an IPPS hospital, enter the 24 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

Health Financial Systems MARGARET MA					n Lieu	of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der CC	CN: 15-1329	Peri od: From 01/01	/2017	Workshe Part I	et S-2	
						Date/Ti		
	In-State	In-State	Out-of	Out-of	Medi ca	5/17/20	018 8:0 ther	1 am
	Medi cai d	Medi cai d	State	State	HMO da		li cai d	
	pai d days	eligible	Medi cai d	Medi cai d		d	ays	
		unpai d days	paid days	el i gi bl e unpai d				
	1. 00	2. 00	3. 00	4. 00	5. 00	6	. 00	
25.00 If this provider is an IRF, enter the in-state	0			0		0		25. 00
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.				Hunta and (De		D-+6	C = = ====	
				Urban/Ru		<u>рате от</u> 2. 0		
26.00 Enter your standard geographic classification (not w	age) status	at the be	ginning of		2	2.0	,,,	26. 00
cost reporting period. Enter "1" for urban or "2" fo								
27.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o				st	2			27. 00
enter the effective date of the geographic reclassif			ppi i cabi c,					
35.00 If this is a sole community hospital (SCH), enter th	e number of	periods S	CH status in	n	0			35. 00
effect in the cost reporting period.				Begi nn	i na:	Endi	na:	
				1.0		2. (
36.00 Enter applicable beginning and ending dates of SCH s		script line	36 for numb	per				36. 00
of periods in excess of one and enter subsequent dat 37.00 If this is a Medicare dependent hospital (MDH), ente		or of norio	de MDH etati	16	0			37. 00
is in effect in the cost reporting period.	i the numbe	er or perro	us wun statt	us	٥			37.00
37.01 Is this hospital a former MDH that is eligible for t				N				37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" f	or yes or "	'N" for no.	(see					
instructions) 38.00 If line 37 is 1, enter the beginning and ending date	s of MDH st	tatus. If I	ine 37 is					38. 00
greater than 1, subscript this line for the number o								
enter subsequent dates.				\/ \/h		V /	N.I.	
				Y/N 1. 0		Y/ 2. 0		
39.00 Does this facility qualify for the inpatient hospita	l payment a	adjustment	for low volu			N N		39. 00
hospitals in accordance with 42 CFR §412.101(b)(2)(i								
for yes or "N" for no. Does the facility meet the mi with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in colum				see				
instructions)	1 2 1 101	yes or 1	101 110. (
40.00 Is this hospital subject to the HAC program reductio						N		40. 00
"N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1			yes or "N" 1	ror				
The Three distance of the dist	(000 1110	., 401, 01,0)			V	XVIII	XIX	
D					1.00	2. 00	3. 00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payme	nt for disr	oronorti ona	te share in	accordance	l N	l N	N	45. 00
with 42 CFR Section §412.320? (see instructions)		•			"	"	'`	45.00
46.00 Is this facility eligible for additional payment exc					N	N	N	46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	t. L, Pt. I	II and Wks	t. L-1, Pt.	I through				
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS	capital? E	enter "Y fo	r yes or "N'	for no.	N	N	N	47. 00
48.00 Is the facility electing full federal capital paymen	t? Enter "	'Y" for yes	or "N" for	no.	N	N	N	48. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in	annroyed (OME program	s? Entar "\	V" for yes	N		I	56. 00
or "N" for no.	appi oved c	JINIE PI OGI AIII	is: Litter	i ioi yes	"			30.00
57.00 If line 56 is yes, is this the first cost reporting	peri od duri	ng which r	esidents in	approved				57. 00
GME programs trained at this facility? Enter "Y" fo								
for yes or "N" for no in column 2. If column 2 is "								
"N", complete Wkst. D, Parts III & IV and D-2, Pt. I								
58.00 If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans' service	es as	N			58. 00
59.00 Are costs claimed on line 100 of Worksheet A? If ye			, Pt. I.		N			59. 00
			NAHE 413. 8			Pass-Th		
			Y/N	Li ne	#	Qualifi Crite		
						Coc		
	(1)(1)(5)		1.00	2. 0	0	3. 0	00	(0.55
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?			N					60.00
programs that meet the criteria under 9415.05!	(300 1113111	10110113)	1	ı	I		1	ı

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider C	F	eriod: From 01/01/2017 o 12/31/2017	Part I Date/Time Pre	pared:
	Y/N	I ME	Direct GME	I ME	5/17/2018 8:0 Direct GME	1 am
	1.00	2. 00	3. 00	4. 00	5. 00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61.04
61.05 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						61.05
61.04 minus line 61.03). (see instructions) 61.06 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)						61.06
	Pro	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3. 00	4. 00	
 61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 				0.00		61. 10
					1.00	
ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital				riod for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruction 62.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro-	ctions) a Teachi gram. (s	ng Health Cen see instruction	nter (THC) into			62.01
Teaching Hospitals that Claim Residents in Nonprovid 63.00 Has your facility trained residents in nonprovider so "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this			N	63.00
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
		lana Catti	1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in N period that begins on or after July 1, 2009 and befo	•		-inis base yea	r is your cost	reporting	
64.00 Enter in column 1, if line 63 is yes, or your facili in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighter resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	ty train n-primar all non d non-pr n column	ned residents Ty care Ty care Ty care Ti mary care To 3 the ratio		0. 00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1329 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/17/2018 8:01 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + FTEs FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if li is yes, or your facility 0.000000 65.00 0.00 0. 00 if line 63 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTEs in FTFs Hospi tal Nonprovi der Si te 2. 00 3. 00 1 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5. 00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 N Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N"

	Financial Systems MARGAREI MARY COMMUNITY HOSPITAL		u of Form CMS	
HOSPI T		eri od:	Worksheet S-	-2
		com 01/01/2017 12/31/2017	Part Date/Time Pr	cepared:
			5/17/2018 8:	
		1. 00		
76. 00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in		0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes o			
	no. Column 2: Did this facility train residents in a new teaching program in accordance			
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y			
	indicate which program year began during this cost reporting period. (see instructions)			
			1.00	
	To a Hard DDC		1. 00	
00 00	Long Term Care Hospital PPS		N.	-
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	noriad? Entar	N	80.0
61.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	perrou? Enter	N	81.0
	TEFRA Providers			-
0E 00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes	or "N" for no	N	85.0
	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section		IN IN	86.0
80.00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	!		80.0
87. 00	Is this hospital an extended neoplastic disease care hospital classified under section		N	87.0
07.00	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		I IV	07.0
	Total (1) (b) (vi): Enter 1 for yes or 14 for no.	V	XIX	
		1. 00	2. 00	
	Title V and XIX Services	11.00	2.00	
90 00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Υ	90.0
, 0. 00	yes or "N" for no in the applicable column.			70.0
91. 00	Is this hospital reimbursed for title V and/or XIX through the cost report either in	N	Υ	91.0
	full or in part? Enter "Y" for yes or "N" for no in the applicable column.			
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92.0
	instructions) Enter "Y" for yes or "N" for no in the applicable column.			
93. 00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N	N	93.0
	"Y" for yes or "N" for no in the applicable column.			
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94.0
	applicable column.			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96. 00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	N	N	96.0
	applicable column.			
	If line 96 is "Y", enter the reduction percentage in the applicable column.	0. 00	0.00	97.0
98. 00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post	Υ	Υ	98. 0
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in			
	column 1 for title V, and in column 2 for title XIX.			
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.	Υ	Y	98. 0
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for			
	title XIX.			
9 8. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation	Υ	Y	98. 0
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1			
20 02	for title V, and in column 2 for title XIX.	NI.	N.	00.0
78. U3	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	N	N	98.0
	for title V, and in column 2 for title XIX.			
20 04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	N	N	98.0
70. 04	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	IN	IN IN	70.0
	in column 2 for title XIX.			
98. 05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on	Υ	Y	98.0
70. 03	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	'	'	70.0
	column 2 for title XIX.			
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	Υ	Y	98. 0
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in			
	column 2 for title XIX.			
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Υ		105.0
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N		106.0
	for outpatient services? (see instructions)			
	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R	N		107.0
107. 00	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If			
107. 00	training programs: Litter 1 for yes of 10 for no fire corumn 1. (see first detrons) if			1
07. 00	yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost			
	yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			
	yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost	N		108.0

ealth Financial Systems MARGARET MARY COMMI OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	UNITY HOSPITA	CCN: 15-1329	Peri od:	I LICC	u of Form CMS Worksheet S	
USPITAL AND HUSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider	.CN: 15-1329	From 01/01/ To 12/31/		Part I Date/Time P 5/17/2018 8	repare
	Physi cal	Occupati ona			Respi ratory	_
09.00 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.	1.00 N	2. 00 N	3. 00 N		4.00 N	109.
					1. 00	
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes o	r "N" for no.	If yes,	5	N	110.
11 00 E this Estility well the second state of	h - F+!	C	1.00		2. 00	111
11.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting Dlumn 1 is Y, ticipating i	period? Ente enter the n column 2.	r N			111.
				1.00	2.00 3.0	0
Miscellaneous Cost Reporting Information						
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	If column 2 it for long t	is "E", ente erm care (inc	r in column Iudes	N	0	115.
16.00 s this facility classified as a referral center? Enter "Y" 17.00 s this facility legally-required to carry malpractice insur			r "N" for	N N		116 117
no.		,				
8.00 s the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	if the polic	y is	1		118
jordim mader Errer E ri the perrey re coodin errer		Premi ums	Losse	S	Insurance	
		1.00	0.00			_
18.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	0	3. 00	0118
		'				
8.02 Are malpractice premiums and paid losses reported in a cost	center other	than the	1. 00 N		2. 00	118
Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE	lule listing	cost centers				119
0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold		Y" for yes or			N	120
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	ualifies for uts? (see ins	tructions)				
"N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	ualifies for uts? (see ins	tructions)				121
"N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	alifies for uts? (see ins untable devic Tined in §190	tructions) es charged to 3(w)(3) of the	Y Y		5. 00	
"N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information	ualifies for uts? (see ins untable devic fined in §190 is "Y", ent	tructions) es charged to 3(w)(3) of the	Y Y		5. 00	122
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Health Financial Systems MARGARET MARY (COMMUNITY HOSPITA	L		In Lieu	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Peri From To	od: n 01/01/2017	Worksheet S- Part I Date/Time Pr	2 epared:
					5/17/2018 8:	01 am
				1. 00	2. 00	
140.00 Are there any related organization or home office costs chapter 10? Enter "Y" for yes or "N" for no in column 1. are claimed, enter in column 2 the home office chain num	If yes, and home	office co		N		140. 00
	2.00		•	3.00		
If this facility is part of a chain organization, enter office and enter the home office contractor name and con		ough 143 th	ne name	and address	of the home	
141.00 Name: Contractor's Name: 142.00 Street: P0 Box:		Contra	ctor's	Number:		141. 00 142. 00
143. 00 Ci ty: State:		Zi p Co	de:			143. 00
					1. 00	-
144.00 Are provider based physicians' costs included in Workshe	et A?				Υ	144. 00
			_	1. 00	2. 00	_
145.00 If costs for renal services are claimed on Wkst. A, line inpatient services only? Enter "Y" for yes or "N" for no no, does the dialysis facility include Medicare utilizat period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the pre	o in column 1. If ion for this cost eviously filed cos	column 1 i: reporting t report?		N.	2.00	145. 00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pu yes, enter the approval date (mm/dd/yyyy) in column 2.	ıb. 15-2, chapter	40, §4020)	IT			
					1.00	
147.00 Was there a change in the statistical basis? Enter "Y" f 148.00 Was there a change in the order of allocation? Enter "Y"					N N	147. 00 148. 00
149.00Was there a change to the simplified cost finding method	,		for no.		N	149. 00
<u> </u>	Part A	Part B		Title V	Title XIX	
Does this facility contain a provider that qualifies for	1.00	2.00	l coti o	3.00	4.00	
or charges? Enter "Y" for yes or "N" for no for each com						
155. 00 Hospi tal	N	N		N	N	155. 00
156.00 Subprovider - IPF 157.00 Subprovider - IRF	N N	l N I N		N N	N N	156. 00 157. 00
158. OOSUBPROVI DER	IN	I IN		IN	IN	158. 00
159. 00 SNF	N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY	N	N N		N	N	160.00
161. 00 CMHC		N N		N	N	161. 00
					1. 00	
Multicampus 165.00 s this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no.	one or more camp	uses in di	fferent	t CBSAs?	N	165. 00
Name	County		Zip Cod		FTE/Campus	
0 166.00 f ine 165 is yes, for each	1. 00	2.00	3. 00	4. 00	5. 00	0166.00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.0	0 186. 00
					1. 00	
Health Information Technology (HIT) incentive in the Ame				ct		
167.00 s this provider a meaningful user under §1886(n)? Ente 168.00 of this provider is a CAH (line 105 is "Y") and is a mea reasonable cost incurred for the HIT assets (see instruc	er "Y" for yes or uningful user (lin	"N" for no			Y	167. 00 0168. 00
168.01 If this provider is a CAH and is not a meaningful user,		r qualify	for a h	nardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or 169.00 If this provider is a meaningful user (line 167 is "Y") transition factor. (see instructions)	"N" for no. (see	instructio	ns)	·	0. 0	0169.00
THE WISH CHARLES IN THE PROPERTY OF THE PROPER				Begi nni ng	Endi ng	
				1. 00	2. 00	170
170.00 Enter in columns 1 and 2 the EHR beginning date and endiperiod respectively (mm/dd/yyyy)	ng date for the r	eporti ng		01/01/2017	12/31/2017	170. 00

Health Financial Systems	In Lie	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	DENTIFICATION DATA			Worksheet S-2	2
			From 01/01/2017 To 12/31/2017	Part Date/Time Pre	narod
			10 12/31/2017	5/17/2018 8:0)1 am
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider	r have any days for indiv	viduals enrolled in	N	C	171.00
section 1876 Medicare cost plans repor	rted on Wkst. S-3, Pt. I,	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1		nter the number of section	on		
1876 Medicare days in column 2. (see i	instructions)				

HOSPI	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider	CCN: 15-1329	Peri od: From 01/01/2017 To 12/31/2017		epared:
			Y/N	Date	T diii
			1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO	responses. Ent		the	
	mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning o		N		1.00
	reporting period? If yes, enter the date of the change in column 2. (se			\/ /I	
		1.00	Date	V/I	+
2. 00	Has the provider terminated participation in the Medicare Program? If	1.00 N	2. 00	3. 00	2.00
2.00	yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.				2.00
3. 00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar				3.00
	relationships? (see instructions))/ /NI	T	Data	
		1.00	2. 00	3. 00	
	Financial Data and Reports	1.00	2.00	3.00	
4. 00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5. 00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5. 00
			Y/N	Legal Oper.	
	Access to Educational Activities		1. 00	2. 00	
, 00	Approved Educational Activities		- N	ı	٠, ,
5. 00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the legal operator of the program?	the provider i	s N		6.00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
3. 00	Were nursing school and/or allied health programs approved and/or renew	ed during the	N N		8.00
	cost reporting period? If yes, see instructions.				
9. 00	Are costs claimed for Interns and Residents in an approved graduate med	ical education	n N		9.00
	program in the current cost report? If yes, see instructions.				
10. 00		the current	N		10.00
	cost reporting period? If yes, see instructions.				1
11. 00		oproved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.	,		Y/N	
				1.00	+
	Bad Debts			1.00	
		ctions		Υ	12.00
12 00			cost reporting	N N	13.00
	If line 12 is yes, did the provider's bad debt collection policy change period? If yes, submit copy.			N	14.00
13. 00 14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments waived? Bed Complement	•			
13. 00 14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments waived? Bed Complement Did total beds available change from the prior cost reporting period? I	fyes, see ins	structi ons.	N	
13. 00 14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments waived? Bed Complement Did total beds available change from the prior cost reporting period? I	f yes, see ins rt A	structions.	N N	
13. 00 14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments waived? Bed Complement Did total beds available change from the prior cost reporting period? I Pa Y/N	f yes, see ins rt A Date	structi ons. Par	N Tt B Date	15. 00
13. 00 14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments waived? Bed Complement Did total beds available change from the prior cost reporting period? I Pa Y/N 1.00	f yes, see ins rt A	structions.	N N	
	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments waived? Bed Complement Did total beds available change from the prior cost reporting period? I Pa Y/N 1.00 PS&R Data	f yes, see ins rt A Date	structions. Par Y/N 3.00	N Tt B Date	

		1. 00	2. 00	3. 00	4. 00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	Y	04/09/2018	Υ	04/09/2018	16. 00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
40.00	cost report? If yes, see instructions.	.,				10.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.	l	[l

Heal th	Financial Systems MARGARET MARY COL	MMUNITY HOSPITA	AI.	Inlie	u of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1329 F	Period: From 01/01/2017	Worksheet S	
				Γο 12/31/2017		
		Descr	iption	Y/N	Y/N	7. 01 diii
00.00	10.11		0	1. 00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N 1.00	2.00	Y/N 3. 00	Date 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	HOSPI TALS)			
22. 00	Capital Related Cost 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.			ng the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases enter	red into during	this cost rep	orting period?	N	24. 00
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	g the cost repo	rting period?	If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during 1	the cost report	ing period? If	yes, see	N	26. 00
27. 00	instructions. Has the provider's capitalization policy changed during th	ne cost reporti	ng period? If	yes, submit	N	27. 00
	Copy. Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	entered into du	ring the cost	reporti ng	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service Re	serve Fund)	N	29. 00
30. 00	Has existing debt been replaced prior to its scheduled matinstructions.		debt? If yes,	see	N	30.00
31. 00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes,	see	N	31.00
	Purchased Services					
32. 00	Have changes or new agreements occurred in patient care so arrangements with suppliers of services? If yes, see instr		ed through con	tractual	N	32.00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 apno, see instructions.	oplied pertaini	ng to competit	ive bidding? If	N	33.00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an a lf yes, see instructions.	arrangement wit	h provi der-bas	ed physicians?	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 p	rovi der-based	Y	35.00
				Y/N 1. 00	Date 2.00	
	Home Office Costs			1.00	2.00	
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	orepared by the	home office?	N N		36. 00 37. 00
	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of	. ,		N		38. 00
	the provider? If yes, enter in column 2 the fiscal year er If line 36 is yes, did the provider render services to oth	nd of the home	offi ce.	N		39.00
	see instructions. If line 36 is yes, did the provider render services to the	•	•	N		40.00
	instructions.	Thomas of the co.		.,		10.00
		1.	00	2.	00	
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	KYLE		SMI TH		41.00
42. 00	held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	BLUE & CO., LL	C			42.00
	preparer.	317-713-7957	.0	VCSMI THADI HEAN		43.00
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7937		KCSMI TH@BLUEAN	DCO. COM	43.00

Health Financial Systems MARGARET MARY	COMMUNITY HOSPITAL	In Lieu	ı of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-1329		Worksheet S-2 Part II	
		To 12/31/2017		pared: 1 am
	3. 00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	SENIOR MANAGER			41.00
held by the cost report preparer in columns 1, 2, and 3				
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cos	-			43.00
report preparer in columns 1 and 2, respectively.				

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN

Provider CCN: 15-1329

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | | Part I | | Date/Time Prepared: | Taylogue | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | | Part I |

						0 12/31/2017	5/17/2018 8:0	
							I/P Days /	1 4111
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		18	6, 570	97, 560. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	
7.00	Total Adults and Peds. (exclude observation			18	6, 570	97, 560. 00	0	7. 00
	beds) (see instructions)							
8. 00	INTENSIVE CARE UNIT	31. 00		7	2, 555	6, 720. 00	0	
9. 00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						_	12.00
13. 00	NURSERY	43. 00					0	
14.00	Total (see instructions)			25	9, 125	104, 280. 00	0	
15. 00	CAH visits						0	15.00
16.00	SUBPROVI DER - I PF							16.00
17. 00	SUBPROVI DER - I RF							17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE	404.00						21.00
22. 00	HOME HEALTH AGENCY	101. 00					0	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	444.00						23.00
24. 00	HOSPI CE	116. 00		0	C)		24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC	00.00						25.00
26. 00	RURAL HEALTH CLINIC	88. 00					0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		٥٦			U	26. 25
27. 00	Total (sum of lines 14-26)			25				27.00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambulance Trips							29.00
30.00	Employee discount days (see instruction)							30.00
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)			0				31. 00 32. 00
32. 00 32. 01				Ü	1	,		32.00
3∠. ∪ I	Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33. 00	LTCH non-covered days							33.00
	LTCH site neutral days and discharges							33.00
33.01	Lion of the heath at days and dischalges		l		I	I	l	1 33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1329

Peri od: Worksheet S-3 From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

5/17/2018 8:01 am I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Title XIX Total All Component Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 4, 065 Hospital Adults & Peds. (columns 5, 6, 7 and 1. 00 1,618 55 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 488 308 2.00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 4 00 0 0 5.00 Hospital Adults & Peds. Swing Bed SNF 0 C 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 55 7.00 1.618 4.065 beds) (see instructions) INTENSIVE CARE UNIT 8 00 175 280 8 00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12 00 13.00 NURSERY 986 13.00 14.00 Total (see instructions) 1, 793 56 5, 331 0.00 554.83 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 22.00 HOME HEALTH AGENCY 5.947 635 10, 306 0.00 22.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 24.00 HOSPI CE 0.00 24.00 0 0 0.00 24. 10 HOSPICE (non-distinct part) 0 0 0 24.10 25.00 CMHC - CMHC 25.00 RURAL HEALTH CLINIC 26.00 1, 261 800 4, 113 0.00 9.98 26.00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26. 25 0 0.00 26.25 Total (sum of lines 14-26) 586. 81 27 00 0 00 27 00 Observation Bed Days 28.00 5 786 28.00 29.00 Ambul ance Trips 0 29.00 30.00 Employee discount days (see instruction) 0 30.00 31 00 Employee discount days - IRF O 31.00 Labor & delivery days (see instructions) 32.00 0 0 0 32.00 Total ancillary labor & delivery room 0 32.01 outpatient days (see instructions) LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

Provider CCN: 15-1329

Peri od: Worksheet S-3 From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared: 5/17/2018 8:01 am

							5/17/2018 8: 0	1 ат
		Full Time Equivalents			Di sch	arges		
	Component	Nonpai d	Title V		Title XVIII	Title XIX	Total All	
	·	Workers					Pati ents	
		11. 00	12. 00		13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	613	22	1, 600	1.00
2.00	HMO and other (see instructions)				145	119		2.00
3.00	HMO IPF Subprovider					0		3.00
4.00	HMO IRF Subprovider					0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF							5.00
6.00	Hospital Adults & Peds. Swing Bed NF							6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)							7. 00
8.00	INTENSIVE CARE UNIT			İ				8.00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY			İ				13.00
14.00	Total (see instructions)	0.00		0	613	22	1, 600	14.00
15.00	CAH visits			İ				15.00
16.00	SUBPROVI DER - I PF			ĺ				16.00
17.00	SUBPROVI DER - I RF			ĺ				17. 00
18.00	SUBPROVI DER			ĺ				18. 00
19.00	SKILLED NURSING FACILITY			ĺ				19.00
20.00	NURSING FACILITY			i				20.00
21.00	OTHER LONG TERM CARE			i				21.00
22.00	HOME HEALTH AGENCY	0.00		1				22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE	0.00						24.00
24. 10	HOSPICE (non-distinct part)							24. 10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC	0.00						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00						26. 25
27.00	Total (sum of lines 14-26)	0.00						27.00
28.00	Observation Bed Days							28. 00
29.00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)							32.00
32.01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days				0			33.00
33. 01	LTCH site neutral days and discharges				0			33. 01

Heal th	Financial Systems MAF	RGARET MARY COMM	MUNITY HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
	BEALTH AGENCY STATISTICAL DATA		Provi der C	CN: 15-1329 CCN: 15-7143	Period: From 01/01/2017 To 12/31/2017	Worksheet S-4 Date/Time Pre	pared:
					Home Health	5/17/2018 8: 0 PPS	01 am
					Agency I		
					1.	00	
0. 00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2.00	3.00	4. 00	5. 00	
1 00	HOME HEALTH AGENCY STATISTICAL DATA		C	,		1 0	1 00
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00	284. 00	I .	0 00 0.00		
				Number of Em	ployees (Full Ti	me Equivalent)	
		F., + +	6 !	Ct-EE	Ctt	T-+-1	
		Enter the number your normal		Staff	Contract	Total	
	HOME HEALTH ACENOV NUMBER OF ENDLOYEES	0		1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40.00	0. (0.00	0.00	3.00
4. 00	Director(s) and Assistant Director(s)			0. (
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			6.8			•
7. 00	Nursi ng Supervi sor			0. (0.00	7. 00
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			4. 4 0. 0		4. 48 0. 00	
10.00	Occupational Therapy Service			1.			•
11.00	Occupational Therapy Supervisor			0.0			
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0. (1
14.00	Medical Social Service			0.	0. 00	0. 18	14.00
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0. (
17. 00	Home Health Aide Supervisor			0. (1
18. 00	Other (specify)			0. (0.00	0.00	18. 00
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				2		19.00
	you provided services during the cost						
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			99915			20.00
	during this cost reporting period (line 20						
20. 01	contains the first code).			17140			20. 01
		Full Ep		LUBA Estas la	DED OU	Talah (asha	
		Without Outliers	With Outliers	LUPA Epi sode	PEP Only Epi sodes	Total (cols. 1-4)	
	DDC ACTIVITY DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	2, 163	590		54 20	2, 827	21.00
22. 00	Skilled Nursing Visit Charges	363, 384	99, 120			474, 936	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	1, 369 276, 538	348 70, 296	1	20 33 40 6, 666	1, 770 357, 540	1
25. 00	Occupational Therapy Visits	494	222	2	3 9	728	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	106, 704 21	47, 952 15	1	1, 944 0 0	157, 248 36	1
28. 00	Speech Pathology Visit Charges	4, 578	3, 270	1	0 0	7, 848	1
29.00	Medical Social Service Visits Medical Social Service Visit Charges	1 020	1		0 0	7	
30. 00 31. 00	Home Health Aide Visits	1, 920 290	320 289		0 0	2, 240 579	
32.00	Home Health Aide Visit Charges	28, 710	28, 611		0 0	57, 321	32.00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4, 343	1, 465		77 62	5, 947	33.00
34.00	Other Charges	0			0 0	0	
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	781, 834	249, 569	13, 70	11, 970	1, 057, 133	35.00
36. 00	Total Number of Episodes (standard/non outlier)	298		:	29 3	330	36.00
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	34, 903	44 8, 686	1	2 73 344		37. 00 38. 00
	,	2 .,	2, 300	'	, , , , , , , , , , , , , , , , , , , ,	, 500	

	Financial Systems MAR	GARET MARY COM	MUNITY HOSPITA	۱L	In Li€	eu of Form CMS-	2552-
10SPI T	TAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1329	Peri od:	Worksheet S-8	3
			Component	CCN: 15-8511	From 01/01/2017 To 12/31/2017		
					RHC I	Cost	Ji aiii
	Taxana and a same and a same and a same and a same and a same and a same and a same and a same and a same and a				1.	. 00	
00	Clinic Address and Identification				440 N BUOKEVE	- CT	1
. 00	Street		CI	+>/	112 N. BUCKEYE	ZIP Code	1. (
				00	State 2.00	3. 00	
. 00	City, State, ZIP Code, County		OSGOOD 1.	00		47037	2.0
	,	'					
						1. 00	
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for			0	3. (
					nt Award	Date	
	Source of Federal Funds				1. 00	2. 00	
. 00	Community Health Center (Section 330(d), PHS	Act)		1		T	4.0
. 00	Migrant Health Center (Section 329(d), PHS A						5.
. 00	Health Services for the Homeless (Section 34)	O(d), PHS Act)					6.
. 00	Appal achi an Regi onal Commission						7.
. 00	Look-Alikes						8.
. 00	OTHER (SPECIFY)						9.
					1. 00	2.00	
0. 00	Does this facility operate as other than a he	ospital-based R	RHC or FQHC? E	nter "Y" for			10.
	yes or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type of hours.)	ate number of c	other operatio	ns in column			
	Thou 3.)	Sund	day	N	Monday	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	Facility hours of operations (1)			08: 00	16: 30	08: 00	111
1.00	CLINIC			06.00	10. 30	06.00	11.
					1. 00	2.00	
2. 00	Have you received an approval for an exception	on to the produ	uctivity stand	ard?	N		12.
				r O coction	N	_	1 12.
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	umn 1. If yes,	enter in colu	mn 2 the	, N	C	
	30.8? Enter "Y" for yes or "N" for no in col	umn 1. If yes,	enter in colu	mn 2 the ders and			
	30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	umn 1. If yes,	enter in colu	mn 2 the ders and	ider name	CCN number 2.00	
3.00	30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	umn 1. If yes, List the names	enter in colu s of all provi	mn 2 the ders and Prov	ider name 1.00	CCN number 2.00	13.
3.00	30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	umn 1. If yes, List the names	enter in colu s of all provi V	mn 2 the ders and Prov	ider name 1.00	CCN number 2.00 Total Visits	13.
4. 00	30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number	umn 1. If yes, List the names	enter in colu s of all provi	mn 2 the ders and Prov	ider name 1.00	CCN number 2.00	14.
4. 00	30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all	umn 1. If yes, List the names	enter in colu s of all provi V	mn 2 the ders and Prov	ider name 1.00	CCN number 2.00 Total Visits	14.
4. 00	30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	umn 1. If yes, List the names	enter in colu s of all provi V	mn 2 the ders and Prov	ider name 1.00	CCN number 2.00 Total Visits	14.
4. 00	30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all	umn 1. If yes, List the names	enter in colu s of all provi V	mn 2 the ders and Prov	ider name 1.00	CCN number 2.00 Total Visits	14.
4. 00	30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	umn 1. If yes, List the names	enter in colu s of all provi V	mn 2 the ders and Prov	ider name 1.00	CCN number 2.00 Total Visits	14.
4. 00	30.8? Enter "Y" for yes or "N" for no in colonumber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	umn 1. If yes, List the names	enter in colu s of all provi V	mn 2 the ders and Prov	ider name 1.00	CCN number 2.00 Total Visits	14.
4. 00	30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	umn 1. If yes, List the names	enter in colu s of all provi V	mn 2 the ders and Prov	ider name 1.00	CCN number 2.00 Total Visits	14.
1. 00	30.8? Enter "Y" for yes or "N" for no in colonumber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	umn 1. If yes, List the names	v 2.00	Prov XVIII 3.00	ider name 1.00	CCN number 2.00 Total Visits	14.
4. 00	30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	umn 1. If yes, List the names	enter in colus of all provi	Prov XVIII 3.00	ider name 1.00	CCN number 2.00 Total Visits	14.
4.00	30.8? Enter "Y" for yes or "N" for no in colonumber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	umn 1. If yes, List the names	enter in colus of all provi	Prov XVIII 3.00	ider name 1.00	CCN number 2.00 Total Visits	14.
4. 00 5. 00	30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	umn 1. If yes, List the names	v 2.00	Prov XVIII 3.00	ider name 1.00 XIX 4.00	CCN number 2.00 Total Visits	14.
4. 00 5. 00	30.8? Enter "Y" for yes or "N" for no in colonumber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	wmn 1. If yes, List the names Y/N 1.00	v 2.00	Prov XVIII 3.00 Inty 00	ider name 1.00 XIX 4.00	CCN number 2.00 Total Visits 5.00	14.0
3. 004. 005. 00	30.8? Enter "Y" for yes or "N" for no in colonumber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	wmn 1. If yes, List the names Y/N 1.00 Tuesday	v 2.00 Cou	Prov XVIII 3.00 winty 00 esday	ider name 1.00 XIX 4.00 Thui	CCN number 2.00 Total Visits 5.00	14. (

Health Financial Systems MA	RGARET MARY COM	In Lieu	u of Form CMS-2552-10			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der CO		Peri od:	Worksheet S-8	
		Component (
	_			RHC I	Cost	
	Fri	day	Sat	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	12: 00				11.00

Heal th	Financial Systems	MAR	GARET MARY COM	MMUNITY HOSPITA	ıL	In Lie	u of Form CMS-2	2552-10
HOSPI 7	FAL-BASED HOSPICE IDENTIFICATION	I DATA		Provider C	CN: 15-1329 N: 15-1551	Period: From 01/01/2017 To 12/31/2017	Worksheet S-9 PARTS I THROU Date/Time Pre	GH IV
				nospi ce oo	10 1001		5/17/2018 8:0	
						Hospi ce I		
		Undupl i cated						
		Days		I				
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled Nursing	Nursing Facility		cols. 1, 2 &	
				Facility	Facility		5)	
		1. 00	2, 00	3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR C					3.00	0.00	
1. 00	Hospi ce Conti nuous Home Care		LICE ODS BEGINN	THO BEFORE OUT	The state of the			1.00
2. 00	Hospice Routine Home Care							2.00
3. 00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST	REPORTING PER	ODS BEGINNING	BEFORE OCTOBE	R 1, 2015			
6.00	Number of patients receiving							6.00
	hospi ce care							
7.00	Total number of unduplicated							7. 00
	Continuous Care hours billable							
0.00	to Medicare							8.00
8. 00	Average Length of Stay (line 5 / line 6)							8.00
9. 00	Unduplicated census count							9. 00
	Parts I and II, columns 1 and 2	l Dalso includo	the days reper	tod in columns	2 and 4			7.00
NOTE.	raits i and ii, cordinis i and z	arso riici uue	the days repor					
				Title XVIII	Title XIX	0ther	Total (sum of	
							col s. 1	
				4.00	0.00	2.00	through 3)	
	DADT III FNDOLIMENT DAVE FOR	COCT DEDODELN	C DEDLODE DECL	1. 00	2.00	3. 00	4. 00	
10 00	PART III - ENROLLMENT DAYS FOR Hospice Continuous Home Care	COST REPORTING	5 PERI UDS BEGI	NNING UN UR AF	TER OCTOBER I		0	10.00
10. 00 11. 00	Hospice Continuous Home Care			12, 385	1 .	0 0 65 1, 481	_	11.00
12.00	Hospice Inpatient Respite Care			12, 363	1	0 8		12.00
13. 00	Hospice General Inpatient Care			6	1	0 1	7	ı
	Total Hospice Days			12, 407	1	65 1, 490		
14.00	PART IV - CONTRACTED STATISTIC	AL DATA FOR CO	ST REPORTING P					1 1 7 . 00
15. 00	Hospice Inpatient Respite Care			0		0 0		15.00
	Hospice General Inpatient Care					0 0		16.00
				•	•		•	

Heal th	Financial Systems MA	ARGARET MARY COMMUNITY HOSP	I TAL	In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		CCN: 15-1329	Peri od:	Worksheet S-1	
				From 01/01/2017 To 12/31/2017	Doto /Time Dro	narad.
				To 12/31/2017	Date/Time Pre 5/17/2018 8:0	
					1. 00	
	Uncompensated and indigent care cost computa	ati on			1.00	
1.00	Cost to charge ratio (Worksheet C, Part I I		/line 202 colu	mn 8)	0. 362027	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid	- 6 M1:: -12			5, 807, 163	2.00
3. 00 4. 00	Did you receive DSH or supplemental payment If line 3 is yes, does line 2 include all D		nonts from Modi	cai d2	N	3. 00 4. 00
5. 00	If line 4 is no, then enter DSH and/or supp			caru:	0	5.00
6. 00	Medi cai d charges	romorrea paymorres rrom mou	oa. a		16, 919, 214	6.00
7.00	Medicaid cost (line 1 times line 6)				6, 125, 212	7. 00
8.00	Difference between net revenue and costs fo	r Medicaid program (line 7	mi nus sum of I	ines 2 and 5; if	318, 049	8. 00
	< zero then enter zero)	(11			
9. 00	Children's Health Insurance Program (CHIP) Net revenue from stand-alone CHIP	(see instructions for each	line)		0	9. 00
10.00	Stand-alone CHIP charges					10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)			ĺ	11.00
12.00	Difference between net revenue and costs fo		minus line 9;	if < zero then	0	12.00
	enter zero)					
40.00	Other state or local government indigent can				1	
13.00	Net revenue from state or local indigent ca	1 3 (·	,	0	13.00
14. 00	Charges for patients covered under state or 10)	rocar murgent care progra	ill (Not Therade	u III IIIles o oi	0	14. 00
15. 00	State or local indigent care program cost (line 1 times line 14)			0	15. 00
16.00	Difference between net revenue and costs fo		care program (I	ine 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cos instructions for each line)	st for Medicaid, CHIP and s	state/local ind	igent care progra	ams (see	
17. 00	Private grants, donations, or endowment inc	ome restricted to funding	charity care		0	17. 00
18.00	Government grants, appropriations or transfe				0	18. 00
19. 00	Total unreimbursed cost for Medicaid, CHIP 8, 12 and 16)	and state and local indig	ent care progra	ms (sum of lines	318, 049	19. 00
	10, 12 and 10)		Uni nsured		Total (col. 1	
			patients	pati ents	+ col . 2)	
	Uncomponented Caro (see instructions for an	ch Lina)	1.00	2. 00	3. 00	
20. 00	Uncompensated Care (see instructions for each Charity care charges and uninsured discount		2, 062, 0	032 0	2, 062, 032	20.00
20.00	(see instructions)	s for the entire radirity	2,002,0	0	2,002,002	20.00
21. 00	Cost of patients approved for charity care	and uninsured discounts (s	ee 746, 5	0	746, 511	21. 00
22. 00	instructions) Payments received from patients for amounts	nreviously written off as		0 0	0	22. 00
22.00	charity care	providusty with their off as				22.00
23. 00	Cost of charity care (line 21 minus line 22)	746, 5	0	746, 511	23.00
					1. 00	
24. 00	Does the amount on line 20 column 2, includ-	e charges for patient days	beyond a Lengt	h of stay limit	N N	24. 00
	imposed on patients covered by Medicaid or	other indigent care program	1?	•		
25. 00	If line 24 is yes, enter the charges for pa stay limit	tient days beyond the indi	gent care progr	am's length of	0	25. 00
26.00	Total bad debt expense for the entire hospi	tal complex (see instruction	ons)		5, 730, 671	26.00
27. 00	Medicare reimbursable bad debts for the ent	. ,			748, 153	
27. 01	Medicare allowable bad debts for the entire		ructions)		1, 151, 005	•
28. 00	Non-Medicare bad debt expense (see instruct	· ·			4, 579, 666	
29.00	Cost of non-Medicare and non-reimbursable M		see instruction	S)	2, 060, 815	
	Cost of uncompensated care (line 23 column Total unreimbursed and uncompensated care c				2, 807, 326 3, 125, 375	
500	1.2.2. Sim of model dod and anotherportourou cur of o	(pr do 11110 00)			1 5, 125, 575	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	E ENDENCES	Provi der C		Peri od:	Worksheet A	10
RECEASE IT CATTON AND ADSOSTMENTS OF TRIAL DALANCE O	I LAFLINGLS	Flovide		From 01/01/2017	WOI KSHEEL A	
				To 12/31/2017		
Cost Contar Decement on	Sal ari es	Other	Total (asl 1	Recl assi fi cat	5/17/2018 8: 0	1 am
Cost Center Description	Sararres	other	+ col . 2)	i ons (See	Reclassified Trial Balance	
			+ (01. 2)	A-6)	(col. 3 +-	
				A-0)	col . 4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT		3, 072, 983	3, 072, 98	3 -10, 989	3, 061, 994	1.00
1.01 00101 NEW CAP REL COSTS-OFFSITE BLDG		773, 121			784, 110	1. 01
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		4, 497, 062			4, 204, 925	2.00
2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	1	292, 137	292, 137	2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	178, 994	12, 136, 603	12, 315, 59	7 0	12, 315, 597	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	6, 477, 897	7, 957, 475			14, 791, 600	5.00
7.00 O0700 OPERATION OF PLANT	0	1, 312, 969			1, 312, 822	7.00
7.01 OO701 OPERATION OF PLANT -OFFSITE	0	208, 151			208, 151	7. 01
7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS	485, 708	14, 514		1	500, 222	7. 02
8.00 00800 LAUNDRY & LI NEN SERVI CE	101, 092	82, 129			171, 465	8. 00
9. 00 00900 HOUSEKEEPI NG	950, 216	306, 196		2 0	1, 256, 412	9. 00
10. 00 01000 DI ETARY	791, 863	540, 103	1		107, 769	10.00
11. 00 01100 CAFETERI A	0	0	1	1, 177, 736	1, 177, 736	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	587, 781	9, 508			597, 288	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	369, 671			54	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	597, 048	2, 685, 977			3, 282, 102	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 178, 664	206, 665	1, 385, 32	9 -4, 274	1, 381, 055	16. 00
30. 00 03000 ADULTS & PEDIATRICS	2, 705, 206	348, 516	3, 053, 72	2 489, 441	3, 543, 163	30. 00
31. 00 03100 NTENSI VE CARE UNIT	2, 703, 200	13, 830			303, 606	31.00
43. 00 04300 NURSERY	240, 730	1, 957			643, 321	43.00
ANCI LLARY SERVI CE COST CENTERS	O _I	1, 757	1, 75	7 041, 304	043, 321	43.00
50. 00 05000 OPERATING ROOM	1, 387, 428	2, 826, 812	4, 214, 24	-2, 303, 114	1, 911, 126	50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 236, 701	247, 588			147, 012	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 066, 815	6, 763, 475			9, 606, 239	54.00
60. 00 06000 LABORATORY	1, 517, 376	2, 271, 724			3, 750, 469	60.00
60. 01 06001 BLOOD LABORATORY	O	0		o	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	473, 434	112, 211	585, 64	5 -27, 270	558, 375	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 070, 372	82, 925	1, 153, 29	7 -16, 942	1, 136, 355	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	389, 730	17, 511	407, 24	1 -8, 109	399, 132	67.00
68. 00 06800 SPEECH PATHOLOGY	174, 217	3, 881	178, 09	-1, 063	177, 035	68.00
69. 00 06900 ELECTROCARDI OLOGY	598, 123	339, 631	937, 75		914, 669	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	2, 385, 725	2, 385, 725	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1	1, 571, 438	1, 571, 438	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS	204 244	100 501		-	224 (27	
88. 00 08800 RURAL HEALTH CLINIC	801, 046	103, 581		I I	904, 627	88. 00
90. 00 09000 CLINI C	1, 564, 326	677, 225			2, 036, 976	90.00
90. 01 09001 WOUND CLINC 91. 00 09100 EMERGENCY	227, 347	376, 210			233, 033	90.01
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 921, 525	2, 446, 623	4, 368, 14	-88, 393	4, 279, 755	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	1, 592, 122	198, 029	1, 790, 15	1 0	1, 790, 151	101 00
SPECIAL PURPOSE COST CENTERS	1, 372, 122	170,027	1, 770, 13	ij oj	1, 770, 131	101.00
113. 00 11300 NTEREST EXPENSE		0	1	lo lo	0	113. 00
116. 00 11600 HOSPI CE	679, 762	386, 977	1	-	1, 066, 739	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	31, 051, 523	51, 391, 833			82, 804, 385	
NONREI MBURSABLE COST CENTERS	0.7, 22.7, 22.2		1			
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	8, 679, 729	2, 021, 566	10, 701, 29	5 0	10, 701, 295	192. 00
192. 01 19201 PEDI ATRI CS	597, 751	55, 974			653, 725	
192. 02 19202 BROOKVI LLE	932, 698	133, 237	1, 065, 93	5 0	1, 065, 935	
192. 03 19203 RADI OLOGY - OSGOOD	28, 160	309			28, 469	
192. 04 19204 ENT	181, 852	37, 884			219, 736	192. 04
194.00 07950 COMMUNITY RELATIONS	345, 160	805, 156			789, 287	
194. 01 07951 COMMUNITY BENEFITS	448, 922	183, 055	631, 97	7 0	631, 977	
194. 02 07952 OTHER NON-REIMBURSABLE	0	0	l .	0 0		194. 02
194. 03 07953 EMS	12, 637	48, 692			61, 329	
200.00 TOTAL (SUM OF LINES 118 through 199)	42, 278, 432	54, 677, 706	96, 956, 13	8 0	96, 956, 138	200. 00

 Heal th Financial
 Systems
 MARGARET MARY COMMUNITY HOSPITAL

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCM

Provi der CCN: 15-1329

Peri od: Worksheet A From 01/01/2017 Date/Time Prepared: 5/17/2018 8: 01 am

COST CENTER DESCRIPTION					5/17/2018 8:0	
		Cost Center Description	Adjustments	Net Expenses		
GENERAL SERVICE COST CENTERS			(See A-8)			
GENERAL SERVICE COST CHRIES 1.00 00100 (New CAP REL COSTS-BUDG & FIXT -92.0 0 00200 (New CAP REL COSTS-BUDG & FIXT -92.0 0 00200 (New CAP REL COSTS-BUDG & 0 0 784,110 1.0 0 1.0 0 1.0 00201 (New CAP REL COSTS-MADEL EQUIP OFFSIT -92.0 0 00200 (New CAP REL COSTS-MADEL EQUIP OFFSIT -92.0 0 00200 (New CAP REL COSTS-MADEL EQUIP OFFSIT -92.0 0 00200 (New CAP REL COSTS-MADEL EQUIP OFFSIT -92.0 0 00200 (New CAP REL COSTS-MADEL EQUIP OFFSIT -92.0 0 00200 (New CAP REL COSTS-MADEL EQUIP OFFSIT -92.0 0 00200 (New CAP REL COSTS-MADEL EQUIP OFFSIT -92.0 0 00200 (New CAP REL COSTS-MADEL EQUIP OFFSIT -92.0 0 00200 (New CAP REL COSTS-MADEL EQUIP OFFSIT -92.0 0 00200 (New CAP REL COSTS-MADEL EQUIP OFFSIT -92.0 0 00200 (New CAP REL COSTS-MADEL EQUIP OFFSIT -93.0 0 00200 (New CAP REL COSTS-MADEL EQUIP OFFSIT -93.0 0 00200 (New CAP REL COSTS-MADEL EQUIP OFFSIT -93.0 0 00200 (NEW CAP REL CO						
1.00			6. 00	7. 00		
1.01 00100 NEW CAP REL COSTS-OFFSITE BLDG 2.01 00200 NEW CAP REL COSTS-AWBLE EQUIP OFFSIT 2.01 00201 NEW CAP REL COSTS-AWBLE EQUIP OFFSIT 3.02 00500 NEW CAP REL COSTS-AWBLE EQUIP OFFSIT 5.00 00500 OREO CHILOTES BERNET SEPARATHER 5.00 00500 ADMINISTRATIVE & GERERAL 7.00 00700 ORESTON OFFSIT 7.00 00700 ORESTON ORESTON 7.0					_	
2.00 00200 NEW CAP REL COSTS-JWINE EQUIP -185,751 4,1019,174 2.0 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 702,137 2.0 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 702,137 2.0 4.00 00700 OPERATION OF PLANT -185,751 1,961,318 5.0 6.00 00500 OPERATION OF PLANT -185,751 -28,133 1,284,689 7.0 6.00 00500 OPERATION OF PLANT -185,751 -28,133 1,284,689 7.0 6.00 00500 OPERATION OF PLANT -185,711 -23,133 1,284,689 7.0 6.00 00500 OPERATION OF PLANT -185,711 -23,133 1,284,689 7.0 6.00 00500 OUSEKEEP NAME -185,711 -27,276 171,087 8.0 6.00 00500 OUSKEEP NAME -185,711 -27,276 171,087 8.0 6.00 00500 OUSKEEP NAME -185,711 -27,276 171,087 8.0 6.00 01000 OUSKEEP NAME -185,711 -23,111			1			1.00
2. 01 00201 NEW CAP REL COSTS-MUBLE EQUIP OFFSIT 0 22, 317 2, 315, 597 4.0 0 00500 APPLOYER ERREFEITS DEPARTMENT 2-2, 810, 282 11, 961, 318 5.0 0 00500 APPLOY RESPECTED TO PLANT 2-2, 810, 282 11, 961, 318 5.0 0 00500 APPLOY RESPECTED TO PLANT 2-2, 810, 282 11, 961, 318 5.0 0 00500 APPLOY PLANT 2-0, 613, 320, 320 11, 961, 318 5.0 0 00701 DEEBATI ON OF PLANT 1-0, 675 STE 0 0 500, 229 7.7 0 0 00701 DEEBATI ON OF PLANT 1-0, 675 STE 0 0 500, 229 7.7 0 0 00700 DEFBATI ON OF PLANT 1-0, 675 STE 0 0 500, 229 7.7 0 0 00700 DEFBATI ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 11, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 675 STE 0 0 10, 600 DEFBAT ON OF PLANT 1-0, 600 DEFBAT						
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT		1	1		•	1
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7. 00 00700 OPERATION OF PLANT - FFSITE -28,133 1, 284,689 7. 7. 01 00701 OPERATION OF PLANT - FFSITE - 28,133 1, 284,689 7. 0. 00 00701 OPERATION OF PLANT - HOSPITAL & OFFS 0 500,222 7. 7. 0. 00702 OPERATION OF PLANT - HOSPITAL & OFFS 0 500,222 7. 7. 0. 00702 OPERATION OF PLANT - HOSPITAL & OFFS 0 500,222 7. 7. 0. 00702 OPERATION OF PLANT - HOSPITAL & OFFS 0 500,222 7. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.			-			
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8. 00 00000 LANIDRY & LINEN SERVICE -378 171, 087 9. 00 1. 256, 412 9. 00 1. 0000 010SEKEEPIN SERVICE -23, 048 84, 721 10. 00 10. 00 10100 CAFETERI A -337, 107 84, 06.29 11. 10 11. 00 1100 CAFETERI A -337, 107 84, 06.29 11. 10 11. 00 1100 CAFETERI A -337, 107 84, 06.29 11. 10 11. 00 1100 CAFETERI A -337, 107 84, 06.29 13. 00 1300 010SIN SERVICES & SUPPLY 0 5.97, 288 13. 00 11. 00 1100 CENTRAL SERVICES & SUPPLY 0 5.54 14. 00					1	
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13. 00 01300 NURSING ADMINISTRATION 0 597,288 13. 0 14. 00 1400 CENTRAL SERVICES & SUPPLY 0 5.4 14. 0 0 1400 CENTRAL SERVICES & SUPPLY 0 3.,282,102 15. 0 16. 0 16. 00 1600 MEDI CAL RECORDS & LIBRARY 4.855 1.376,200 16. 0 16. 0 1600 MEDI CAL RECORDS & LIBRARY 4.855 1.376,200 16. 0					·	
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43. 00 04300 NURSERY 0 643, 321 43. 04 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM -75,000 1, 836, 126 50. 06 52. 00 05200 DELI VEEY ROOM & LABOR ROOM 0 147, 012 52. 06 54. 00 05400 RADIOLOGY-DI AGNOSTIC -1, 221, 779 8, 384, 460 54. 06 66. 00 06600 06000 LABORATORY 0 0 0 0 66. 01 06600 06000 LABORATORY 0 0 0 0 66. 00 06600 OFERATING ROOM 0 0 0 0 66. 00 06600 OFERATING ROOM 0 0 0 0 67. 00 06500 RESPI RATORY THERAPY 0 0 558, 375 655 67. 00 06500 06500 RESPI RATORY THERAPY 0 0 158, 375 0 67. 00 06700 0CCUPATI ONAL THERAPY -1, 825 397, 407 67. 06 68. 00 06600 SPEECH PATHOLOGY 0 177, 035 68. 06 69. 00 06900 ELECTROCARDI OLOGY -179, 044 735, 625 69. 06 69. 00 06900 ELECTROCARDI OLOGY -179, 044 735, 625 69. 07 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2, 385, 725 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 1, 571, 438 72. 07 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 74. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 75. 00 07400 07400 07400 07400 07400 76. 00 07400 07400 07400 07400 07400 07400 77. 00 07400 07400 07400 07400 07400 07400 78. 00 07400 07400 07400 07400 07400 07400 07400 78. 00 074			1			1
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52.00 05200 DELLVERY ROOM & LABOR ROOM 0 147, 012 52, 00 40.00 06000 LABORATORY 0 3, 750, 469 60.00 60.01 06001 BLOOD LABORATORY 0 0 558, 375 66.00 65.00 06600 RESPIRATORY THERAPY 0 558, 375 66.00 66.00 06600 PHYSI CAL THERAPY -10, 820 1, 125, 535 66.00 66.00 06600 PHYSI CAL THERAPY -10, 820 1, 125, 535 66.00 66.00 06600 PHYSI CAL THERAPY -10, 820 1, 125, 535 66.00 67.00 06700 0CCUPATIONAL THERAPY -17, 725 397, 407 67.00 68.00 06800 SPECH PATHOLOGY 0 177, 035 68.00 69.00 06900 ELECTROCARDI OLOGY -179, 044 735, 625 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2, 385, 725 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 1, 571, 438 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 74.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 75.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 76.00 09000 CLI NI C 0 0 0 77.00 07000 MUDID CLI NIC 0 0 904, 627 79.00 09000 09000 0000 0000 0000 0000 0000 79.00 09000 0000 0000 0000 0000 0000 0000 0000 79.00 09000 0000 0000 0000 0000 0000 0000 79.00 09000 0000 0000 0000 0000 0000 79.00 09000 0000 0000 0000 0000 0000 79.00 09000 0000 0000 0000 0000 0000 79.00 09000 0000 0000 0000 0000 0000 79.00 09000 0000 0000 0000 0000 0000 79.00 09000 0000 0000 0000 0000 0000 79.00 09000 0000 0000 0000 0000 0000 79.00 09000 0000 0000 0000 0000 0000 0000 0000 79.00 09000 0000	50.00		-75, 000	1, 836, 126	5	50.00
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60. 00 06000 LABORATORY 0 3,750,469 66. 00 60. 01 06000 BLOOD LABORATORY 0 0 0 65. 00 06500 RESPIRATORY THERAPY 0 558,375 65. 00 66. 00 06600 PHYSI CAL THERAPY -10,820 1,125,535 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY -1,725 397,407 67. 00 68. 00 06800 SEECH PATHOLOGY 0 177,035 68. 00 69. 00 06900 ELECTROCARDI OLOGY -1,725 398,725 67. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 2,385,725 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 1,571,438 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC -844,170 1,192,806 90. 00 90. 01 099001 WOUND CLINC -844,170 1,192,806 90. 00 90. 01 099001 WOUND CLINC -1,851,840 2,427,915 91. 00 90. 00 090000 OBSERVATION BEDS (NON-DISTINCT PART) 0 1,790,151 91. 00 101. 00 10100 HOME HEALTH AGENCY 0 1,790,151 91. 00 113. 00 11300 INTEREST EXPENSE 0 1,066,739 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -9,637,781 73,166,604 118. 00 119. 00 19200 PHYSI CLANS' PRIVATE OFFICES 0 10,701,295 192. 01 192. 01 19200 PHYSI CLANS' PRIVATE OFFICES 0 10,701,295 192. 01 192. 01 19200 PHYSI CLANS' PRIVATE OFFICES 0 10,701,295 192. 01 192. 01 19200 PHYSI CLANS' PRIVATE OFFICES 0 10,701,295 192. 01 192. 01 19200 PHYSI CLANS' PRIVATE OFFICES 0 10,701,295 192. 01 192. 01 19200 PHYSI CLANS' PRIVATE OFFICES 0 10,701,295 192. 01 192. 01 19200 PHYSI CLANS' PRIVATE OFFICES 0 10,701,295 192. 01 192. 01 19200 PHYSI CLANS' PRIVATE OFFICES 0 10,701,295 192. 01 192. 01 19200 PHYSI CLANS' PRIVATE OFFICES 0 10,701,295 192. 01 192. 01 19200 PHYSI CLANS' PRIVATE OFFICES 0 10,701,295 192. 01 192. 01 19200 PHYSI CLANS' PRIVATE OFFICES 0 10,701,295 192. 01 192. 01 19200 PHYSI CLANS' PRIVATE			-1, 221, 779		•	54.00
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68. 00	66.00	06600 PHYSI CAL THERAPY	-10, 820	1, 125, 535	5	66.00
69. 00 06900 ELECTROCARDI OLOGY	67.00	06700 OCCUPATI ONAL THERAPY	-1, 725	397, 407	7	67.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 2, 385, 725 1, 00 1,	68.00	06800 SPEECH PATHOLOGY	0	177, 035	5	68. 00
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73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 385, 725	5	71.00
SECOND CONTROL CONTR			0	1, 571, 438	3	72.00
88. 00	73. 00		0	0		73.00
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92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS			-			
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SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	404 0			4 700 454	,	101 00
113. 00 11300 INTEREST EXPENSE 0 0 1, 066, 739 116. 00 1, 066, 739 116. 00 1, 066, 739 116. 00 1, 066, 739 117. 00 1, 066, 739 118. 00 1, 066, 739 118. 00 1, 066, 739 118. 00 10, 001, 001, 001, 001, 001, 001,	101.00		0	1, 790, 151	I	101.00
116. 00	112 0			1		112 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) -9, 637, 781 73, 166, 604 118.00 NONREI MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 10, 701, 295 192.01 19201 PEDI ATRI CS 0 653, 725 192.02 19202 BROOKVI LLE 0 1, 065, 935 192.03 19203 RADI OLOGY - OSGOOD 0 28, 469 192.03 19204 ENT 0 219, 736 192.04 19204 ENT 0 219, 736 192.05 194.00 19750 COMMUNI TY RELATI ONS 0 789, 287 194.00 19751 COMMUNI TY BENEFITS 0 631, 977 194.02 07952 OTHER NON-REI MBURSABLE 0 0 194.05			4			1
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192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 19201 19201 19201 19202 19202 19202 19202 19203 19203 19203 19203 19204 19204 19204 19204 19204 19204 19205	118.00		-9,637,781	/3, 166, 604	1	1118.00
192. 01 19201 PEDI ATRI CS 0 653, 725 192. 02 19202 BROOKVI LLE 0 1, 065, 935 192. 03 19203 RADI OLOGY - OSGOOD 0 28, 469 192. 04 19204 ENT 0 219, 736 192. 04 19205 COMMUNI TY RELATI ONS 0 789, 287 194. 01 07951 COMMUNI TY BENEFI TS 0 631, 977 194. 02 07952 OTHER NON-REI MBURSABLE 0 0 194. 05	102 0			10 701 205	-	102.00
192. 02 19202 BROOKVI LLE 0 1, 065, 935 192. 03 192. 03 19203 RADI OLOGY - OSGOOD 0 28, 469 192. 03 192. 04 19204 ENT 0 219, 736 192. 04 194. 00 07950 COMMUNI TY RELATI ONS 0 789, 287 194. 00 194. 01 07952 OTHER NON-REI MBURSABLE 0 631, 977 194. 00 194. 02 07952 OTHER NON-REI MBURSABLE 0 194. 00						
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Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/17/2018 8:01 am Provi der CCN: 15-1329

						10	Date/IIMe Prepared: 5/17/2018 8:01 am
2.00 3.00 4.00 5.00			Increases			,	 1
A - CAFETERIA		Cost Center	Li ne #	Sal ary	0ther		
1.00 CAFETERIA		2. 00	3. 00	4. 00	5. 00		
O		A - CAFETERIA					
B - 0B RECLASS	1.00	CAFETERI A	<u>11.</u> 00	70 <u>0, 1</u> 72	<u>477, 5</u> 64		1.00
1.00 ADULTS & PEDIATRICS 30.00 528.670 59.901 2.00		0		700, 172	477, 564		
NURSERY							
1.00 C - COMMUNI TY RELATIONS 1.00 2.00 2.00 2.00 2.00 2.00							
1.00	2. 00	NURSERY	43.00				2.00
1.00		0		1, 104, 672	125, 353		
1.00	1 00		F 00	100.00/	0.40, 000		1.00
1.00	1.00	ADMINISTRATIVE & GENERAL					1.00
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BLDG	1 00			٥	10,000		1 00
NEW CAP REL COSTS-MYBLE	1.00		1.01	٥	10, 969		1.00
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1.00	2.00		2.01	٩	272, 137		2.00
1.00		0	+		303. 126		
1.00		E - IMPLANTABLE SUPPLIES RECL	_ASS	-1	2227		
2.00	1.00			0	1, 571, 438		1.00
C - CENTRAL SUPPLY RECLASS 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 2.385,725 1.00		PATI ENT					
1. 00	2.00		0.00		0		2.00
1. 00 MEDI CAL SUPPLIES CHARGED TO 71. 00 0 2, 385, 725 2. 00 3. 00 4. 00 5. 00 0.		0		0	1, 571, 438		
PATI ENTS 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0							
2. 00 3. 00 0. 00 0 0 3. 00 4. 00 5. 00 0. 00 0 0 4. 00 5. 00 0. 00 0 0 0 5. 00 6. 00 0. 00 0 0 0 6. 00 7. 00 8. 00 0 0 0 7. 00 8. 00 0. 00 0 0 0 7. 00 8. 00 0. 00 0 0 0 9. 00 10. 00 0. 00 0 0 0 10. 00 11. 00 11. 00 0. 00 0 0 0 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 12. 00 13. 00 14. 00 12. 00 13. 00 14. 00 15. 00 15. 00 15. 00 15. 00 15. 00 16. 00 17. 00 16. 00 17. 00 18. 00 19. 00 0 19. 00 20. 00 21. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00	1. 00		71. 00	0	2, 385, 725		1.00
3.00 0.00 0.00 0.00 3.00 4.00 0.00 0.00 0.00 5.00 6.00 0.00 0.00 0.00 6.00 7.00 0.00 0.00 0.00 0.00 8.00 9.00 0.00 0.00 0.00 9.00 10.00 0.00 0.00 0.00 0.00 10.00 11.00 0.00 0.00 0.00 0.00 11.00 12.00 0.00 0.00 0.00 0.00 12.00 13.00 0.00 0.00 0.00 0.00 14.00 15.00 0.00 0.00 0.00 0.00 15.00 16.00 0.00 0.00 0.00 0.00 17.00 18.00 0.00 0.00 0.00 0.00 19.00 20.00 0.00 0.00 0.00 0.00 21.00 22.00 0.00 0.00 0.00 0.00 22.00 22.00 0.00 0.00 0.00 0.00 0.00 22.00		PATI ENTS					
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11. 00 0.00 0 0 0 11. 00 12. 00 0.00 0 0 0 12. 00 13. 00 0.00 0 0 0 13. 00 14. 00 0.00 0 0 0 14. 00 15. 00 0.00 0 0 0 15. 00 16. 00 0.00 0 0 0 16. 00 17. 00 0.00 0 0 0 17. 00 18. 00 0.00 0 0 0 18. 00 19. 00 0.00 0 0 0 19. 00 20. 00 0.00 0 0 0 0 20. 00 21. 00 0.00 0 0 0 0 21. 00 22. 00 0 0 0 0 0 0 0			•				
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15. 00 0.00 0 0 15. 00 16. 00 0.00 0 0 16. 00 17. 00 0.00 0 0 17. 00 18. 00 0.00 0 0 18. 00 19. 00 0.00 0 0 19. 00 20. 00 0.00 0 0 20. 00 21. 00 0.00 0 0 21. 00 22. 00 0 0.00 0 0 22. 00	13.00		0.00	O	0		13.00
16. 00 0.00 0 0 16. 00 17. 00 0.00 0 0 17. 00 18. 00 0.00 0 0 18. 00 19. 00 0.00 0 0 19. 00 20. 00 0.00 0 0 20. 00 21. 00 0.00 0 0 21. 00 22. 00 0 0 0 21. 00 0 0 0 0 22. 00	14.00		0. 00	0	0		14.00
17. 00 0.00 0 0 17. 00 18. 00 0.00 0 0 18. 00 19. 00 0.00 0 0 19. 00 20. 00 0.00 0 0 20. 00 21. 00 0.00 0 0 21. 00 22. 00 0 0 0 23. 385, 725	15.00		0.00	0	0		15. 00
18.00 0.00 0 0 19.00 0.00 0 0 20.00 0.00 0 0 21.00 0.00 0 0 22.00 0 0 0 0 0 0 0 22.00 0 0 0 22.00 0 0 0	16.00			0	0		16.00
19.00 0.00 0 0 20.00 0.00 0 0 21.00 0.00 0 0 22.00 0.00 0 0 0 0 0 0 22.00 0 0 0 22.00 0 0 0			•	0			
20. 00			•	0			
21. 00 22. 00 0 0 0 0 21. 00 0 22. 00 22. 00				0			
22. 00 0 0 0 0 0 0 2, 385, 725				0			
0 2,385,725				0	0		
	22.00			🏪	0		22.00
300.00 parana ratar. The eases 1, 425, 650 5, 103, 424 500.00	E00 00	Crand Total: Increases		1 025 450			E00.00
	500.00	joi and Total. THE Eases		1, 720, 000	5, 105, 429		300.00

Heal th Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-1329 Period: Worksheet A-6
From 01/01/2017 To 12/31/2017 Date/Time Prepared:

					10	5/17/2018	
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - CAFETERIA						
1.00	DI ETARY	1000	70 <u>0, 1</u> 72	47 <u>7, 5</u> 64			1.00
	0		700, 172	477, 564			_
1 00	B - OB RECLASS	F2 00	1 104 (70	105 050			1 00
1.00	DELIVERY ROOM & LABOR ROOM	52. 00	1, 104, 672 0	125, 353	1		1.00
2. 00		0.00		0			2. 00
			1, 104, 672	125, 353	j		_
1 00	C - COMMUNITY RELATIONS COMMUNITY RELATIONS	104 00	120, 806	240 222	0		1 100
1. 00	COMMUNITY RELATIONS	194.00	120, 806	24 <u>0, 2</u> 23 240, 223			1.00
	D - OFFSITE BUILDING DEPR REC	1 100	120, 806	240, 223			_
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	10, 989	9		1.00
1.00	FIXT	1.00	٩	10, 909	9		1.00
2.00	NEW CAP REL COSTS-MVBLE	2. 00	0	292, 137	, 9		2.00
2.00	EQUI P	2.00	٩	272, 137	7		2.00
	0	+		303, 126			·
	E - IMPLANTABLE SUPPLIES RECL	ASS	<u> </u>	303, 120	'II		
1. 00	OPERATI NG ROOM	50.00	0	1, 567, 274	0		1.00
2. 00	CLINIC	90.00	o	4, 164			2.00
	0			1, 571, 438			1
	G - CENTRAL SUPPLY RECLASS		· · ·		· · · · · · · · · · · · · · · · · · ·		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	4, 801	0		1.00
2.00	OPERATION OF PLANT	7. 00	o	147	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8. 00	o	11, 756	0		3.00
4.00	DI ETARY	10.00	o	46, 461	0		4.00
5.00	NURSING ADMINISTRATION	13. 00	О	1	0		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14. 00	o	369, 617	0		6.00
7.00	PHARMACY	15. 00	0	923	0		7. 00
8.00	MEDICAL RECORDS & LIBRARY	16. 00	0	4, 274	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	99, 220	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	6, 954	0		10.00
11.00	OPERATING ROOM	50.00	0	735, 840	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	107, 252	0		12.00
13.00	RADI OLOGY-DI AGNOSTI C	54.00	0	224, 051			13. 00
14.00	LABORATORY	60. 00	0	38, 631			14. 00
15. 00	RESPI RATORY THERAPY	65. 00	0	27, 270			15. 00
16.00	PHYSI CAL THERAPY	66. 00	0	16, 942	1		16. 00
17. 00	OCCUPATIONAL THERAPY	67. 00	0	8, 109	1		17. 00
18. 00	SPEECH PATHOLOGY	68. 00	0	1, 063	1		18. 00
19. 00	ELECTROCARDI OLOGY	69. 00	0	23, 085	1		19. 00
20.00	CLI NI C	90. 00	0	200, 411	1		20.00
21. 00	WOUND CLINC	90. 01	0	370, 524			21.00
22. 00	EMERGENCY	<u>91.</u> 00		8 <u>8, 3</u> 93			22. 00
E00 00	U Donal Talak Bases		0	2, 385, 725			500 00
500.00	Grand Total: Decreases		1, 925, 650	5, 103, 429	'I		500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Worksheet A-7 Part I Date/Time Prepared: 5/17/2018 8:01 am Provider CCN: 15-1329 Peri od: From 01/01/2017 To 12/31/2017 Acqui si ti ons Begi nni ng Bal ances Disposals and Retirements Purchases Donati on Total

		bai arices				Ke ti i ellietits	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	2, 553, 658	0	0	0	0	1.00
2.00	Land Improvements	468, 364	89, 381	0	89, 381	0	2.00
3.00	Buildings and Fixtures	76, 061, 360	4, 526, 629	0	4, 526, 629	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	6, 341, 285	0	0	0	1, 005	5.00
6.00	Movable Equipment	52, 060, 884	15, 973, 699	0	15, 973, 699	9, 142, 278	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	137, 485, 551	20, 589, 709	0	20, 589, 709	9, 143, 283	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	137, 485, 551	20, 589, 709	0	20, 589, 709	9, 143, 283	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	2, 553, 658					1.00
2. 00	Land Improvements	557, 745					2.00
3.00	Buildings and Fixtures	80, 587, 989	0				3. 00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	6, 340, 280					5.00
6.00	Movable Equipment	58, 892, 305	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	148, 931, 977	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	148, 931, 977	0				10.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet A-7 | From 01/01/2017 | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | P Provi der CCN: 15-1329

				T	o 12/31/2017	Date/Time Pre 5/17/2018 8:0	pared: 1 am
			SU	IMMARY OF CAPIT	AL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
		0.00	10.00	44.00	instructions)	10.00	
	DART II. DECONOLILATION OF MICHIES FROM WOR	9. 00	10.00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			4 00
1.00	NEW CAP REL COSTS-BLDG & FIXT	2, 048, 108	0	1, 024, 875	0	0	1.00
1. 01	NEW CAP REL COSTS-OFFSITE BLDG	773, 121	0	0	0	0	1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4, 497, 062	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)	7, 318, 291	0	1, 024, 875	0	0	3. 00
		SUMMARY 0	F CAPITAL				
		0.11	T				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at					
			9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	· · · · · · · · · · · · · · · · · · ·				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3, 072, 983				1.00
1. 01	NEW CAP REL COSTS-OFFSITE BLDG	0	773, 121				1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	4, 497, 062				2.00
2. 01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0				2. 01
3. 00	Total (sum of lines 1-2)	0	8, 343, 166				3. 00

Heal th	Financial Systems MAR	RGARET MARY COM	IMUNITY HOSPITA	.L	In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/17/2018 8:0	pared:
		COM	PUTATION OF RA	TI 0S	OS ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1. 00	2. 00	3.00	4. 00	5. 00	
_	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	NEW CAP REL COSTS-BLDG & FIXT	62, 625, 202	0	62, 625, 20	0. 420495	0	1.00
1. 01	NEW CAP REL COSTS-OFFSITE BLDG	19, 152, 954	0	19, 152, 95	4 0. 128602	0	1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	67, 153, 821	0	67, 153, 82	0. 450903	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)	148, 931, 977	0	148, 931, 97			3.00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY (F CAPITAL	
	Cost Center Description	Taxes	Other Capi tal -Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6, 00	7.00	8. 00	9, 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		7.00	0.00	7. 00	10.00	
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		0 2, 037, 119	0	1.00
1. 01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	,	784, 110		1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	,	0 4, 019, 174		2.00
2. 01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	,	0 292, 137	0	2. 01
3.00	Total (sum of lines 1-2)	0	0	,	7, 132, 540	0	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
	•		(see	instructions)	Capi tal -Rel at	(sum of cols.	
			instructions)		ed Costs (see instructions)	9 through 14)	
		11. 00	12. 00	13.00	14.00	15.00	
	DADT III DECONCILIATION OF CADITAL COSTS C	ENTERC					

196, 018

196, 018

0

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-OFFSITE BLDG

Total (sum of lines 1-2)

NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP OFFSIT

1.00

1.01

2. 00 2. 01

3. 00

2, 233, 137

784, 110 4, 019, 174

292, 137 7, 328, 558

1.00

1.01

2. 00 2. 01

3.00

ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/17/2018 8:0	
				Expense Classification on			T CIII
				o/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter			EW CAP REL COSTS-BLDG & XT	1.00	0	1.00
1. 01	2) Investment income - NEW CAP		OINE	EW CAP REL COSTS-OFFSITE	1. 01	0	1. 01
1.01	REL COSTS-OFFSITE BLDG			_DG	1.01		1.01
2. 00	(chapter 2) Investment income - NEW CAP		ONE	EW CAP REL COSTS-MVBLE	2. 00	0	2. 00
	REL COSTS-MVBLE EQUIP (chapter 2)		EC	QUI P			
2. 01	Investment income - NEW CAP			EW CAP REL COSTS-MVBLE	2. 01	0	2. 01
	REL COSTS-MVBLE EQUIP OFFSIT (chapter 2)		EC	QUIP OFFSIT			
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		O		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)						
7. 00	Tel ephone servi ces (pay stati ons excluded) (chapter		0		0.00	0	7. 00
8. 00	21) Television and radio service		0		0.00	0	8. 00
	(chapter 21)						
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-4, 654, 696		0.00	0	
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Rel ated organization	A-8-1	o			0	12.00
	transactions (chapter 10)	A-0-1				_	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00		
15. 00	Rental of quarters to employee and others		0		0.00	0	15.00
16. 00	Sale of medical and surgical		О		0.00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing and allied health		O		0.00	0	19.00
	education (tuition, fees, books, etc.)						
20.00	Vending machines		0		0.00		
21. 00	interest, finance or penalty		o _l		0.00	0	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to		1			_	
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	ORE	ESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0 PF	HYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0 **	** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL		ONE	EW CAP REL COSTS-BLDG &	1. 00	0	26. 00
	COSTS-BLDG & FLXT		FI	XT			
26. 01	Depreciation - NEW CAP REL COSTS-OFFSITE BLDG			EW CAP REL COSTS-OFFSITE LDG	1. 01	0	26. 01
	· '	'	,		•	•	-

Health Financial Systems ADJUSTMENTS TO EXPENSES Provi der CCN: 15-1329 Peri od: Worksheet A-8 From 01/01/2017 | Worksheet A-8 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared:

				T	o 12/31/2017	Date/Time Pre 5/17/2018 8:0	
				Expense Classification on To/From Which the Amount is		37 177 2010 0.0	ı allı
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00		4. 00	Ref. 5.00	
27. 00	Depreciation - NEW CAP REL	1.00		3.00 NEW CAP REL COSTS-MVBLE	2.00	5.00	27. 00
27. 01	COSTS-MVBLE EQUIP Depreciation - NEW CAP REL		0	EQUIP NEW CAP REL COSTS-MVBLE	2. 01	0	27. 01
28. 00	COSTS-MVBLE EQUIP OFFSIT Non-physician Anesthetist			EQUIP OFFSIT *** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0	cost center bereted	0.00	0	
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest	А	-185, 751	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	9	32.00
33. 00	OTHEROPERATING GIRLS ON THE RUN REVE	В	-33, 669	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
34. 00	OTHEROPERATING OTHOP -	В	2, 099	ADMINISTRATIVE & GENERAL	5. 00	0	34.00
35. 00	INTERNAL SALE MMCH OTHER OPERATING	В	-8, 233	ADMINISTRATIVE & GENERAL	5. 00	0	35. 00
36. 00	COMMBENEFITS SC OTHEROPERATING DIABETES	В	-34, 549	ADMINISTRATIVE & GENERAL	5. 00	0	36. 00
37. 00	PROGRAM OTHEROPERATING OTHOP-COMMUNITY	В	-5, 430	ADMINISTRATIVE & GENERAL	5. 00	0	37. 00
38. 00	OTHEROPERATING OTHOP-PURCHASE	В	-88	ADMINISTRATIVE & GENERAL	5. 00	0	38. 00
40. 00	OTHEROPERATING OTHOP - MISC	В	-27, 633	OPERATION OF PLANT	7. 00	0	40. 00
41. 00	REVENUE MMCH NON-OPERATING R NONOP -	В	-500	OPERATION OF PLANT	7. 00	0	41. 00
43. 00	MI SCELL OTHEROPERATI NG OTHOP - LAUNDRY	В	-378	LAUNDRY & LINEN SERVICE	8. 00	0	43. 00
44. 00	OTHEROPERATING OTHOP - VENDING	В	-4, 264	DI ETARY	10. 00	0	44.00
45. 00	SALES OTHEROPERATING OTHOP - DIET	В	-18, 784	DI ETARY	10. 00	0	45. 00
45. 01	SUPP/INS CAFETERIA OFFSET	В		CAFETERI A	11. 00	0	
45. 02	OTHEROPERATING OTHOP - MEDRED TRANSC	В	-4, 855	MEDICAL RECORDS & LIBRARY	16. 00	0	45. 02
45. 03	OTHEROPERATING OTHOP-PHYSICAL THERAP	В	-10, 820	PHYSI CAL THERAPY	66. 00	0	45. 03
45. 04	OTHEROPERATI NG OTHOP- OCCUPATI ONAL T	В	-1, 725	OCCUPATI ONAL THERAPY	67. 00	0	45. 04
45. 05	INTEREST OFFSET	А		NEW CAP REL COSTS-BLDG & FIXT	1. 00	11	45. 05
45. 06	LOBBYING EXPENSE	A	-4, 926	ADMINISTRATIVE & GENERAL	5. 00	0	
45. 07 45. 08	MEDICAL STAFF RETENTION COST MEDICAL STAFF PLACEMENT FEE	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	45. 07 45. 08
45. 09	PHYSICIAN RECRUITMENT	Ä		ADMINISTRATIVE & GENERAL	5. 00	0	1
45. 10	HAF	Α		ADMINISTRATIVE & GENERAL	5. 00	0	
45. 11	TELEPHONE & TV OFFSET	A		ADMINISTRATIVE & GENERAL	5. 00	0	
45. 12 45. 13	BOUTIQUE OFFSET HOSPITALIST OFFSET	A A		RADI OLOGY-DI AGNOSTI C ADULTS & PEDI ATRI CS	54. 00 30. 00	0	45. 12 45. 13
50. 00	TOTAL (sum of lines 1 thru 49)	A	-730, 327 -9, 637, 781		30.00	U	50.00
	(Transfer to Worksheet A,		1,007,701				
	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
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 01/01/2017 Provider CCN: 15-1329

								To 12/31/2017	7 Date/Time Pre 5/17/2018 8:0	epared: 01 am
	Wkst. A Line #	Cost Center/Physician	Total	Profe	essi on	al	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Com	ponent		Component		ider Component	
									Hours	
	1. 00	2. 00	3. 00	4	1. 00		5. 00	6. 00	7. 00	
1. 00		ADULTS & PEDIATRICS	569, 665		484,	665	85, 000			1. 00
2. 00		OPERATING ROOM	130, 000	1	75,			l e	0	2.00
3. 00	54. 00	RADI OLOGY-DI AGNOSTI C	1, 277, 977	·l 1	, 219,		58, 000	l o	0	3.00
4. 00	60. 00	LABORATORY	64, 880			0	64, 880		0	4.00
5. 00	69. 00	ELECTROCARDI OLOGY	219, 205		179, (044	40, 161	0	0	5. 00
6. 00		CLINIC	844, 170	1	844,		0	0	0	6.00
7. 00	91. 00	EMERGENCY	2, 302, 300) 1	, 851,	840	450, 460	l o	0	7. 00
8. 00	0.00		0	ol .		0	0	0	0	8. 00
9. 00	0.00		0	ol .		0	0	0	0	9. 00
10.00	0.00		0	ol .		0	0	0	0	10.00
200.00			5, 408, 197	4	, 654,	696	753, 501		0	
	Wkst. A Line #	Cost Center/Physician	Unadiusted RCE				Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadj u	sted	RCE	Memberships &	Component	of Mal practice	
					imit		Continuing	Share of col.	Insurance	
							Educati on	12		
	1. 00	2. 00	8. 00	9	9. 00		12. 00	13. 00	14.00	
1. 00	30. 00	ADULTS & PEDIATRICS	0			0	0	0	0	1.00
2.00		OPERATING ROOM	0			0	0	0	0	2.00
3.00		RADI OLOGY-DI AGNOSTI C	0			0	0	0	0	3.00
4.00		LABORATORY	0			0	0	0	0	4.00
5.00	69. 00	ELECTROCARDI OLOGY	0			0	0	0	0	5. 00
6.00	90. 00	CLINIC	0			0	0	0	0	6.00
7. 00	91. 00	EMERGENCY	0			0	0	0	0	7. 00
8. 00	0.00		0			0	0	0	0	8. 00
9. 00	0. 00		0			0	0	0	0	9. 00
10.00	0. 00		0			0	0	0	0	10.00
200.00			0			0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der		sted R	CE	RCE	Adjustment		
		ldenti fi er	Component	L	imit		Di sal I owance			
			Share of col.							
			14							
	1. 00	2.00	15. 00		6. 00		17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	0	1		0				1.00
2.00		OPERATING ROOM	0	1		0	0	,		2.00
3. 00		RADI OLOGY-DI AGNOSTI C	0)		0	0	1, 219, 977	1	3. 00
4.00		LABORATORY	0	2		0	0	0		4.00
5. 00		ELECTROCARDI OLOGY	0)		0	0	179, 044		5.00
6.00		CLINIC	0)		0	0	844, 170		6. 00
7. 00		EMERGENCY	0)		0	0	1, 851, 840	1	7. 00
8. 00	0. 00		0)		0	0	0	1	8. 00
9. 00	0. 00		0)		0	0	0	1	9. 00
10. 00	0. 00		0)		0	0	0	1	10.00
200. 00			0	P		0	0	4, 654, 696	1	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1329

Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

5/17/2018 8:01 am CAPITAL RELATED COSTS NEW MVBLE Cost Center Description Net Expenses NEW BLDG & NEW OFFSITE NEW MVBLE EQUIP OFFSIT for Cost FIXT BI DG **FOULP** Allocation (from Wkst A col. 7) 0 1.00 1. 01 2.00 2. 01 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2, 233, 137 2, 233, 137 1 00 00101 NEW CAP REL COSTS-OFFSITE BLDG 784, 110 1.01 784, 110 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 4, 019, 174 4, 019, 174 2.00 2.00 2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 292, 137 292, 137 2.01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 12, 315, 597 9,622 17, 318 0 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 11, 961, 318 372,007 267 669, 534 99 5.00 00700 OPERATION OF PLANT 1, 284, 689 7.00 7 00 358, 063 5 840 644, 437 2 176 00701 OPERATION OF PLANT -OFFSITE 7.01 208, 151 0 0 0 7.01 7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS 500, 222 0 0 0 7.02 00800 LAUNDRY & LINEN SERVICE 8.00 171, 087 24, 853 0 44, 731 0 8.00 00900 HOUSEKEEPI NG 1,057 394 9 00 1, 256, 412 28, 428 51, 164 9 00 01000 DI ETARY 10.00 84, 721 9, 933 0 17,877 0 10.00 01100 CAFETERI A 840, 629 75, 832 0 136, 481 0 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 597, 288 1, 551 13.00 862 0 0 01400 CENTRAL SERVICES & SUPPLY O 14 00 54 C 0 0 14 00 15.00 01500 PHARMACY 3, 282, 102 11, 911 0 21, 437 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1, 376, 200 40,508 72, 907 0 16.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 328, 171 205, 736 0 370, 280 0 30.00 03100 INTENSIVE CARE UNIT 303, 606 19, 527 0 35, 144 0 31.00 31.00 <u>10, 3</u>85 43.00 04300 NURSERY 643, 321 0 18, 691 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 836, 126 44, 309 0 79, 747 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 39, 111 0 52.00 147.012 21, 731 52.00 05400 RADI OLOGY-DI AGNOSTI C 8, 384, 460 0 54.00 270.348 486, 570 0 54.00 06000 LABORATORY 49, 170 0 3, 750, 469 60.00 88, 495 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 37, 598 06500 RESPIRATORY THERAPY 65.00 558, 375 67, 668 65.00 66.00 06600 PHYSI CAL THERAPY 1, 125, 535 79, 350 0 142, 813 66.00 0 06700 OCCUPATI ONAL THERAPY 397, 407 0 29, 727 67 00 16, 517 0 67.00 15, 090 06800 SPEECH PATHOLOGY 177, 035 27, 159 0 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 735, 625 32, 229 0 58,005 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 19, 352 71.00 2, 385, 725 10, 752 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 1, 571, 438 56, 531 101, 744 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS C 0 73.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 904, 627 88 00 60.560 22, 563 90.00 09000 CLI NI C 1, 192, 806 197, 456 24, 463 355, 379 9, 114 90.00 90.01 09001 WOUND CLINC 233, 033 9,537 17, 165 0 90.01 91.00 09100 EMERGENCY 0 233, 139 91.00 2, 427, 915 129, 537 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 1, 790, 151 48, 251 2, 543 86, 842 947 101. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1,066,739 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 186, 073 94.730 3, 934, 468 35, 293 118. 00 118.00 73, 166, 604 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 10, 701, 295 240 533, 661 432 198, 828 192. 00 192. 01 19201 PEDI ATRI CS 653, 725 26, 492 47, 681 0 192.01 192. 02 19202 BROOKVI LLE 1, 065, 935 155 719 58, 016 192. 02 C 0 192. 03 19203 RADI OLOGY - OSGOOD 28, 469 C 0 0 0 192.03 192. 04 19204 ENT 219, 736 0 0 0 192.04 194. 00 07950 COMMUNITY RELATIONS 789, 287 3,843 0 6, 917 0 194.00 194. 01 07951 COMMUNITY BENEFITS 0 194. 01 631, 977 16, 489 0 29, 676 0 0 194. 02 194. 02 07952 OTHER NON-REI MBURSABLE 194. 03 07953 EMS 0 0 194.03 61, 329 0 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 0 201.00 202.00 TOTAL (sum lines 118 through 201) 87, 318, 357 2, 233, 137 784, 110 4, 019, 174 292, 137 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1329

Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

5/17/2018 8:01 am Cost Center Description **EMPLOYEE** Subtotal ADMINISTRATIV OPERATION OF OPERATION OF **BENEFITS** PLANT E & GENERAL **PLANT DEPARTMENT** -OFFSITE 5.00 7. 00 4A 7 01 4 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP REL COSTS-OFFSITE BLDG 1.01 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 2 00 2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 12, 342, 537 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 1, 934, 581 14, 937, 806 14, 937, 806 5.00 00700 OPERATION OF PLANT 2, 768, 887 7 00 2, 295, 205 473.682 0 7 00 7.01 00701 OPERATION OF PLANT -OFFSITE 208, 151 42, 958 251, 109 7.01 7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS 142, 398 642,620 132, 623 0 7 02 00800 LAUNDRY & LINEN SERVICE 46, 079 29, 638 270, 309 55. 786 8.00 8.00 0 00900 HOUSEKEEPING 1, 616, 036 333, 516 9 00 278, 581 52, 706 303 9 00 10.00 01000 DI ETARY 26,882 139, 413 28, 772 18, 416 0 10.00 11.00 01100 CAFETERI A 205, 274 1, 258, 216 259, 669 140, 594 0 11.00 13.00 01300 NURSING ADMINISTRATION 172, 323 1, 598 772,024 159, 330 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 54 11 0 14.00 01500 PHARMACY 175.040 3, 490, 490 22.083 15.00 15 00 720, 364 0 01600 MEDICAL RECORDS & LIBRARY
INPATIENT ROUTINE SERVICE COST CENTERS 1<u>, 835, 171</u> 75, 104 16.00 16.00 0 345, 556 378, 741 30.00 03000 ADULTS & PEDIATRICS 948, 095 3, 852, 282 381, 439 30.00 795, 030 0 03100 INTENSIVE CARE UNIT 31.00 86, 994 445, 271 91, 895 36, 203 0 31.00 04300 NURSERY 168, 870 43.00 841, 267 173,620 19, 254 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 406, 761 2, 366, 943 488, 487 82, 151 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 38, 708 246, 562 50, 885 40, 289 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 899, 117 10, 040, 495 2, 072, 147 54 00 501, 234 0 54 00 60.00 06000 LABORATORY 444, 858 4, 332, 992 894, 239 91, 162 0 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 06500 RESPIRATORY THERAPY 138.799 802, 440 165, 607 69.707 0 65.00 65.00 06600 PHYSI CAL THERAPY 342, 900 147, 117 66.00 313, 807 1, 661, 505 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 114, 259 557, 910 115, 141 30, 623 0 67.00 06800 SPEECH PATHOLOGY 68.00 51,076 270, 360 55, 797 27, 977 0 68.00 69 00 06900 ELECTROCARDI OLOGY 175, 355 1 001 214 206, 630 59.753 0 69 00 498, 576 19, 935 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 2, 415, 829 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 1, 729, 713 356, 976 104, 810 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 73.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 1, 222, 597 88.00 08800 RURAL HEALTH CLINIC 234, 847 252, 318 17, 380 09000 CLI NI C 2, 237, 841 366, 089 7,021 90.00 458, 623 461, 843 90.00 90 01 09001 WOUND CLINC 66, 653 326, 388 67, 360 17, 682 90.01 0 09100 EMERGENCY 91.00 563, 345 3, 353, 936 692, 182 240, 165 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 466, 772 2, 395, 506 494, 382 89 459 730 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 199, 290 1, 266, 029 261, 282 0 116.00 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 9, 086, 502 25, 434 118.00 68, 832, 575 11, 122, 749 2, 681, 629 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 13, 979, 136 2, 884, 981 180, 985 192. 00 2,544,680 445 192. 01 19201 PEDI ATRI CS 175, 246 903, 144 0 192. 01 186, 390 49.117 44, 690 192. 02 192 02 19202 BROOKVILLE 273 445 1, 553, 115 320 530 0 192. 03 19203 RADI OLOGY - OSGOOD 8, 256 36, 725 7, 579 0 0 192.03 192. 04 19204 ENT 53, 315 273, 051 56, 352 0 0 192.04 194. 00 07950 COMMUNITY RELATIONS 0 194.00 65, 775 178.687 7.125 865, 822 194. 01 07951 COMMUNITY BENEFITS 0 194.01 131, 613 809, 755 167, 116 30, 571 194. 02 07952 OTHER NON-REIMBURSABLE 0 194. 02 194. 03 07953 EMS 3, 705 65, 034 0 0 194.03 13, 422 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 12, 342, 537 87, 318, 357 14, 937, 806 2.768.887 251, 109 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-1329

Period: Worksheet B
From 01/01/2017 Part I
To 12/31/2017 Parte/Time Prepared:

				To	12/31/2017	Date/Time Pre	epared:
	Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	5/17/2018 8: 0 CAFETERI A) alli
		7. 02	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 1. 01 2. 00 2. 01 4. 00 5. 00 7. 00 7. 01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-OFFSITE BLDG 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT						1. 00 1. 01 2. 00 2. 01 4. 00 5. 00 7. 00 7. 01
7. 01	00702 OPERATION OF PLANT - HOSPITAL & OFFS	775, 243					7. 02
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	8, 312 9, 688	380, 486 97, 715	2, 109, 964			8. 00 9. 00
10.00	01000 DI ETARY	3, 322	l .		203, 178	4 705 000	10.00
11.00	01100 CAFETERI A	25, 362	1	99, 900	0	1, 785, 038	1
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	288	0 3, 189	1, 135 0	0	51, 531 0	1
15. 00	01500 PHARMACY	3, 984			0	47, 070	1
	01600 MEDI CAL RECORDS & LI BRARY	13, 548	l .		0	138, 497	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	10,010		00,000	<u> </u>	100, 177	10.00
30.00	03000 ADULTS & PEDI ATRI CS	68, 810	42, 832	271, 035	192, 890	315, 339	30.00
31.00	03100 INTENSIVE CARE UNIT	6, 531	2, 579	25, 724	10, 288	34, 267	31.00
43.00		3, 473	15, 506	13, 681	0	62, 947	43.00
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATING ROOM	14, 820	, , , , ,		0	166, 313	
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	7, 268 90, 420			0	14, 428 170, 305	
60.00	06000 LABORATORY	16, 445			0	212, 403	
60. 01	06001 BL00D LABORATORY	10, 443		04,770	0	212, 403	1
65. 00	06500 RESPIRATORY THERAPY	12, 575	_	_	o	57, 621	1
66.00	06600 PHYSI CAL THERAPY	26, 539			0	0	1
67.00	06700 OCCUPATI ONAL THERAPY	5, 524	0	21, 759	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	5, 047	0	19, 880	0	0	
69.00	06900 ELECTROCARDI OLOGY	10, 779	1		0	64, 680	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 596		14, 165	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	18, 907	28, 397 0	74, 474	0	0	
73.00	OUTPATIENT SERVICE COST CENTERS		0	0	<u> </u>		73.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
90.00	09000 CLI NI C	75, 997	14, 313	260, 127	0	0	90.00
90. 01	09001 WOUND CLINC	3, 190		12, 564	0	0	90. 01
91.00	09100 EMERGENCY	43, 325	25, 984	170, 651	0	227, 535	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	17 172	0	47 442	ol		101.00
101.00	SPECIAL PURPOSE COST CENTERS	17, 173	0	67, 642	U	0	1101.00
113.00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0	0	o	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	494, 923	369, 385	1, 839, 338	203, 178	1, 562, 936	
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	201, 279		208, 940	0	108, 542	
	19201 PEDI ATRI CS	8, 861			0		192. 01
	2 19202 BROOKVI LLE	63, 380		0	0		192. 02
	3 19203 RADI OLOGY - OSGOOD 1 19204 ENT	0	_	0	0		192. 03 192. 04
	19204 ENT 07950 COMMUNITY RELATIONS	1, 285	_	-	0		192.04
	107951 COMMUNITY BENEFITS	5, 515	l .		0		194. 00
	207952 OTHER NON-REI MBURSABLE	0,010	Ö	0	ol		194. 02
	07953 EMS	0	0	0	o		194. 03
200.00	, ,				ļ		200. 00
201.00		0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	775, 243	380, 486	2, 109, 964	203, 178	1, 785, 038	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-1329

Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

				10	0 12/31/2017	Date/IIMe Pre 5/17/2018 8:0	
Cost Center	Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	i diii
oost center	beset i per on	ADMI NI STRATI O	SERVICES &	111/11/11/10/1	RECORDS &	Subtotal	
		N	SUPPLY		LI BRARY		
		13. 00	14. 00	15.00	16.00	24.00	
GENERAL SERVICE C	COST CENTERS						
1.00 00100 NEW CAP REL	COSTS-BLDG & FLXT						1.00
1.01 00101 NEW CAP REL	COSTS-OFFSITE BLDG						1. 01
2.00 00200 NEW CAP REL	COSTS-MVBLE EQUIP						2.00
2.01 00201 NEW CAP REL	COSTS-MVBLE EQUIP OFFSIT						2. 01
4.00 00400 EMPLOYEE BE	NEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRAT	IVE & GENERAL						5.00
7.00 00700 OPERATION 0	F PLANT						7.00
7. 01 00701 OPERATION O	F PLANT -OFFSITE						7. 01
	F PLANT - HOSPITAL & OFFS						7. 02
8.00 00800 LAUNDRY & L							8. 00
9. 00 00900 HOUSEKEEPI N	G						9. 00
10. 00 01000 DI ETARY							10.00
11. 00 01100 CAFETERI A							11. 00
13.00 01300 NURSI NG ADM	I NI STRATI ON	985, 906					13.00
14.00 01400 CENTRAL SER	VICES & SUPPLY	0	3, 254				14.00
15.00 01500 PHARMACY		39, 137	1	4, 338, 820			15.00
16. 00 01600 MEDI CAL REC		0	3	0	2, 494, 430		16. 00
	SERVICE COST CENTERS						
30.00 03000 ADULTS & PE		262, 194	61	0	1, 641, 072	7, 822, 984	30.00
31.00 03100 I NTENSI VE C	ARE UNIT	28, 492	5	0	0	681, 255	31.00
43. 00 04300 NURSERY		52, 339	0	0	0	1, 182, 087	43.00
ANCILLARY SERVICE							
50. 00 05000 OPERATI NG R		0	1, 398	0	183, 800	3, 384, 195	50.00
52. 00 05200 DELI VERY RO		11, 997	67	0	0	430, 587	52.00
54. 00 05400 RADI OLOGY-D	I AGNOSTI C	141, 604	211	0	334, 779	13, 754, 529	54.00
60. 00 06000 LABORATORY		176, 607	828		0	5, 789, 452	60.00
60. 01 06001 BLOOD LABOR		0	0	0	0	0	60. 01
65. 00 06500 RESPI RATORY		47, 910	63	0	0	1, 210, 766	65.00
66. 00 06600 PHYSI CAL TH		0	11	0	0	2, 308, 759	66.00
67. 00 06700 0CCUPATI ONA		0	5	0	0	730, 962	67.00
68. 00 06800 SPEECH PATH		0	1	0	0	379, 062	68.00
69. 00 06900 ELECTROCARD		34, 904	28		19, 693	1, 442, 756	69.00
, ,	PLIES CHARGED TO PATIENTS	0	0	0	0	2, 952, 101	71.00
	CHARGED TO PATIENT	0	0	4 222 222	0	2, 313, 277	72.00
73. 00 07300 DRUGS CHARG		0	0	4, 338, 820	U	4, 338, 820	73.00
OUTPATIENT SERVICE					٥١	1 402 201	00 00
88. 00 08800 RURAL HEALT	H CLINIC	0	6	0	01 000	1, 492, 301	88.00
90. 00 09000 CLI NI C		0	121	0	91, 900	3, 515, 252	90.00
90. 01 09001 WOUND CLINC 91. 00 09100 EMERGENCY		100 100	217	0	202 402	431, 174	90.01
	BEDS (NON-DISTINCT PART)	189, 188	55	0	203, 493	5, 146, 514	91. 00 92. 00
OTHER REIMBURSABL							92.00
101.00 10100 HOME HEALTH		0	18	0	ol	3, 064, 910	101 00
SPECIAL PURPOSE O		<u> </u>	10	U	<u> </u>	3,004,910	101.00
113. 00 11300 I NTEREST EX							113.00
116. 00 11600 HOSPI CE	I ENSE	o	13	0	o	1, 527, 324	
	SUM OF LINES 1 through 117)	984, 372	3, 112		-	63, 899, 067	
NONREI MBURSABLE O		704, 372	5, 112	4, 330, 020	2, 414, 131	03, 077, 007	1110.00
192. 00 19200 PHYSI CI ANS'		ام	119	0	19, 693	17, 595, 221	192 00
192. 01 19201 PEDI ATRI CS	1111 1111 0111 020		9	Ö	17, 070	1, 222, 987	
192. 02 19202 BROOKVI LLE		l ol	10		0	1, 981, 725	
192. 03 19203 RADI OLOGY -	OSG00D	l ol	0		ol		192. 03
192. 04 19204 ENT		l ol	0	0	o	329, 403	1
194. 00 07950 COMMUNITY R	ELATI ONS	l o	0	Ö	ol	1, 079, 204	1
194. 01 07951 COMMUNI TY B		l ol	4	0	ol	1, 084, 612	
194. 02 07952 OTHER NON-R		l ol	0	Ö	ol		194. 02
194. 03 07953 EMS		1, 534	0	0	o		194. 03
200.00 Cross Foot	Adjustments					•	200.00
201.00 Negative Co		ol	0	0	o	0	201.00
202.00 TOTAL (sum	lines 118 through 201)	985, 906	3, 254	4, 338, 820	2, 494, 430	87, 318, 357	202.00
•	-	,	,	,	,		

| Period: | Worksheet B | From 01/01/2017 | Part | To | 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MARGARET MARY COMMUNITY HOSPITAL Provider CCN: 15-1329

			To 12/31/2017	Date/Time Prepared:
Cost Center Description	Intern &	Total		5/17/2018 8:01 am
	Resi dents			
	Cost & Post			
	Stepdown			
	Adjustments 25.00	26. 00		
GENERAL SERVICE COST CENTERS	23.00	20.00		
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT				1.00
1.01 O0101 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 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT				2.01
5. 00 00500 ADMI NI STRATI VE & GENERAL				4. 00 5. 00
7. 00 O0700 OPERATION OF PLANT				7.00
7.01 00701 OPERATION OF PLANT -OFFSITE				7. 01
7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS				7. 02
8. 00 00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY				9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A				10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
15. 00 01500 PHARMACY				15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY				16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	ol	7, 822, 984		30.00
31. 00 03100 NTENSIVE CARE UNIT		681, 255		31.00
43. 00 04300 NURSERY	o	1, 182, 087		43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0	3, 384, 195		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	430, 587 13, 754, 529		52. 00 54. 00
60. 00 06000 LABORATORY		5, 789, 452		60.00
60. 01 06001 BLOOD LABORATORY	o	0		60. 01
65. 00 06500 RESPIRATORY THERAPY	0	1, 210, 766		65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 308, 759		66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	730, 962		67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		379, 062 1, 442, 756		68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	2, 952, 101		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	2, 313, 277		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	4, 338, 820		73. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	O	1 402 201		99.00
88. 00 08800 RURAL HEALTH CLINI C 90. 00 09000 CLINI C		1, 492, 301 3, 515, 252		88. 00 90. 00
90. 01 09001 WOUND CLINC	o	431, 174		90.01
91. 00 09100 EMERGENCY	0	5, 146, 514		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	ol	3, 064, 910		101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	3,004,710		101.00
113. 00 11300 NTEREST EXPENSE				113.00
116. 00 11600 HOSPI CE	0	1, 527, 324		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	63, 899, 067		118. 00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	ol	17, 595, 221		192. 00
192. 01 19201 PEDI ATRI CS		1, 222, 987		192.00
192. 02 19202 BR00KVI LLE	0	1, 981, 725		192. 02
192. 03 19203 RADI OLOGY - OSGOOD		44, 304		192. 03
192. 04 19204 ENT	0	329, 403		192. 04
194.00 07950 COMMUNITY RELATIONS 194.01 07951 COMMUNITY BENEFITS		1, 079, 204 1, 084, 612		194. 00 194. 01
194. 01 07951 COMMUNITY BENEFITS 194. 02 07952 OTHER NON-REIMBURSABLE		0		194.01
194. 03 07953 EMS		81, 834		194. 03
200.00 Cross Foot Adjustments	0	0		200. 00
201.00 Negative Cost Centers	o o	07 210 257		201.00
202.00 TOTAL (sum lines 118 through 201)	0	87, 318, 357		202.00

| Peri od: | Worksheet B | From 01/01/2017 | Part | I | To | 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1329

				To	12/31/2017				
					CAPI TAL RELATED COSTS 5/17/2018 8: 01 am				
		Cost Center Description	Directly	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE		
			Assigned New Capital	FIXT	BLDG	EQUI P	EQUIP OFFSIT		
			Related Costs						
			0	1.00	1. 01	2. 00	2. 01		
		AL SERVICE COST CENTERS							
1. 00 1. 01		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-OFFSITE BLDG						1. 00 1. 01	
2. 00		NEW CAP REL COSTS-OFFSITE BLDG						2.00	
2. 01		NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2. 01	
4.00		EMPLOYEE BENEFITS DEPARTMENT	o	9, 622	0	17, 318	0	4.00	
5.00		ADMINISTRATIVE & GENERAL	0	372, 007		669, 534	99	5.00	
7.00		OPERATION OF PLANT	0	358, 063		644, 437	2, 176	7.00	
7. 01 7. 02		OPERATION OF PLANT -OFFSITE OPERATION OF PLANT - HOSPITAL & OFFS	0	0		0	0	7. 01 7. 02	
8. 00		LAUNDRY & LINEN SERVICE	0	24, 853	1	44, 731	0	8.00	
9. 00		HOUSEKEEPI NG	o	28, 428		51, 164	394	9. 00	
10.00		DI ETARY	0	9, 933	1	17, 877	0	10. 00	
11.00		CAFETERI A	0	75, 832	1	136, 481	0	11.00	
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	862 0		1, 551 0	0	13. 00 14. 00	
15. 00	1	PHARMACY	0	11, 911	0	21, 437	0	15.00	
16. 00		MEDICAL RECORDS & LIBRARY	O	40, 508		72, 907	0	16.00	
		IENT ROUTINE SERVICE COST CENTERS							
30.00		ADULTS & PEDIATRICS	0	205, 736		370, 280	0	30.00	
31. 00 43. 00		INTENSIVE CARE UNIT NURSERY	0	19, 527 10, 385	l	35, 144 18, 691	0	31. 00 43. 00	
43.00		LARY SERVICE COST CENTERS	١	10, 363	<u> </u>	10, 091	0	43.00	
50.00		OPERATING ROOM	0	44, 309	0	79, 747	0	50.00	
52.00		DELIVERY ROOM & LABOR ROOM	0	21, 731	0	39, 111	0	52.00	
54.00		RADI OLOGY-DI AGNOSTI C	0	270, 348	l	486, 570	0	54.00	
60. 00 60. 01		LABORATORY BLOOD LABORATORY	0	49, 170 0		88, 495 0	0	60. 00 60. 01	
65.00		RESPIRATORY THERAPY	0	37, 598		67, 668	0	65.00	
66. 00		PHYSI CAL THERAPY	o	79, 350	l	142, 813	0	66.00	
67.00	06700	OCCUPATI ONAL THERAPY	O	16, 517	0	29, 727	0	67. 00	
68.00		SPEECH PATHOLOGY	0	15, 090	1	27, 159	0	68.00	
69. 00 71. 00		ELECTROCARDI OLOGY	0	32, 229		58, 005	0	69.00	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	0	10, 752 56, 531	0	19, 352 101, 744	0	71. 00 72. 00	
73. 00		DRUGS CHARGED TO PATIENTS	l ol	0 0		0	Ö	73.00	
	OUTPA	TIENT SERVICE COST CENTERS	- 1						
88. 00		RURAL HEALTH CLINIC	0	0		0	22, 563	88. 00	
90.00		CLINIC	0	197, 456		355, 379	9, 114	90.00	
90. 01 91. 00	1	WOUND CLINC EMERGENCY		9, 537 129, 537		17, 165 233, 139	0	90. 01 91. 00	
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART)		127,007		200, 107		92.00	
	OTHER	REIMBURSABLE COST CENTERS							
101.00		HOME HEALTH AGENCY	0	48, 251	2, 543	86, 842	947	101. 00	
112 00		AL PURPOSE COST CENTERS						112 00	
		I NTEREST EXPENSE HOSPI CE	o	0	0	0	0	113. 00 116. 00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	o	2, 186, 073	94, 730	3, 934, 468	35, 293		
		IMBURSABLE COST CENTERS	· /-	,					
		PHYSICIANS' PRIVATE OFFICES	0	240		432	198, 828		
		PEDI ATRI CS	0	26, 492	l	47, 681		192. 01	
		BROOKVI LLE RADI OLOGY - OSGOOD	0	0	1	0	58, 016	192. 02 192. 03	
192. 03				0		n		192. 03	
	1	COMMUNITY RELATIONS	l ol	3, 843	o	6, 917		194. 00	
194. 01	07951	COMMUNITY BENEFITS	0	16, 489	1	29, 676	0	194. 01	
		OTHER NON-REIMBURSABLE	0	0	0	0		194. 02	
194. 03 200. 00			0	0	0	0	0	194. 03 200. 00	
200.00	1	Cross Foot Adjustments Negative Cost Centers		Λ	0	n	n	200. 00 201. 00	
202.00		TOTAL (sum lines 118 through 201)	О	2, 233, 137	784, 110	4, 019, 174	292, 137		
								÷	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | From 01/20210 | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri od: | Peri Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1329

			1	0 12/31/2017	5/17/2018 8:0	
Cost Center Description	Subtotal	EMPLOYEE	ADMI NI STRATI V	OPERATION OF	OPERATION OF	
'		BENEFI TS	E & GENERAL	PLANT	PLANT	
		DEPARTMENT			-0FFSITE	
	2A	4. 00	5. 00	7. 00	7. 01	
GENERAL SERVICE COST CENTERS			ı			
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 NEW CAP REL COSTS-OFFSITE BLDG 2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.01
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2. 00 2. 01
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	26, 940	26, 940				4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	1, 041, 907	4, 223				5.00
7. 00 00700 OPERATION OF PLANT	1, 010, 516	0				7.00
7. 01 00701 OPERATION OF PLANT -OFFSITE	0	0			3, 008	7. 01
7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS	O	311	9, 288	0	0	7. 02
8.00 00800 LAUNDRY & LINEN SERVICE	69, 584	65	3, 907	17, 369	0	8. 00
9. 00 00900 HOUSEKEEPI NG	81, 043	608	23, 357	19, 867	4	9. 00
10. 00 01000 DI ETARY	27, 810	59			0	10.00
11. 00 01100 CAFETERI A	212, 313	448			0	11. 00
13. 00 01300 NURSING ADMINISTRATION	2, 413	376		602	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0		0	0	14.00
15. 00 01500 PHARMACY	33, 348	382			0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	113, 415	754	26, 524	28, 309	0	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	F74 014	2.070	FE 477	142 770	0	20.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	576, 016 54, 671	2, 070 190			0	30. 00 31. 00
43. 00 04300 NURSERY	29, 076	369			0	43.00
ANCI LLARY SERVICE COST CENTERS	27,070	307	12, 137	7,250	<u> </u>	1 43.00
50. 00 05000 OPERATING ROOM	124, 056	888	34, 209	30, 965	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	60, 842	84	3, 564		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	756, 918	1, 963			0	54.00
60. 00 06000 LABORATORY	137, 665	971	62, 625	34, 362	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	-	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	105, 266	303			0	65.00
66. 00 06600 PHYSI CAL THERAPY	222, 163	685			0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	46, 244	249			0	67.00
68. 00 06800 SPEECH PATHOLOGY	42, 249	111			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	90, 234	383		22, 523	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	30, 104 158, 275	0			0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	156, 275	0			0	73.00
OUTPATIENT SERVICE COST CENTERS	Ο _Ι	0	0	<u> </u>	0	73.00
88. 00 08800 RURAL HEALTH CLINIC	83, 123	513	17, 670	0	208	88. 00
90. 00 09000 CLINIC	586, 412	1, 001	32, 344		84	90.00
90. 01 09001 WOUND CLINC	26, 702	146			0	90. 01
91. 00 09100 EMERGENCY	362, 676	1, 230			0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			·		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	138, 583	1, 019	34, 622	33, 720	9	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE		105	40.000			113.00
116. 00 11600 HOSPI CE	0	435			0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 250, 564	19, 836	778, 944	1, 010, 798	305	118. 00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	722 141	E EE1	202 052	140	2 140	192. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	733, 161 74, 173	5, 551 383				192.00
192. 01 19201 PEDIATRICS 192. 02 19202 BROOKVI LLE	213, 735	597				192.01
192. 03 19203 RADI OLOGY - OSGOOD	213, 733	18				192. 02
192. 04 19204 ENT	ol	116				192. 04
194. 00 07950 COMMUNITY RELATIONS	10, 760	144				194.00
194. 01 07951 COMMUNITY BENEFITS	46, 165	287				194. 01
194. 02 07952 OTHER NON-REIMBURSABLE	0	0			0	194. 02
194. 03 07953 EMS	0	8	940	o	0	194. 03
200.00 Cross Foot Adjustments	0					200. 00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	7, 328, 558	26, 940	1, 046, 130	1, 043, 689	3, 008	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1329

				To	rom 01/01/2017 o 12/31/2017		
	Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	5/17/2018 8: C CAFETERI A	i alli
	JOSHEDAL OFFICE COOT OFFITS DO	7. 02	8. 00	9. 00	10. 00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 00 1. 01 2. 00 2. 01 4. 00 5. 00 7. 00 7. 01 7. 02 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	00100 NEW CAP REL COSTS-DEDG A FIXT ON O1001 NEW CAP REL COSTS-DEDG A FIXT O200 NEW CAP REL COSTS-MYBLE EQUIP O2001 NEW CAP REL COSTS-MYBLE EQUIP OFFSIT O4400 EMPLOYEE BENEFITS DEPARTMENT O5500 ADMINISTRATIVE & GENERAL O7001 OPERATION OF PLANT O701 OPERATION OF PLANT O702 OPERATION OF PLANT - OFFSITE O7020 OPERATION OF PLANT - HOSPITAL & OFFS O8800 LAUNDRY & LINEN SERVICE O9900 HOUSEKEEPING O1000 DIETARY O1100 CAFETERIA O1300 NURSING ADMINISTRATION O1400 CENTRAL SERVICES & SUPPLY O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY	9, 599 103 120 41 314 4 0 49	91, 028 23, 377 41 310 0 763	148, 376 920 7, 025 80 0 1, 103	37, 828 0 0 0 0	291, 590 8, 418 0 7, 689 22, 624	1. 01 2. 00 2. 01 4. 00 5. 00 7. 01 7. 02 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	100		0,700	<u> </u>	22,021	10.00
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY ANCILLARY SERVICE COST CENTERS	852 81 43	10, 247 617 3, 710		35, 913 1, 915 0	51, 508 5, 598 10, 283	31.00
50. 00 52. 00 54. 00 60. 01 65. 00 66. 00	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	183 90 1, 120 204 0 156 329 68	7, 288 11, 286 0 0 1, 271	2, 013 25, 045 4, 555 0 3, 483 7, 351 1, 530	0 0 0 0 0 0 0	27, 168 2, 357 27, 820 34, 697 0 9, 413 0	52. 00 54. 00 60. 00 60. 01 65. 00 66. 00 67. 00
68. 00 69. 00 71. 00 72. 00 73. 00	06900 ELECTROCARDIOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 0UTPATIENT SERVICE COST CENTERS	62 133 45 234 0	626		0 0 0 0	0 10, 566 0 0	69. 00 71. 00 72. 00
88. 00 90. 00	08800 RURAL HEALTH CLINIC 09000 CLINIC	941	3, 424	18, 293	0	0	90.00
90. 01 91. 00 92. 00	09001 WOUND CLINC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	39 536	ŀ		0	0 37, 168	
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	213	0	4, 757	0	0	101.00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0 6, 128	0 88, 372	0 129, 345	0 37, 828	0 255, 309	113. 00 116. 00 118. 00
192. 01 192. 02 192. 03 192. 04 194. 00 194. 01 194. 02	Negative Cost Centers	2, 492 110 785 0 0 16 68 0 0	0 0 0 0 0 0 0	2, 454 0 0 0 356 1, 528 0	0 0 0 0 0 0 0 0 0 0 37, 828	0 0 3, 467 8, 156 0 301	192. 01 192. 02 192. 03 192. 04 194. 00 194. 01 194. 02 194. 03 200. 00 201. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-1329

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Par

			To	12/31/2017	Date/Time Pre 5/17/2018 8:0	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	l alli
oust content besoft per on	ADMI NI STRATI O	SERVICES &	111111111111111111111111111111111111111	RECORDS &	Subtotal	
	N	SUPPLY		LI BRARY		
	13. 00	14. 00	15. 00	16. 00	24. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 NEW CAP REL COSTS-OFFSITE BLDG						1. 01
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 O0201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7. 00
7. 01 00701 OPERATION OF PLANT - OFFSITE						7. 01
7. 02 00702 OPERATION OF PLANT - HOSPITAL & OFFS						7. 02
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A						10.00
13. 00 01300 NURSI NG ADMINI STRATI ON	22 051					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	23, 051 0	764				14.00
15. 00 01500 PHARMACY	915	0	102, 258			15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	1	102, 230	195, 548		16.00
I NPATIENT ROUTINE SERVICE COST CENTERS	O _I		O _I	175, 540		10.00
30. 00 03000 ADULTS & PEDIATRICS	6, 131	14	0	128, 649	1, 029, 915	30.00
31. 00 03100 I NTENSI VE CARE UNI T	666	1	0	.20, 0.19	85, 630	1
43. 00 04300 NURSERY	1, 224	Ó	0	o	65, 084	1
ANCILLARY SERVICE COST CENTERS	, ,	- 1	- 1	- 1		
50.00 O5000 OPERATING ROOM	0	328	0	14, 409	241, 553	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	280	16	0	0	91, 720	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 311	50	0	26, 245	1, 187, 805	54.00
60. 00 06000 LABORATORY	4, 129	195	0	0	279, 403	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	
65. 00 06500 RESPIRATORY THERAPY	1, 120	15	0	0	158, 900	1
66. 00 06600 PHYSI CAL THERAPY	0	3	0	0	316, 255	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	1	0	0	67, 698	1
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	58, 274	1
69. 00 06900 ELECTROCARDI OLOGY	816	/	0	1, 544	144, 289	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	73, 575	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	102, 258	0	235, 047 102, 258	1
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	102, 236	<u>U</u>	102, 236	73.00
88. 00 08800 RURAL HEALTH CLINIC	0	1	0	0	101, 515	88. 00
90. 00 09000 CLI NI C	o	28	Ö	7, 204	787, 722	1
90. 01 09001 WOUND CLINC	0	51	0	0	40, 107	1
91. 00 09100 EMERGENCY	4, 423	13	0	15, 953	579, 215	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 120		J	.0, 700	0,7,210	92.00
OTHER REIMBURSABLE COST CENTERS	,			'		
101.00 10100 HOME HEALTH AGENCY	0	4	0	0	212, 927	101.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0	3	0	0	18, 736	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	23, 015	731	102, 258	194, 004	5, 877, 628	118. 00
NONREI MBURSABLE COST CENTERS		1				
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	28	0	1, 544	982, 244	1
192. 01 19201 PEDI ATRI CS	0	2	0	0	115, 315	
192. 02 19202 BROOKVI LLE	0	2	0	0	238, 101	1
192. 03 19203 RADI OLOGY - OSGOOD	0	U	0	U		192.03
192. 04 19204 ENT 194. 00 07950 COMMUNITY RELATIONS	0	O	0	0		192. 04 194. 00
194.00 07950 COMMUNITY RELATIONS 194.01 07951 COMMUNITY BENEFITS	0	0	0	0		194.00
194.02 07952 OTHER_NON-REIMBURSABLE	0	1	0	0		194.01
194. 03 07953 EMS	36	٥	0	0		194. 02
200.00 Cross Foot Adjustments	30	Y	U	٩	· ·	200.00
201.00 Negative Cost Centers	n	n	n	n		201.00
202.00 TOTAL (sum lines 118 through 201)	23, 051	764	102, 258	195, 548	7, 328, 558	
		- 1				

ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der Co	CN: 15-1329		Worksheet B	
					From 01/01/2017 To 12/31/2017	Part II Date/Time Prepa	arod:
					10 12/31/2017	5/17/2018 8: 01	areu: am
	Cost Center Description	Intern &	Total		<u>'</u>		
	·	Resi dents					
		Cost & Post					
		Stepdown					
		Adjustments					
		25. 00	26. 00				
	GENERAL SERVICE COST CENTERS						
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 NEW CAP REL COSTS-OFFSITE BLDG						1. 01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2. 01	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2. 01
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7. 01	00701 OPERATION OF PLANT -OFFSITE						7. 01
7. 02	00702 OPERATION OF PLANT - HOSPITAL & OFFS						7. 02
8. 00	00800 LAUNDRY & LI NEN SERVI CE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY					l l	14.00
15.00	01500 PHARMACY						15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY						16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		1 000 015				20.00
30.00	03000 ADULTS & PEDIATRICS	0	1, 029, 915	1			30.00
31.00	03100 INTENSIVE CARE UNIT 04300 NURSERY	0	85, 630	1		•	31.00
43. 00	ANCILLARY SERVICE COST CENTERS	l ol	65, 084	1			43. 00
50. 00	05000 OPERATING ROOM	O	241, 553				50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	91, 720			•	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 187, 805	1		•	54.00
60.00	06000 LABORATORY	0	279, 403	1		· · · · · · · · · · · · · · · · · · ·	60.00
60. 01	06001 BLOOD LABORATORY		277, 403	1		· · · · · · · · · · · · · · · · · · ·	60. 01
65. 00	06500 RESPIRATORY THERAPY		158, 900	1		· · · · · · · · · · · · · · · · · · ·	65. 00
66. 00	06600 PHYSI CAL THERAPY	l o	316, 255	1		•	66.00
67. 00	06700 OCCUPATI ONAL THERAPY		67, 698	1			67.00
68. 00	06800 SPEECH PATHOLOGY	l ol	58, 274	1		•	68. 00
69. 00	06900 ELECTROCARDI OLOGY	l ol	144, 289	1		•	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	l ol	73, 575	1		•	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	o	235, 047	1		•	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	102, 258			l l	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	101, 515				88. 00
90.00	09000 CLI NI C	0	787, 722				90.00
90. 01	09001 WOUND CLINC	0	40, 107				90. 01
91.00	09100 EMERGENCY	0	579, 215				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	212, 927			1(01.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						13.00
	11600 H0SPI CE	0	18, 736				16. 00
118.00		0	5, 877, 628			1	18. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	982, 244	1			92.00
	19201 PEDI ATRI CS	0	115, 315	1			92. 01
	19202 BROOKVI LLE	0	238, 101				92. 02
	19203 RADI OLOGY - OSGOOD	0	549	1			92. 03
	19204 ENT	0	4, 062				92. 04
	07950 COMMUNITY RELATIONS	0	29, 943				94.00
	07951 COMMUNITY BENEFITS	0	79, 431				94. 01
	07952 OTHER NON-REIMBURSABLE	0	1 205				94. 02
	07953 EMS	0	1, 285				94. 03
200.00		0	0				00.00
201. 00 202. 00		0	0 7, 328, 558				01. 00 02. 00
202. UC	TOTAL (Suil TITIES 118 LITTOUGH 201)	ı V	1, 328, 358	1		20	∪∠. UU

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-1329

					T	o 12/31/2017	Date/Time Pre 5/17/2018 8:0	
				CAPI TAL REI	ATED COSTS		107 177 2010 010	
		Cost Center Description	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE	EMPLOYEE	
			FI XT (SQUARE	BLDG (SQUARE	EQUI P (SQUARE	EQUIP OFFSIT (SQUARE	BENEFITS DEPARTMENT	
			FEET)	FEET)	FEET)	FEET)	(GROSS	
			1. 00	1. 01	2. 00	2. 01	SALARI ES) 4. 00	
	GENER	AL SERVICE COST CENTERS		1.01	2.00	2.01	4.00	
1. 00 1. 01		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-OFFSITE BLDG	158, 051 0	67, 535				1. 00 1. 01
2. 00	00200	NEW CAP REL COSTS-MVBLE EQUIP	O	07,333	158, 051			2.00
2. 01 4. 00		NEW CAP REL COSTS-MVBLE EQUIP OFFSIT EMPLOYEE BENEFITS DEPARTMENT	681	0	0 681	67, 535 0	42, 099, 438	2. 01 4. 00
5. 00		ADMINISTRATIVE & GENERAL	26, 329	23	26, 329	23	6, 598, 703	5.00
7.00	1	OPERATION OF PLANT	25, 342	503	· ·	503	0	7.00
7. 01 7. 02		OPERATION OF PLANT -OFFSITE OPERATION OF PLANT - HOSPITAL & OFFS	0	0		0	0 485, 708	7. 01 7. 02
8.00		LAUNDRY & LINEN SERVICE	1, 759	0	' '	0	101, 092	8.00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	2, 012 703	91 0	2, 012 703	91 0	950, 216 91, 691	9. 00 10. 00
11. 00	01100	CAFETERI A	5, 367	0	5, 367	0	700, 172	11. 00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	61 0	0	61	0	587, 781 0	13. 00 14. 00
15. 00	01500	PHARMACY	843	0	843	O	597, 048	1
16. 00		MEDICAL RECORDS & LIBRARY IENT ROUTINE SERVICE COST CENTERS	2, 867	0	2, 867	0	1, 178, 664	16.00
30. 00	03000	ADULTS & PEDIATRICS	14, 561	0	· ·	0	3, 233, 876	1
31. 00 43. 00		INTENSIVE CARE UNIT NURSERY	1, 382 735	0	· ·	0	296, 730 576, 002	1
	ANCI L	LARY SERVICE COST CENTERS						
50. 00 52. 00		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	3, 136 1, 538			0	1, 387, 428 132, 029	1
54. 00		RADI OLOGY-DI AGNOSTI C	19, 134	0		o	3, 066, 815	
60.00		LABORATORY BLOOD LABORATORY	3, 480 0	0		0	1, 517, 376	
60. 01 65. 00		RESPIRATORY THERAPY	2, 661	0	2, 661	o	0 473, 434	60. 01 65. 00
66.00		PHYSI CAL THERAPY	5, 616	0	5, 616	o	1, 070, 372	1
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	1, 169 1, 068	0	1, 169 1, 068	0	389, 730 174, 217	67. 00 68. 00
69. 00	06900	ELECTROCARDI OLOGY	2, 281	0	2, 281	0	598, 123	69. 00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	761 4, 001	0	761 4, 001	0	0	71. 00 72. 00
	07300	DRUGS CHARGED TO PATIENTS	0	0		O	0	1
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0	5, 216	0	5, 216	801, 046	88. 00
90.00	09000	CLI NI C	13, 975	2, 107	13, 975	2, 107	1, 564, 326	90.00
90. 01 91. 00		WOUND CLINC EMERGENCY	675 9, 168	0	675 9, 168	0	227, 347 1, 921, 525	1
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7, 100		7, 100		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	92.00
101 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY	3, 415	219	3, 415	219	1, 592, 122	101 00
	SPECI	AL PURPOSE COST CENTERS	5, 1.5	2.,	5, 1.5	2.7	1,0,2,122	
		I NTEREST EXPENSE HOSPI CE	0	0	0	0	679, 762	113. 00 116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	154, 720			- 1	30, 993, 335	
192.00		IMBURSABLE COST CENTERS PHYSICIANS' PRIVATE OFFICES	17	45, 964	17	45, 964	8, 679, 729	192. 00
192. 01	19201	PEDI ATRI CS	1, 875	0	1, 875	O	597, 751	192. 01
		BROOKVI LLE RADI OLOGY - OSGOOD	0	13, 412 0	0	13, 412 0	932, 698 28, 160	1
192. 04	19204	ENT	0	0	ō	O	181, 852	192. 04
		COMMUNITY RELATIONS COMMUNITY BENEFITS	272 1, 167	0	272 1, 167	0	224, 354 448, 922	
194. 02	07952	OTHER NON-REIMBURSABLE	0	0	0	ő	0	194. 02
194. 03 200. 00		EMS Cross Foot Adjustments	0	0	0	0	12, 637	194. 03 200. 00
201.00		Negative Cost Centers						201.00
202.00)	Cost to be allocated (per Wkst. B, Part I)	2, 233, 137	784, 110	4, 019, 174	292, 137	12, 342, 537	202. 00
203.00	1	Unit cost multiplier (Wkst. B, Part I)	14. 129218	11. 610424	25. 429602	4. 325713	0. 293176	
204.00		Cost to be allocated (per Wkst. B, Part II)					26, 940	204. 00
205.00		Unit cost multiplier (Wkst. B, Part					0. 000640	205. 00
206.00)							206. 00
		(per Wkst. B-2)						

RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-	2552-10
	Provi der Co			Worksheet B-1	
			To 12/31/2017	Date/Time Pre 5/17/2018 8:0	
	CAPITAL REI	_ATED COSTS			
NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE	EMPLOYEE	
FI XT	BLDG	EQUI P	EQUIP OFFSIT		
(SQUARE	(SQUARE	(SQUARE	(SQUARE	DEPARTMENT	
FEET)	FEET)	FEET)	FEET)	(GROSS	
				SALARI ES)	
1. 00	1. 01	2. 00	2. 01	4. 00	
					207. 00
	NEW BLDG & FI XT (SQUARE FEET)	Provi der Co	CAPITAL RELATED COSTS NEW BLDG & NEW OFFSITE NEW MVBLE EQUIP (SQUARE (SQUARE FEET) FEET)	Provi der CCN: 15-1329 Peri od: From 01/01/2017 To 12/31/2017 CAPI TAL RELATED COSTS NEW BLDG & NEW OFFSI TE BLDG EQUI P SUJARE (SQUARE FEET) FEET) Peri od: From 01/01/2017 To 12/31/2017 NEW MVBLE EQUI P SUJARE (SQUARE FEET)	Provi der CCN: 15-1329 Peri od: From 01/01/2017 To 12/31/2017 Date/Time Provider CCAPI TAL RELATED COSTS NEW BLDG & NEW OFFSITE NEW MVBLE EQUI P OFFSIT BENEFI TS (SQUARE (SQUARE (SQUARE SQUARE FEET) FEET) FEET) FEET) FEET) FEET) FEET) FEET) GROSS SALARI ES)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1329 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/17/2018 8:01 am Cost Center Description Reconciliatio ADMINISTRATIV OPERATION OF OPERATION OF OPERATION OF E & GENERAL PLANT **PLANT PLANT** n (ACCUM. (SQUARE -OFFSITE HOSPITAL & (SQUARE 0FFS COST) FEET) (SQUARE FEET) FEET) 5.00 7.00 7. 01 5A GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 NEW CAP REL COSTS-OFFSITE BLDG 1.01 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 -14, 937, 806 5.00 00500 ADMINISTRATIVE & GENERAL 72, 380, 551 5.00 7.00 00700 OPERATION OF PLANT 2, 295, 205 105, 699 7.00 00701 OPERATION OF PLANT -OFFSITE 208, 151 75, 361 7.01 7 01 0 00702 OPERATION OF PLANT - HOSPITAL & OFFS 7.02 0 642,620 0 164, 051 7.02 8.00 00800 LAUNDRY & LINEN SERVICE 0 270, 309 1.759 1,759 8.00 2,050 00900 HOUSEKEEPI NG 0 0 91 9.00 9.00 1, 616, 036 2.012 01000 DI ETARY 10.00 139, 413 703 0 703 10.00 11.00 01100 CAFETERI A 1, 258, 216 5, 367 0 5, 367 11.00 13.00 01300 NURSING ADMINISTRATION 0 0 0 772, 024 61 61 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14 00 14 00 54 0 0 15.00 01500 PHARMACY 3, 490, 490 843 0 843 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 835, 171 0 2, 867 16.00 16.00 2.867 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 0 3, 852, 282 0 14 561 30.00 03000 ADULTS & PEDIATRICS 14 561 03100 INTENSIVE CARE UNIT 31.00 0 445, 271 1, 382 0 1, 382 31.00 04300 NURSERY 0 0 43.00 841, 267 735 735 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 2, 366, 943 50 00 3.136 3.136 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 246, 562 1,538 0 1,538 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 10, 040, 495 0 54.00 19, 134 19, 134 54.00 0 06000 LABORATORY 0000000 60.00 4, 332, 992 3, 480 3, 480 60.00 06001 BLOOD LABORATORY 60.01 0 0 60.01 06500 RESPIRATORY THERAPY 802, 440 2, 661 0 2, 661 65.00 65.00 o 66.00 06600 PHYSI CAL THERAPY 1, 661, 505 5, 616 5, 616 66.00 0 06700 OCCUPATI ONAL THERAPY 1, 169 557, 910 67 00 67.00 1, 169 0 68.00 06800 SPEECH PATHOLOGY 270, 360 1,068 1,068 68.00 06900 ELECTROCARDI OLOGY 0 69.00 1,001,214 2, 281 2, 281 69.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 415, 829 761 71.00 761 07200 IMPL. DEV. CHARGED TO PATIENT 72 00 1, 729, 713 4.001 0 4.001 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 0 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 1, 222, 597 88.00 5, 216 88.00 0 0 13, 975 90.00 09000 CLI NI C 2, 237, 841 2.107 16,082 90.00 90.01 09001 WOUND CLINC 0 326, 388 675 675 90.01 91.00 09100 EMERGENCY 3, 353, 936 9, 168 0 9, 168 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 2, 395, 506 3, 415 219 3, 634 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 266, 029 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) -14, 937, 806 118.00 53, 894, 769 102, 368 7,633 104, 732 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 13, 979, 136 17 54, 316 42, 593 192. 00 192. 01 19201 PEDI ATRI CS 0 903, 144 1,875 1, 875 192. 01 0 13, 412 192. 02 192. 02 19202 BROOKVI LLE 1, 553, 115 13, 412 0 0 0 192.03 192. 03 19203 RADI OLOGY - OSGOOD 36, 725 0 0 192. 04 19204 ENT 273, 051 0 0 0 192.04 194.00 07950 COMMUNITY RELATIONS 272 194.00 0 0 865, 822 272 0 194. 01 07951 COMMUNITY BENEFITS ol 1, 167 194, 01 809, 755 1, 167 194. 02 07952 OTHER NON-REI MBURSABLE 0 194.02 0 0 194. 03 07953 EMS 65,034 0 0 194.03 200.00 Cross Foot Adjustments 200.00 201 00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 14, 937, 806 2, 768, 887 251, 109 775, 243 202. 00 Part I) Unit cost multiplier (Wkst. B, Part I) 26. 195962 4. 725622 203. 00 203.00 0.206379 3.332082 Cost to be allocated (per Wkst. B, 1,043,689 3,008 9, 599 204. 00 204.00 1,046,130 Part II) 0. 058512 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 0.014453 9.874162 0.039915 11) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

Health Financial Systems MA	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				From 01/01/2017 To 12/31/2017	Doto/Time Dro	norod.
	_			To 12/31/2017	Date/Time Pre 5/17/2018 8:0	1 am
Cost Center Description	Reconciliatio	ADMI NI STRATI V	OPERATION OF	OPERATION OF	OPERATION OF	
	n	E & GENERAL	PLANT	PLANT	PLANT -	
		(ACCUM.	(SQUARE	-OFFSITE	HOSPITAL &	
		COST)	FEET)	(SQUARE	0FFS	
				FEET)	(SQUARE	
					FEET)	
	5A	5. 00	7. 00	7. 01	7. 02	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	LLOCATION - STATISTICAL BASIS	NOAKET WAKE COM	Provi der Co	CN: 15-1329 Pe	eri od:	Worksheet B-1	
				To		Date/Time Pre 5/17/2018 8:0	epared:
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSI NG ADMI NI STRATI O N (HOURS OF SERVI CE)	
		8. 00	9. 00	10. 00	11. 00	13. 00	
1 00	GENERAL SERVICE COST CENTERS		I				1 1 00
1.00 1.01 2.00 2.01 4.00 5.00 7.00 7.01 7.02 8.00 10.00 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-MYBLE EQUIP 00201 NEW CAP REL COSTS-MYBLE EQUIP OFFSIT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - OFFSITE 00702 OPERATION OF PLANT - HOSPITAL & OFFS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	363, 971 93, 474 163 1, 241 0 3, 051	113, 355 703 5, 367 61 0 843	13, 548 0 0 0	464, 557 13, 411 0 12, 250	308, 589 0 12, 250 0	14. 00 15. 00
20 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	40, 973	1.4 5.61	12 062	92.067	92.067	30 00
30. 00 31. 00	03100 NTENSIVE CARE UNIT	2, 467				82, 067 8, 918	1
43. 00	04300 NURSERY	14, 833					
F0 00	ANCILLARY SERVICE COST CENTERS	00.050	2.40/		40, 000		1
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	20, 959 29, 141				0 3, 755	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	45, 128				44, 322	
60.00	06000 LABORATORY	0					
60. 01	06001 BLOOD LABORATORY	0	_	_	0	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	5, 081 25, 017		0	14, 996	14, 996	65. 00 66. 00
67.00	06700 OCCUPATI ONAL THERAPY	25,017			0	0	
68. 00	06800 SPEECH PATHOLOGY	0	1, 068	0	0	0	
	06900 ELECTROCARDI OLOGY	2, 503		0	16, 833		
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	27, 164		0		0	
	07300 DRUGS CHARGED TO PATIENTS	27, 104		0			1
	OUTPATIENT SERVICE COST CENTERS		1				
88. 00 90. 00	08800 RURAL HEALTH CLINIC 09000 CLINIC	13, 692	_		0	0	
90.00	09001 WOUND CLINC	3, 609			0		
91.00	09100 EMERGENCY	24, 856			59, 216		1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	3, 634	O	0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS		3,034	0	0	0	1101.00
	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0	0	0		116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	353, 352	98, 816	13, 548	406, 755	308, 109]118.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	10, 619	11, 225	0	28, 248	0	192.00
	19201 PEDI ATRI CS	0	.,				192. 01
	19202 BROOKVI LLE	0	0	0			192. 02
	19203 RADI OLOGY		0	0			192. 03 192. 04
194.00	07950 COMMUNITY RELATIONS	0	272	Ö	5, 523	Ö	194.00
194. 01	07951 COMMUNITY BENEFITS	0	1, 167	0	12, 994	0	194. 01
	07952 OTHER NON-REIMBURSABLE 07953 EMS	0	0	0	0 480		194. 02 194. 03
200.00				J	460	460	200.00
201. 00 202. 00	Negative Cost Centers	380, 486	2, 109, 964	203, 178	1, 785, 038	985, 906	201.00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	1. 045374 91, 028	l .	14. 996900 37, 828		3. 194884 23, 051	
205.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 250097	1. 308950	2. 792146	0. 627673	0. 074698	205. 00
206.00							206. 00
207. 00							207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-1329

				7	Го 12/31/2017	Date/Time Prepared: 5/17/2018 8:01 am
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL		
		SERVI CES & SUPPLY	(100% PHARMACY)	RECORDS & LI BRARY		
		(COSTED		(TIME		
		REQUIS.)	15.00	SPENT)		
	GENERAL SERVICE COST CENTERS	14. 00	15. 00	16. 00		
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
1. 01	00101 NEW CAP REL COSTS-OFFSITE BLDG 00200 NEW CAP REL COSTS-MVBLE EQUIP					1.01
2. 00 2. 01	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2. 00 2. 01
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00	00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00 7. 01	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT -OFFSITE					7. 00 7. 01
7. 02	00702 OPERATION OF PLANT - HOSPITAL & OFFS					7. 02
8. 00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY					9.00
10. 00 11. 00						10.00 11.00
13. 00						13. 00
14. 00		5, 550, 268				14.00
15. 00 16. 00		923 4, 274	100 0			15. 00 16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4,274	U	700	7	10.00
30.00	03000 ADULTS & PEDIATRICS	104, 388	0			30.00
31.00		8, 476				31.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	(<u>) </u>	43.00
50. 00		2, 384, 914	0	56	5	50.00
52.00		115, 184	0			52.00
54.00	1	360, 195	0	102		54.00
60. 00 60. 01	l i	1, 413, 300	0	(60. 00 60. 01
65. 00	l i	107, 088	0			65. 00
66. 00		18, 451	0	(66.00
67. 00 68. 00	l i	8, 544 1, 063	0	()	67. 00 68. 00
69. 00		47, 277	0		5	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(71.00
72.00	l i	0	0 100	(72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		100	(<u> </u>	73. 00
	08800 RURAL HEALTH CLINIC	10, 000				88.00
90. 00 90. 01		206, 361	0	28		90.00
91.00		370, 747 94, 607	0	62		91.00
		71,007		0.		92.00
101 00	OTHER REIMBURSABLE COST CENTERS	20 504			<u></u>	101.00
101.00	0 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	30, 504	0	(<u>) </u>	101.00
113.00	0 11300 I NTEREST EXPENSE					113.00
	0 11600 H0SPI CE	21, 566				116.00
118. 00	O SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	5, 307, 862	100	754	1	118. 00
192.00	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	202, 471	0	ć	5	192. 00
	1 19201 PEDI ATRI CS	15, 766				192. 01
	2 19202 BROOKVI LLE	17, 221	0	(192. 02 192. 03
	3 19203 RADIOLOGY - OSGOOD 4 19204 ENT	84	0	-		192. 03
194.00	0 07950 COMMUNITY RELATIONS	22	Ō	(194. 00
	1 07951 COMMUNITY BENEFITS	6, 842	0			194. 01
	2 O7952 OTHER NON-REIMBURSABLE 3 O7953 EMS	0	0	()	194. 02 194. 03
200. 00						200. 00
201.00	Negative Cost Centers					201. 00
202.00	O Cost to be allocated (per Wkst. B, Part I)	3, 254	4, 338, 820	2, 494, 430		202. 00
203.00	O Unit cost multiplier (Wkst. B, Part I)		43, 388. 200000	-		203.00
204.00	O Cost to be allocated (per Wkst. B, Part II)	764	102, 258	195, 548	3	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000138	1, 022. 580000	257. 300000		205.00
206. 00						206.00
207. 00	(per Wkst. B-2)					207. 00
	O NAHE unit cost multiplier (Wkst. D,	1		1	1	1207.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1329	Peri od: From 01/01/2017	Worksheet C Part I

12/31/2017 Date/Time Prepared: To 5/17/2018 8:01 am Title XVIII Hospi tal Cost Costs Total Cost Cost Center Description Therapy Limit Total Costs RCE Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 2.00 4. 00 5. 00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 822, 984 7, 822, 984 0 0 30.00 03100 INTENSIVE CARE UNIT 681, 255 681, 255 0 0 31.00 31.00 43.00 04300 NURSERY 1, 182, 087 1, 182, 087 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 384, 195 3, 384, 195 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 430, 587 430, 587 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 13, 754, 529 13, 754, 529 0 0 0 0 0 0 0 0 0 54.00 54.00 0 06000 LABORATORY 5, 789, 452 5, 789, 452 60.00 0 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 65.00 06500 RESPIRATORY THERAPY 1, 210, 766 1, 210, 766 0 65.00 2, 308, 759 06600 PHYSI CAL THERAPY 2, 308, 759 66.00 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 730, 962 C 730, 962 0 67.00 68.00 06800 SPEECH PATHOLOGY 379, 062 379, 062 0 68.00 06900 ELECTROCARDI OLOGY 69.00 1, 442, 756 1, 442, 756 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 952, 101 2, 952, 101 71.00 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 2, 313, 277 2, 313, 277 0 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 338, 820 4, 338, 820 0 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 1, 492, 301 88.00 1, 492, 301 0 0 88.00 90.00 09000 CLI NI C 3, 515, 252 3, 515, 252 0 0 90.00 09001 WOUND CLINC 0 90.01 90.01 431, 174 431, 174 0 91 00 09100 EMERGENCY 5, 146, 514 ol Ω 91.00 5, 146, 514 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1, 267, 543 1, 267, 543 0 92.00 OTHER REIMBURSABLE COST CENTERS 101, 00 10100 HOME HEALTH AGENCY 3, 064, 910 3, 064, 910 0 101, 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 116.00 1, 527, 324 1, 527, 324 200 00 Subtotal (see instructions) 65, 166, 610 0 65, 166, 610 0 0 200.00 201.00 0 201.00 Less Observation Beds 1, 267, 543 1, 267, 543 202.00 Total (see instructions) 63, 899, 067 63, 899, 067 0 0 202.00

Provider CCN: 15-1329
Cost Center Description
Inpati ent
INPATIENT ROUTINE SERVICE COST CENTERS 5, 196, 035 30.00 03000 ADULTS & PEDI ATRI CS 5, 196, 035 551, 189 31.00 04300 NURSERY 2, 518, 792 2, 518, 792 43.00 05200 DELI VERY ROOM & LABOR ROOM 262, 104 43, 647 305, 751 1, 408293 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 468, 539 59, 839, 805 61, 308, 344 0.224350 0.000000 60.00 60.00 06000 LABORATORY 2, 942, 229 25, 954, 700 28, 96, 929 0.200348 0.000000 60.00 65.00 06500 RESPI RATORY THERAPY 3, 368, 769 1, 354, 668 4, 723, 437 0.256332 0.000000 65.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS
INPATIENT ROUTINE SERVICE COST CENTERS
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 5, 196, 035 5, 196, 035 30.00 31.00 03100 INTENSI VE CARE UNI T 551, 189 551, 189 31.00 43.00 04300 NURSERY 2, 518, 792 2, 518, 792 43.00 ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 3, 677, 475 13, 166, 172 16, 843, 647 0. 200918 0. 0000000 50.00 50.00 05000 DELI VERY ROOM & LABOR ROOM 262, 104 43, 647 305, 751 1. 408293 0. 0000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 468, 539 59, 839, 805 61, 308, 344 0. 224350 0. 000000 54.00 60.00 06000 LABORATORY 2, 942, 229 25, 954, 700 28, 896, 929 0. 200348 0. 000000 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 0 0. 000000 0. 000000 60.01 65.00 06500 RESPI RATORY THERAPY 3, 368, 769 1, 354, 668 4, 723, 437 0. 256332 0. 000000 65.00
30. 00
31. 00
43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM 3, 677, 475 13, 166, 172 16, 843, 647 0. 200918 0. 000000 50. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 262, 104 43, 647 305, 751 1. 408293 0. 000000 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 468, 539 59, 839, 805 61, 308, 344 0. 224350 0. 000000 54. 00 60. 01 06001 BLOOD LABORATORY 2, 942, 229 25, 954, 700 28, 896, 929 0. 200348 0. 000000 60. 01 65. 00 06500 RESPI RATORY THERAPY 3, 368, 769 1, 354, 668 4, 723, 437 0. 256332 0. 000000 65. 00
50. 00 05000 0PERATING ROOM 3, 677, 475 13, 166, 172 16, 843, 647 0. 200918 0. 000000 50. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 262, 104 43, 647 305, 751 1. 408293 0. 000000 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 468, 539 59, 839, 805 61, 308, 344 0. 224350 0. 000000 54. 00 60. 01 06000 LABORATORY 2, 942, 229 25, 954, 700 28, 896, 929 0. 200348 0. 000000 60. 01 65. 00 06500 RESPI RATORY THERAPY 3, 368, 769 1, 354, 668 4, 723, 437 0. 256332 0. 000000 65. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 262, 104 43, 647 305, 751 1.408293 0.000000 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1,468,539 59,839,805 61,308,344 0.224350 0.000000 54.00 60. 01 06001 LABORATORY 2,942,229 25,954,700 28,896,929 0.200348 0.000000 60.00 65. 00 06500 RESPI RATORY THERAPY 3,368,769 1,354,668 4,723,437 0.256332 0.000000 65.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 468, 539 59, 839, 805 61, 308, 344 0. 224350 0. 000000 54. 00 60. 00 06000 LABORATORY 2, 942, 229 25, 954, 700 28, 896, 929 0. 200348 0. 000000 60. 00 65. 00 06500 RESPI RATORY THERAPY 3, 368, 769 1, 354, 668 4, 723, 437 0. 256332 0. 000000 65. 00
60. 00 06000 LABORATORY 2, 942, 229 25, 954, 700 28, 896, 929 0. 200348 0. 000000 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0. 000000 60. 01 65. 00 06500 RESPI RATORY THERAPY 3, 368, 769 1, 354, 668 4, 723, 437 0. 256332 0. 000000 65. 00
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0
65. 00 06500 RESPI RATORY THERAPY 3, 368, 769 1, 354, 668 4, 723, 437 0. 256332 0. 000000 65. 00
66 OD D66OD PHYSICAL THEPAPY 107 100000 1 107 146L 4 O64 358L 4 261 504L 0 541771L 0 000000 66 OD
67. 00 06700 0CCUPATI ONAL THERAPY 117, 126 1, 300, 349 1, 417, 475 0. 515679 0. 000000 67. 00
68. 00 06800 SPEECH PATHOLOGY 74, 913 635, 067 709, 980 0. 533905 0. 000000 68. 00
69. 00 06900 ELECTROCARDI OLOGY 422, 425 4, 414, 313 4, 836, 738 0. 298291 0. 000000 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 175, 043 4, 651, 924 7, 826, 967 0. 377170 0. 000000 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT 1, 343, 488 920, 802 2, 264, 290 1. 021635 0. 000000 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 3, 455, 331 9, 689, 912 13, 145, 243 0. 330068 0. 000000 73. 00
OUTPATIENT SERVICE COST CENTERS
88. 00 08800 RURAL HEALTH CLINIC 0 783, 344 783, 344 88. 00
90. 00 09000 CLI NI C 131, 812 6, 150, 643 6, 282, 455 0. 559535 0. 000000 90. 00
90. 01 09001 WOUND CLINC 20, 906 1, 853, 640 1, 874, 546 0. 230015 0. 000000 90. 01
91. 00 09100 EMERGENCY 227, 119 7, 414, 416 7, 641, 535 0. 673492 0. 000000 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 9,530 853,372 862,902 1.468930 0.000000 92. 00
OTHER REIMBURSABLE COST CENTERS
101. 00 101.00 HOME HEALTH AGENCY 0 1,879,747 1,879,747 101. 00
SPECIAL PURPOSE COST CENTERS
113. 00 11300 I NTEREST EXPENSE 113. 00
116. 00 11600 HOSPI CE 0 2, 372, 559 2, 372, 559 116. 00
200.00 Subtotal (see instructions) 29, 159, 971 147, 343, 438 176, 503, 409 200.00
201.00 Less Observation Beds 201.00
202.00 Total (see instructions) 29, 159, 971 147, 343, 438 176, 503, 409 202.00

			10 12/31/2017	5/17/2018 8:0	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
60. 01 06001 BLOOD LABORATORY	0. 000000				60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88. 00
90. 00 09000 CLI NI C	0. 000000				90.00
90. 01 09001 WOUND CLINC	0. 000000				90. 01
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202. 00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1329	Peri od: From 01/01/2017	Worksheet C Part I

12/31/2017 Date/Time Prepared: To 5/17/2018 8:01 am Title 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 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 822, 984 7, 822, 984 7, 822, 984 30.00 681, 255 03100 INTENSIVE CARE UNIT 681, 255 0 681, 255 31.00 31.00 43.00 04300 NURSERY 1, 182, 087 1, 182, 087 0 1, 182, 087 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 384, 195 3, 384, 195 3, 384, 195 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 430, 587 430, 587 0 430, 587 52.00 05400 RADI OLOGY-DI AGNOSTI C 13, 754, 529 13, 754, 529 0 54.00 13, 754, 529 54.00 5, 789, 452 60.00 06000 LABORATORY 5, 789, 452 5, 789, 452 60 00 60.01 06001 BLOOD LABORATORY 0 60.01 65.00 06500 RESPIRATORY THERAPY 1, 210, 766 1, 210, 766 0 0 1, 210, 766 65.00 2, 308, 759 2, 308, 759 2, 308, 759 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 730, 962 C 730, 962 730, 962 67.00 68.00 06800 SPEECH PATHOLOGY 379, 062 379, 062 0 379, 062 68.00 0 69.00 06900 ELECTROCARDI OLOGY 1, 442, 756 1, 442, 756 1, 442, 756 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 952, 101 2, 952, 101 71 00 2, 952, 101 71 00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 2, 313, 277 2, 313, 277 0 2, 313, 277 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 338, 820 73.00 4, 338, 820 4, 338, 820 73.00 OUTPATIENT SERVICE COST CENTERS 1, 492, 301 88.00 08800 RURAL HEALTH CLINIC 1, 492, 301 0 1, 492, 301 88.00 90.00 09000 CLI NI C 3, 515, 252 3, 515, 252 0 3, 515, 252 90.00 09001 WOUND CLINC 90.01 431, 174 431, 174 0 431, 174 90.01 91 00 09100 EMERGENCY 5, 146, 514 ol 5, 146, 514 91 00 5, 146, 514 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1, 267, 543 1, 267, 543 1, 267, 543 92.00 OTHER REIMBURSABLE COST CENTERS 101, 00 10100 HOME HEALTH AGENCY 3, 064, 910 3, 064, 910 3, 064, 910 101. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 527, 324 1, 527, 324 1, 527, 324 116. 00 65, 166, 610 200. 00 200 00 Subtotal (see instructions) 65, 166, 610 0 65, 166, 610 0 201.00 Less Observation Beds 1, 267, 543 1, 267, 543 1, 267, 543 201. 00 202.00 Total (see instructions) 63, 899, 067 0 63, 899, 067 0 63, 899, 067 202. 00

Heal th	Financial Systems MAF	RGARET MARY COMM	MUNITY HOSPITAL	L	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der CC	CN: 15-1329	Peri od:	Worksheet C	
					From 01/01/2017		
					To 12/31/2017		pared:
				\/I\/		5/17/2018 8: 0	1 am
				e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	5, 196, 035		5, 196, 03			30.00
31.00	03100 INTENSIVE CARE UNIT	551, 189		551, 18			31.00
43.00	04300 NURSERY	2, 518, 792		2, 518, 79	92		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	3, 677, 475	13, 166, 172	16, 843, 64			
52.00	05200 DELIVERY ROOM & LABOR ROOM	262, 104	43, 647	305, 75	1. 408293	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 468, 539	59, 839, 805	61, 308, 34	0. 224350	0.000000	54.00
60.00	06000 LABORATORY	2, 942, 229	25, 954, 700	28, 896, 92	0. 200348	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	O	0		0.000000	0.000000	60. 01
65.00	06500 RESPIRATORY THERAPY	3, 368, 769	1, 354, 668	4, 723, 43	0. 256332	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	197, 146	4, 064, 358	4, 261, 50	0. 541771	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	117, 126	1, 300, 349	1, 417, 47	0. 515679	0. 000000	67.00
68. 00	06800 SPEECH PATHOLOGY	74, 913	635, 067	709, 98		0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	422, 425	4, 414, 313	4, 836, 73		0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 175, 043	4, 651, 924	7, 826, 96			
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 343, 488	920, 802	2, 264, 29			
	07300 DRUGS CHARGED TO PATIENTS	3, 455, 331	9, 689, 912	13, 145, 24			
70.00	OUTPATIENT SERVICE COST CENTERS	07 1007 00 1	7,007,712	.0707 2	0.00000	0.00000	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	783, 344	783, 34	1. 905039	0.000000	88. 00
90.00	09000 CLI NI C	131, 812	6, 150, 643	6, 282, 45			
90. 01	09001 WOUND CLINC	20, 906	1, 853, 640	1, 874, 54			
91. 00	09100 EMERGENCY	227, 119	7, 414, 416	7, 641, 53			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 530	853, 372	862, 90			
72.00	OTHER REIMBURSABLE COST CENTERS	7, 550	033, 372	002, 70	1. 400750	0.000000	72.00
101 00	10100 HOME HEALTH AGENCY	l ol	1, 879, 747	1, 879, 74	7		101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	1,077,747	1,017,17			101.00
113 00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	0	2, 372, 559	2, 372, 55	30		116.00
200.00		29, 159, 971	147, 343, 438	176, 503, 40			200.00
200.00		27, 137, 971	147, 343, 430	170, 503, 40	77		200.00
201.00		29, 159, 971	147, 343, 438	176, 503, 40	10		201.00
202.00	Total (See Histructions)	27, 139, 971	147, 343, 430	170, 303, 40	י די	i	1202.00

				5/17/2018 8:01 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 I NTENSI VE CARE UNI T				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BL00D LABORATORY	0. 000000			60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 WOUND CLINC	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00
				•

Health Financial Systems MAF	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2017 To 12/31/2017		
			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	
ANCILLARY SERVICE COST CENTERS	T					
50. 00 05000 OPERATI NG ROOM	241, 553				13, 786	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	91, 720	· ·			396	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 187, 805				14, 769	
60. 00 06000 LABORATORY	279, 403	28, 896, 929		1 '	14, 095	
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY	158, 900			1 '	68, 964	
66. 00 06600 PHYSI CAL THERAPY	316, 255				8, 785	
67. 00 06700 OCCUPATI ONAL THERAPY	67, 698				3, 520	
68. 00 06800 SPEECH PATHOLOGY	58, 274	· ·			4, 784	
69. 00 06900 ELECTROCARDI OLOGY	144, 289				7, 530	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	73, 575			1 '	10, 683	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	235, 047				57, 010	
73. 00 O7300 DRUGS CHARGED TO PATIENTS	102, 258	13, 145, 243	0. 00777	9 1, 652, 521	12, 855	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	101, 515	· ·			0	88. 00
90. 00 09000 CLI NI C	787, 722				13, 455	
90. 01 09001 WOUND CLINC	40, 107				345	
91. 00 09100 EMERGENCY	579, 215					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	166, 875	· ·				92.00
200.00 Total (lines 50 through 199)	4, 632, 211	163, 985, 087		9, 236, 719	234, 633	200.00

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1329 | Peri od: | Worksheet D | From 01/01/2017 | Part IV | To | 12/31/2017 | Date/Time Prepared: THROUGH COSTS

					10 12/31/2017	5/17/2018 8: 0	pared: 1 am
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
		0	0		0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
	06000 LABORATORY	0	0		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	1	0	0	60. 01
	06500 RESPI RATORY THERAPY	0	0	1	0	0	65.00
	06600 PHYSI CAL THERAPY	0	0	1	0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67.00
	06800 SPEECH PATHOLOGY	0	0		0	0	68.00
		0	0		0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	1	0	0	72.00
73. 00		0	0		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS		_	1		I	
	08800 RURAL HEALTH CLINIC	0	0	1	0	0	88. 00
	09000 CLI NI C	0	0	1	0	0	90.00
	09001 WOUND CLINC	0	0		0	0	90. 01
	09100 EMERGENCY	0	0	1	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			U	0	92.00
200.00	Total (lines 50 through 199)	0	0	1	0	0	200. 00

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1329 | Peri od: | Worksheet D | From 01/01/2017 | Part IV | To | 12/31/2017 | Date/Time Prepared: THROUGH COSTS

			1	0 12/31/2017	5/17/2018 8: 0	
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst.	to Charges	
	Educati on	through col.	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col. 2, 3 and	col. 8)	col. 7)	
			4)			
ANOULL ARV OFRIGOR OFFICERS	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1		1	4, 0,0,1,7		
50. 00 05000 OPERATI NG ROOM	0	0	0	16, 843, 647	l .	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	305, 751	l .	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	61, 308, 344	l .	
60. 00 06000 LABORATORY	0	0	0	28, 896, 929	l .	
60. 01 06001 BLOOD LABORATORY	0	0	0	4 700 407	0.000000	60. 01 65. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0	0	4, 723, 437		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	4, 261, 504	l .	
68. 00 06700 OCCUPATIONAL THERAPY	0	0	0	1, 417, 475 709, 980		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	4, 836, 738		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		7, 826, 967		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0		2, 264, 290	l	
73. 00 07300 DRUGS CHARGED TO PATTENTS	0			13, 145, 243		
OUTPATIENT SERVICE COST CENTERS	0			13, 143, 243	0.000000	73.00
88. 00 08800 RURAL HEALTH CLINIC	1	0	1	783, 344	0.000000	88. 00
90. 00 09000 CLI NI C	0	0		6, 282, 455		90.00
90. 01 09001 WOUND CLI NC	0	١		1, 874, 546		90.01
91. 00 09100 EMERGENCY	0	١		7, 641, 535		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		١	1 0	862, 902	l .	
200.00 Total (lines 50 through 199)	1 0	١	0	163, 985, 087	l	200.00
	'	'	'			

Health Financial Systems	MARGARET MARY COMM	UNI TY HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-1329		Worksheet D
THROUGH COSTS			From 01/01/2017	Part IV

	H COSTS	WICE OTHER TASS	Trovider co	F	From 01/01/2017 Fo 12/31/2017		epared: 01 am
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷		Costs (col. 8	1	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS			,			
	05000 OPERATING ROOM	0. 000000	961, 317		0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	1, 321		0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	762, 328		0	0	54.00
	06000 LABORATORY	0. 000000	1, 457, 745	(0	0	60.00
	06001 BLOOD LABORATORY	0. 000000	0	(0	0	60. 01
	06500 RESPI RATORY THERAPY	0. 000000	2, 049, 994		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	118, 377	(0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000	73, 697	(0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	58, 280	(0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	252, 426	(0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 136, 462	(0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	549, 195	(0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 652, 521	(0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0	(0	0	88. 00
90.00	09000 CLI NI C	0. 000000	107, 312	(0	0	90.00
90. 01	09001 WOUND CLINC	0. 000000	16, 113	(0	0	90. 01
91.00	09100 EMERGENCY	0. 000000	34, 090	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	5, 541	(0	0	92.00
200.00	Total (lines 50 through 199)		9, 236, 719	(0	0	200.00

In Lieu of Form CMS-2552-10 Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1329 Peri od: Worksheet D From 01/01/2017 To 12/31/2017 Part V Date/Time Prepared: 5/17/2018 8:01 am Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 4.00 5.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 200918 2, 952, 400 50.00 05200 DELIVERY ROOM & LABOR ROOM 1.408293 52.00 52.00 0 1,650 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 21, 373, 199 0. 224350 4, 364 0 54.00 60.00 06000 LABORATORY 0. 200348 7, 214, 662 0 0 60.00 60.01 06001 BLOOD LABORATORY 0.000000 o 0 60.01 06500 RESPIRATORY THERAPY 0. 256332 65.00 423, 582 0 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.541771 1, 171, 778 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 515679 267, 029 0 67.00 o 68.00 06800 SPEECH PATHOLOGY 0.533905 0 30, 113 0 68.00 0. 298291 06900 ELECTROCARDI OLOGY 0 1, 754, 599 0 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.377170 0 1, 266, 287 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 294, 040 0 72.00 1.021635 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 3, 618, 055 0. 330068 0 1,041 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 90.00 09000 CLI NI C 0. 559535 0 2, 033, 938 0 90.00 09001 WOUND CLINC 0 90. 01 90 01 0. 230015 844, 914 124 0 91.00 91.00 09100 EMERGENCY 0.673492 0 1, 921, 764 910 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 468930 422, 224 0 92.00 0 200.00 200.00 Subtotal (see instructions) 0 45, 590, 234 6, 439 Less PBP Clinic Lab. Services-Program

45, 590, 234

6, 439

201.00

0 202.00

201.00

202.00

Only Charges

Net Charges (line 200 - line 201)

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1329 Period: From 01/01/2017 To 12/31/2017 Part V Date/Time Prepared: 5/17/2018 8:01 am

Cost Cost Center Description Cost Cost

					5/17/2018 8: 01	am
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	,					
50.00 05000 OPERATING ROOM	593, 190	0			!	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 324				l	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 795, 077	979			!	54.00
60. 00 06000 LABORATORY	1, 445, 443	0				60.00
60. 01 06001 BL00D LABORATORY	0	0				60. 01
65. 00 06500 RESPI RATORY THERAPY	108, 578	0				65.00
66. 00 06600 PHYSI CAL THERAPY	634, 835	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	137, 701	0				67.00
68. 00 06800 SPEECH PATHOLOGY	16, 077	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	523, 381	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	477, 605	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	300, 402	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 194, 204	344				73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0			;	88. 00
90. 00 09000 CLI NI C	1, 138, 059	0				90.00
90. 01 09001 WOUND CLINC	194, 343	29				90. 01
91. 00 09100 EMERGENCY	1, 294, 293	613				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	620, 218	0				92.00
200.00 Subtotal (see instructions)	13, 475, 730	1, 965			20	00.00
201.00 Less PBP Clinic Lab. Services-Program	0				20	01.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	13, 475, 730	1, 965			20	02.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1329	From 01/01/2017	Worksheet D-1 Date/Time Pre 5/17/2018 8:0	pared:
	Title XVIII	Hospi tal	Cost	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				
1 00 Inpatient days (including private roo	m days and swing-bed days excluding newborn)		4 851	1 1 00

	Title XVIII Hospital	Cost	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 851	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4, 851	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	4, 065	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	0	7.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 618	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15.00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16.00
17. 00	SWING BED ADJUSTMENT Medicago rate for awing had SNE comitions applicable to comitions through December 31 of the cost		17. 00
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
	reporting period		
19. 00	Medical drate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7, 822, 984	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
22.00	5 x line 17)	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
24 00	x line 20)	0	26, 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0 7, 822, 984	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	7,022,704	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)	0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	7, 822, 984	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 612. 65	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	2, 609, 268	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 609, 268	41.00

COMPUI	Financial Systems MAR ATION OF INPATIENT OPERATING COST	RGARET MARY COM	Provider C	CN: 15-1329	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/17/2018 8:0	
			Title	XVIII	Hospi tal	Cost	/ I dill
	Cost Center Description	Total Inpatient Cost	Total I npati ent Days	Average Per Diem (col. 1 ÷ col. 2)		Program Cost (col. 3 x col. 4)	
42.00	MUDCEDY (+; +Lo V & VLV colv)	1. 00	2. 00	3.00	4. 00 0 0	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units		<u> </u>	0.0	0	0	42.00
43. 00	INTENSIVE CARE UNIT	681, 255	280	2, 433. 0	5 175	425, 784	43.00
44. 00							44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	oost conten bosci i pti cii					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					3, 022, 127	
49. 00	5 1 ,	41 through 48)	(see instructi	ons)		6, 057, 179	49.00
EO 00	PASS THROUGH COST ADJUSTMENTS	ationt routing	convices (fro	m Wkst D su	m of Dorte L and		 E0 00
50. 00	Pass through costs applicable to Program inp	atrent routine	services (110	II WKSt. D, Sui	II OI PALLS I AND		50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	rv services (f	rom Wkst. D. s	sum of Parts II	o	51.00
	and IV)		,	. ,		-	
52.00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclu	9 1	elated, non-ph	ysician anesti	netist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0. 00	55.00
56.00	Target amount (line 54 x line 55)					0	
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting ported	onding 1006	undated and co	ampounded by the	0.00	
37.00	market basket	por tring period	enaring 1770,	updated and co	Silipourided by the	0.00	37.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	odated by the	market basket		0. 00 ¹	60.00
61. 00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		ts (lines 54 x	60), or 1% o	f the target		
62 00	Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			Ö	
	PROGRAM INPATIENT ROUTINE SWING BED COST	•					
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ing period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ner 31 of the	cost reporting	a period (See	0	65.00
03.00	instructions)(title XVIII only)	ts arter beceilik	Jei 31 Oi tile	cost reporting	g perrou (see	ا ا	05.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	n December 31	of the cost re	eporting period	0	67.00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost ren	orting period	0	68.00
00.00	(line 13 x line 20)	c costs arter t	Secember of or	the cost rep	or tring perrod		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NI						70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)		70.00
72.00	Program routine service cost (line 9 x line	, ,	THE 70 - THE	2)			72.00
73. 00	Medically necessary private room cost applic		m (line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv	•					74.00
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Norksheet B, I	Part II, column		75.00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76.00
77. 00	Program capital-related costs (line 9 x line						77.00
78. 00	Inpatient routine service cost (line 74 minu						78.00
79. 00	Aggregate charges to beneficiaries for exces			*.			79.00
80.00	9		cost limitatio	n (line 78 mii	nus line 79)		80.0
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81.0
83. 00	Reasonable inpatient routine service costs (* .				83.0
84. 00	Program inpatient ancillary services (see in		-,				84.0
85. 00	Utilization review - physician compensation	(see instruction					85.00
86.00	Total Program inpatient operating costs (sum		nrough 85)				86.00
00.00	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
		1				704	7 07 0
87. 00 88. 00	Total observation bed days (see instructions	•	+ line 2)			786 1, 612. 65	

Health Financial Systems MAF	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/17/2018 8:0	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	1, 029, 915	7, 822, 984	0. 13165	2 1, 267, 543	166, 875	90.00
91.00 Nursing School cost	0	7, 822, 984	0.00000	0 1, 267, 543	0	91.00
92.00 Allied health cost	0	7, 822, 984	0.00000	0 1, 267, 543	0	92.00
93.00 All other Medical Education	0	7, 822, 984	0. 00000	0 1, 267, 543	0	93.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lie	u of Form CMS-	2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1329	Peri od:	Worksheet D-1		
		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/17/2018 8:0		
	Title XIX	Hospi tal	Cost		
Cost Center Description					
			1. 00		
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private roo	4, 851	1.00			
2.00 Inpatient days (including private roo	4, 851	2.00			
3.00 Private room days (excluding swing-be	d and observation bed days). If you have only	private room days,	0	3. 00	

	Cost Center Description	4 00	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 851	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4, 851	
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)	4, 065	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	4,003	
	reporting period	_	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	Ü	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	55	9. 00
40.00	newborn days)		40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	Ü	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
40.00	through December 31 of the cost reporting period		10.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only)	986	
16.00	Nursery days (title V or XIX only)	0	
	SWING BED ADJUSTMENT		
17. 00			17.00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18.00
10.00	reporting period		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	7, 822, 984	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24.00	X line 18)	0	24.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7, 822, 984	27.00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	0	
30.00		0	1
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31)	0. 00 0. 00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	7, 822, 984	1
	27 minus line 36)]
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		-
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1, 612. 65	20 00
38.00	Program general inpatient routine service cost per diem (see instructions)	1, 612, 65 88, 696	1
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	00,070	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	88, 696	

7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	55	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14. 00 15. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)		14. 00 15. 00
16. 00			16.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20.00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	7, 822, 984 0	1
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6)		
24. 00	Is line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line)	0	
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8)	0	25. 00
26. 00	x line 20)	0	
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	7, 822, 984	
28. 00		0	28. 00
29.00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00		0	
31.00		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)		32.00
33.00			33.00
34. 00 35. 00			34. 00 35. 00
36.00	Average per diem private room cost differential (line 34 x line 31)	0.00	36.00
37.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	- 1	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00		1, 612. 65	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	88, 696	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	88, 696	

(()(//P)	Financial Systems MAF ATION OF INPATIENT OPERATING COST	RGARET MARY COMM	Provi der C		In <u>Lie</u> Period:	u of Form CMS-2 Worksheet D-1	
JOINI UI	MITON OF THE MITCHES OF ENAMENO COOL		Troviuei G	F	From 01/01/2017 To 12/31/2017	Date/Time Pre	
						5/17/2018 8:0	
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	oost outton bescription	Inpatient	Inpatient	Diem (col. 1	11 ogi am bays	(col . 3 x	
		Cost	Days	÷ col . 2)	4.00	col . 4)	
42.00	NURSERY (title V & XIX only)	1. 00 1, 182, 087	2. 00 986	3. 00 1, 198. 87	4.00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units		700	1, 170. 0	<u> </u>	<u> </u>	72.00
43.00	INTENSIVE CARE UNIT	681, 255	280	2, 433. 05	1	2, 433	1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			91, 015	48.00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		182, 144	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	convices (free	m Wkst D sum	of Darts L and	0	50.00
30.00	[111]	atrent routine	services (IIO	II WKSt. D, Suii	OF PALES F ALL	0	30.00
51.00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D, s	um of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu		lated, non-phy	ysician anesth	etist, and	0	
	medical education costs (line 49 minus line	52)					1
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)					0	
57.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (ine 56 minus	line 53)	0	
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, i	updated and co	mpounded by the		
	market basket	. 0.		•			
60.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0. 00 0	1
61.00	which operating costs (line 53) are less that					U	01.00
	amount (line 56), otherwise enter zero (see instructions)						
62.00	62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	62.00
PROGRAM I NPATI ENT ROUTI NE SWI NG BED COST						0] 03.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	period (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	na costs (lina	64 nlus lina	45) (+i +l	Lonly) For	0	66.00
	CAH (see instructions)	·	·		3,		
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost re	porting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	rting period	0	68.00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)		0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service of	•					71.00
72.00	Program routine service cost (line 9 x line	71)		•			72.00
73.00	Medically necessary private room cost applic		7	,			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	,			art II. column		74.00
	26, line 45)			,			
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76.00 77.00
78.00	Inpatient routine service cost (line 74 minu						78.00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p		,			79.00
80.00	Total Program routine service costs for comp		ost limitation	n (line 78 min	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81.00
83. 00	Reasonable inpatient routine service costs (see instruction	* .				83.00
84.00	Program inpatient ancillary services (see in						84.00
85. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
86 NN			. cagir oo,				1 55. 55
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS	0 1111100011 0001					
87. 00	Total observation bed days (see instructions	i)				786	
87. 00 88. 00) diem (line 27 ÷				786 1, 612. 65 1, 267, 543	88.00

Health Financial Systems MAI	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Pre 5/17/2018 8:0	pared: 1 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	1, 029, 915	7, 822, 984	0. 13165	2 1, 267, 543	166, 875	90.00
91.00 Nursing School cost	0	7, 822, 984	0.00000	0 1, 267, 543	0	91.00
92.00 Allied health cost	0	7, 822, 984	0.00000	0 1, 267, 543	0	92.00
93.00 All other Medical Education	0	7, 822, 984	0. 00000	0 1, 267, 543	0	93. 00

Health Financial Systems MARGARET MARY CO				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 01/01/2017	Worksheet D-3	
			To 12/31/2017		pared:
				5/17/2018 8:0	
	Titl∈	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	1 1 1 1 1 1 1	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 710, 252		30.00
31.00 03100 INTENSIVE CARE UNIT			334, 419		31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 20091		193, 146	
52.00 O5200 DELIVERY ROOM & LABOR ROOM		1. 40829		1, 860	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 22435			
60. 00 06000 LABORATORY		0. 20034			
60. 01 06001 BL00D LABORATORY		0.00000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY		0. 25633			65.00
66. 00 06600 PHYSI CAL THERAPY		0. 54177			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 51567			
68. 00 06800 SPEECH PATHOLOGY		0. 53390			
69. 00 06900 ELECTROCARDI OLOGY		0. 29829	1 252, 426	75, 296	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 37717	0 1, 136, 462	428, 639	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		1. 02163		561, 077	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 33006	8 1, 652, 521	545, 444	73.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000	0	0	88. 00
90. 00 09000 CLI NI C		0. 55953			
90. 01 09001 WOUND CLINC		0. 23001			90. 01
91. 00 09100 EMERGENCY		0. 67349			
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 46893	0 5, 541		92.00
200 00 Total (sum of Lines 50 through 94 and 96 through 98))	1	9 236 719	3 022 127	lann nn

91.00 | 09100 | EMERGENCY
92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART)
200.00 | Total (sum of lines 50 through 94 and 96 through 98)
201.00 | Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

202.00

8, 139 92. 00 3, 022, 127 200. 00 201. 00

9, 236, 719

9, 236, 719

202.00

Health Financial Systems MARGARET MARY COM INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od:	u of Form CMS-2 Worksheet D-3	
INFATIENT ANCIELART SERVICE COST AFFORTIONWILINT	FI OVI dei C		From 01/01/2017		
			To 12/31/2017	Date/Time Pre	
				5/17/2018 8:0	1 am
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
				col . 2)	
LABATI ENT. POUTLAGE OFFINA OF COOT OFFITEDO		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				ı	
30. 00 03000 ADULTS & PEDI ATRI CS			7, 337		30.00
31. 00 03100 NTENSI VE CARE UNI T			1, 279		31.00
43. 00 04300 NURSERY			32, 743		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 20091			
52. 00 05200 DELI VERY ROOM & LABOR ROOM		1. 40829			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 22435			
60. 00 06000 LABORATORY		0. 20034			
60. 01 06001 BL00D LABORATORY		0.00000		-	60. 01
65. 00 06500 RESPI RATORY THERAPY		0. 25633			
66. 00 06600 PHYSI CAL THERAPY		0. 54177			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 51567			67.00
68. 00 06800 SPEECH PATHOLOGY		0. 53390			68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 29829		293	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 37717			
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		1. 02163			
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 33006	16, 999	5, 611	73.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		1. 90503			88. 00
90. 00 09000 CLI NI C		0. 55953		104	90.00
90. 01 09001 WOUND CLINC		0. 23001	-	4	90. 01
91. 00 09100 EMERGENCY		0. 67349		2, 258	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 46893		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			137, 910	l 91 015	200 00

92.00 0 91, 015 200. 00 201.00

202.00

137, 910

202.00

91.00 O9100 EMERGENCY
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1329	Period: From 01/01/2017 To 12/31/2017 Worksheet E Part B Date/Time Prepared: 5/17/2018 8:01 am

NAME S WEDLOAL AND OTHER HEALTH SENVICES 1.00				10 12/31/2017	5/17/2018 8: 0	
Note Note			Title XVIII	Hospi tal		ı uııı
MORE MIDICAL AND DITHER HEATH SERVICES 1.0 Medical and other services (see instructions) 1.3,477,665 1.0 1.0 Medical and other services (see instructions) 0.2 0.0 0				•		
					1. 00	
Medical and other services reinbursed under OPPS (see instructions)						
00PS payments 0 3.0						
0.00 0.00		· · · · · · · · · · · · · · · · · · ·	tions)			
0.001 cr reconcilitation amount (see instructions)						
Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 1.00						4.00
Line 2 times line 5		, , , , , , , , , , , , , , , , , , ,				4. 01
2.00 Sum of Fines 3, 4, and 4.01, divided by Fine 6 0.00 7.00			ctions)			
Transitional corridor payment (see instructions) 0 8.00 0 0 0 0 0 0 0 0 0					_	
9.00 Ancillary service other pass through costs from Wist. D, Pt. IV, col. 13. Iline 200 9.0						
10.00 Organ acquisitions 13,477,695 11.00 Total cost (sum of lines 1 and 10) (see Instructions) 13,477,695 11.00 Total cost (sum of lines 1 and 10) (see Instructions) 12.00 Anciliary service charges 12.00 Anciliary service charges 12.00 Anciliary service charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (from West. D-4, Pt. 111, coll. 4, line 69) 12.00 13.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 13) Organ acquisition charges (sum of lines 2) Organ ac		, , , , , , , , , , , , , , , , , , , ,	IV col 12 line 200			
1.00 Total cost (sum of lines 1 and 10) (see instructions) 1.0 1			TV, COL. 13, TTHE 200		_	
COMPUTATION OF LESSER OF COST OR CHARGES					_	
Reasonable charges	11.00				13, 477, 073	111.00
12.00 Ancil lary service charges 0 12.0						1
13.00 organ acquisition charges (from Wist. D-4, Pt. III, col. 4, line 69) 0 13.0 0 14.0 0 14.0 Total reasonable charges (sum of lines 12 and 13) 0 14.0 0 14.0 0 0 14.0 0 0 14.0 0 14.0 0 14.0 0 14.0 0 14.0 0 14.0 0 14.0 0 14.0 0 14.0 0 15.0 0 0 15.0 0 0 15.0 0 0 15.0 0 0 15.0 0 0 15.0 0 0 15.0 0 0 15.0 0 0 15.0 0 0 15.0 0 0 15.0 0 0 15.0 0 0 15.0 0 0 15.0 0 0 0 0 0 0 0 0 0	12 00				0	12 00
14.00 Total reasonable charges (sum of lines 12 and 13)			ine 69)			
Country charges						
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.0					_	1
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had accordance with 42 CFR \$413.31(c) 0.000000 17.0000000 17.000000 17.0000000 17.0000000 17.0000000 17.0000000 17.0000000 17.0000000 17.0000000 17.00000000 17.000000000 17.000000000 17.0000000000 17.00000000000000000000 17.000000000000000000000000000000000000	15.00		payment for services on	a charge basis	0	15.00
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.0 18.00 18.00	16.00				0	16.00
18.00 Total customary charges (see instructions)		had such payment been made in accordance with 42 CFR §413.13(e)	Ü	I	
19.00 Excess of customary charges over reasonable cost (complete only If line 18 exceeds line 11) (see 0 19.0	17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
Instructions	18.00	Total customary charges (see instructions)			0	18.00
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.0	19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	0	19.00
instructions 13,612,472 21.0 22.0 Interns and residents (see instructions) 0,22.0 22.0 Interns and residents (see instructions) 0,22.0 22.0 23.0 23.0 25.0					I	
21.00 Lesser of cost or charges (see instructions) 13,612,472 21.00 22.00 Lerons and residents (see instructions) 0.20 22.00 23.00 25.01	20. 00		ly if line 11 exceeds li	ne 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0 22.0 23.00						
23.00 Cost of physicians' services in a teaching hospital (see instructions) 0 24.0						
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 24.0 24.0		· · · · · · · · · · · · · · · · · · ·				
COMPUTATION OF RELIMBUSESMENT SETILEMENT 25.00 Deductibles and coinsurance (for CAH, see instructions) 159,546 25.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 7,626,996 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 0.28.00 Especial Color of the col			ructions)			
25 00 Deductibles and coinsurance (for CAH, see instructions) 159,546 25.0 26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 7,626,996 26.0 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 7,626,996 27.0 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.0 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.0 30.00 Subtotal (sum of lines 27 through 29) 5,825,930 30.0 31.00 Primary payer payments 3,315 31.0 32.00 Subtotal (sum of lines 27 through 29) 5,822,615 32.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.0 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.0 34.00 Allowable bad debts (see instructions) 710,392 35.0 35.00 Adjusted reimbursable bad debts (see instructions) 710,392 35.0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 710,392 35.0 37.00 Subtotal (see instructions) 788,77 799,979 7	24.00				0	24.00
26. 00 Deductible sand Coinsurance relating to amount on line 24 (for CAH, see instructions) 7, 626, 996 26. 27. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 5,825,930 27. 0 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 36) 0 29. 0 30. 00 Subtotal (sum of lines 27 through 29) 5,825,930 30. 30 31. 00 Primary payer payments 5,825,930 33. 315 32. 00 Subtotal (line 30 minus line 31) 5,822,615 32.0 33. 00 Composite rate ESRD (from Wkst. I-5, line 11) 0 1,092,911 34. 00 Allowable bad debts (see instructions) 1,092,911 33. 0 35. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 1,092,911 30. 0 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 6,533,007 37. 0 38. 00 MSP-LCC reconciliation amount from PS&R 6,533,007 37. 0 39. 00 OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 9 39. 99 RECOVERY OF ACCELERA	25 00				1EO E44	25 00
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		· · · · · · · · · · · · · · · · · · ·	r CAU soo instructions			1
Instructions Direct graduate medical education payments (from Wkst. E-4, line 50) 28. 0 28. 0 29. 0 29. 0 28. 0 29. 0		· · ·				1
28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28. 0 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 0 29. 0 30. 00 Subtotal (sum of lines 27 through 29) 5. 825, 930 30. 0 31. 00 Primary payer payments 3, 315 31. 00 20. 00 Subtotal (line 30 minus line 31) 5, 822, 615 32. 0 20. 01 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 5, 822, 615 32. 0 34. 00 All lowable bad debts (see instructions) 1, 092, 911 34. 0 35. 00 Adjusted reimbursable bad debts (see instructions) 710, 392 35. 0 36. 00 All lowable bad debts for dual eligible beneficiaries (see instructions) 588, 575 36. 0 37. 00 Subtotal (see instructions) 6, 533, 007 37. 0 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 0 39. 01 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 0 39. 97 Poincer ACO demonstration payment adjustment (see instructions) 0 39. 9 39. 99 RECOVERY OF ACCELERATED DEPRECIATION <	27.00		prus the sum of filles 22	and 23] (See	5, 625, 750	27.00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.0 30.00 Subtotal (sum of lines 27 through 29) 5,825,930 30.00 30.00 Subtotal (sum of lines 27 through 29) 5,825,930 30.00 30.00 Subtotal (line 30 minus line 31) 31.00 Primary payer payments 3,315 31.00 5,822,615 32.00	28 00		ine 50)		0	28 00
30.00 Subtotal (sum of lines 27 through 29) 5,825,930 30.00 Primary payer payments 3,315 31.00 Subtotal (line 30 minus line 31) 5,822,615 32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)						29.00
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34.00 Allowable bad debts (see instructions) 1,092,911 34.0 35.00 Adjusted relimbursable bad debts (see instructions) 710,392 35.0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 588,575 36.00 37.00 Subtotal (see instructions) 6,533,007 37.00 Subtotal (see instructions) 0 38.0 MSP-LCC reconciliation amount from PS&R 0 38.0 MSP-LCC reconciliation amount from PS&R 0 38.0 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 0 39.9 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.9 RECOVERY OF ACCELERATED DEPRECIATION 0 39.9 RECOVERY OF ACCELERATED DEPRECIATION 0 39.9 RECOVERY of ACCELERATED DEPRECIATION 0 39.9 RECOVERY of Acceleration adjustment (see instructions) 130,660 40.0 40.00		ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
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TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)				- ep //	ı	
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92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.0		, ,				
	92.00	t en en en en en en en en en en en en en			0.00	92.00
94.00 Total (sum of lines 91 and 93) 0 94.0	93.00	Time Value of Money (see instructions)				
	94.00	Total (sum of lines 91 and 93)			0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1329 Peri od: Worksheet E-1 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/17/2018 8:01 am Title XVIII Hospi tal Cost Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 4, 927, 913 1.00 Total interim payments paid to provider 6, 790, 349 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 07/27/2017 218, 600 3.01 3.02 0 3.02 0 3 03 0 0 3 03 3.04 0 0 3.04 0 3.05 3.05 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 0 3.51 3.51 0 0 3.52 3.52 3 53 0 0 3 53 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 218, 600 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 6, 790, 349 4.00 5, 146, 513 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 0 5.02 0 5.02 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 5.52 0 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5. 50-5. 98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1)

280, 623

Contractor

Number

1.00

5, 427, 136

6.01

6.02

7.00

8.00

0

388, 002

6, 402, 347

NPR Date

(Mo/Day/Yr)

2.00

6.01

6.02

7.00

SETTLEMENT TO PROVIDER

Total Medicare program liability (see instructions)

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-	2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1329 Period: From 01/01/2017 To 12/31/2017 Date/Time Pr 5/17/2018 8:	epared:			
Title XVIII Hospital Cost				
1.00				
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1.00			
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2. 00 3. 00			
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200				
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6. 00 7. 00			
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I				
8.00 Calculation of the HIT incentive payment (see instructions)	8.00			
9.00 Sequestration adjustment amount (see instructions)	9. 00			
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)	10.00			
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00 Initial/interim HIT payment adjustment (see instructions)	30.00			
31.00 Other Adjustment (specify)	31.00			
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00			

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1329	Peri od: From 01/01/2017	Worksheet E-3	
			Date/Time Pre	
	Title XVIII	Hospi tal	5/17/2018 8:0 Cost	<u>1 am</u>

				5/17/2018 8: 0	1 am
	Title XVIII		Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services				1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0	2.00
3. 00	Organ acqui si ti on			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			6, 057, 179	4.00
5. 00	Primary payer payments			0	5.00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			6, 117, 751	
	COMPUTATION OF LESSER OF COST OR CHARGES			5,,	
	Reasonabl e charges				
7.00	Routine service charges			0	7.00
8. 00	Ancillary service charges			0	
9. 00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	
10.00	Customary charges			0	10.00
11. 00	Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	0	11. 00
12.00	Amounts that would have been realized from patients liable for			. 0	12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e		on a charge basis	. 0	12.00
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	:)		0. 000000	12 00
14. 00	Total customary charges (see instructions)			0.000000	
15. 00	Excess of customary charges over reasonable cost (complete or	ly if line 14 exceeds li	no 6) (soo	0	
13.00	instructions)	ily II IIIle 14 exceeds II	ne o) (see	U	13.00
16. 00	Excess of reasonable cost over customary charges (complete or	ly if line 6 eyecods lin	20 14) (600	0	16. 00
10.00	instructions)	if y it title o exceeds itt	16 14) (366	U	10.00
17. 00		ructions)		0	17. 00
17.00	OO Cost of physicians' services in a teaching hospital (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT			U	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-	4 Line 40)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	4, TITIE 49)		6, 117, 751	
20.00	Deductibles (exclude professional component)			615, 644	
21. 00	Excess reasonable cost (from line 16)			015, 044	
21.00	Subtotal (line 19 minus line 20 and 21)			5, 502, 107	
23. 00	· · · · · · · · · · · · · · · · · · ·				
24.00	Coinsurance			1, 974	
				5, 500, 133	
25. 00			58, 094		
26. 00				37, 761	
27. 00			27, 036		
28. 00			5, 537, 894		
29. 00			0	29. 00	
29. 50				0	29. 50
29. 99	1			0	29. 99
30.00	Subtotal (see instructions)			5, 537, 894	
30. 01	Sequestration adjustment (see instructions)			110, 758	
30. 02	Demonstration payment adjustment amount after sequestration		0	30. 02	
31. 00	Interim payments			5, 146, 513	
32. 00	Tentative settlement (for contractor use only)			0	32.00
33.00				280, 623	
34.00				0	34.00
	§115. 2		l		

Health Financial Systems	cial Systems MARGARET MARY COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1329	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/17/2018 8:01 am			

		-	To 12/31/2017	Date/Time Pre 5/17/2018 8:0	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		182, 144		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		182, 144	0	4. 00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		182, 144	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		41, 359		8. 00
9.00	Ancillary service charges		137, 910	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		179, 269	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for s	ervices on a charge	0	0	13. 00
	basis				
14.00	Amounts that would have been realized from patients liable for p		0	0	14.00
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	1
16. 00	Total customary charges (see instructions)		179, 269	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	0	0	17. 00
40.00	line 4) (see instructions)	. 6 1	0.075	0	40.00
18. 00	Excess of reasonable cost over customary charges (complete only	IT line 4 exceeds line	2, 875	0	18. 00
10 00	16) (see instructions)			0	10.00
	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruc		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		182, 144	0	21.00
22 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be coll Other than outlier payments	mpreted for PPS provid		0	22.00
			0	0	
	Outlier payments Program capital payments		0	U	24.00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	•
	Subtotal (sum of lines 22 through 26)		0	0	l
28. 00	, ,		0	0	
	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		182, 144	0	1
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		102, 144	0	29.00
30. 00	Excess of reasonable cost (from line 18)		2, 875	0	30.00
			182, 144	0	
	Deductibles		102, 144	0	1
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review		0	U	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		182, 144	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		102, 144	0	
	Subtotal (line 36 ± line 37)		182, 144	0	
39. 00	Direct graduate medical education payments (from Wkst. E-4)		102, 144	U	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		182, 144	0	
41. 00	Interim payments		111, 746	0	
42.00	Balance due provider/program (line 40 minus line 41)		70, 398	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,		70, 348	0	
43.00	chapter 1, §115. 2	with ows rub 13-2,		O	13.00
	1		1		'

Health Financial Systems MARGARET MARY OF BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-1329

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/17/2018 8:01 am

UIII y)					5/17/2018 8:0	1 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	3, 335, 168	0	0	0	1.00
2.00	Temporary investments	0	0	0		2.00
3.00	Notes receivable	0	0	0	0	3.00
4. 00	Accounts receivable	33, 672, 379	0	0	0	4.00
5. 00 6. 00	Other receivable Allowances for uncollectible notes and accounts receivable	-19, 092, 902		0	0	5. 00 6. 00
7. 00	Inventory	1, 063, 357		0	0	7. 00
8. 00	Prepaid expenses	1, 834, 378		0	Ö	8. 00
9.00	Other current assets	400, 408		0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	21, 212, 788	0	0	0	11.00
10.00	FIXED ASSETS	2 552 450	ı ol	0	0	12.00
12. 00 13. 00	Land Land improvements	2, 553, 658 557, 745		0	0	12. 00 13. 00
14. 00	Accumulated depreciation	-410, 431		0	0	14.00
15. 00	Bui I di ngs	80, 587, 989		0	Ö	15. 00
16.00	Accumulated depreciation	-42, 861, 573		0	0	16.00
17. 00	Leasehold improvements	0	0	0	0	17.00
18. 00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	6, 340, 280		0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	-6, 163, 103		0	0	20. 00 21. 00
22. 00	Accumulated depreciation			0	0	22.00
23. 00	Major movable equipment	58, 892, 305	-	0	Ö	23. 00
24. 00	Accumulated depreciation	-36, 246, 568		0	0	24. 00
25.00	Mi nor equi pmen't depreci abl e	0	0	0	0	25.00
26. 00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28.00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	63, 250, 302	0	0	0	29. 00 30. 00
30.00	OTHER ASSETS	03, 230, 302	.] 0	0	0	30.00
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	82, 670, 632		0	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	82, 670, 632		0	0	35. 00 36. 00
30.00	CURRENT LIABILITIES	167, 133, 722	.[0	U	30.00
37. 00	Accounts payable	2, 504, 486	o	0	0	37. 00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39. 00	Payrol I taxes payable	6, 567, 697	0	0	0	39.00
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41. 00	Deferred income	0	0	0	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	0		0	0	42. 00 43. 00
44.00	Other current liabilities	3, 388, 898		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	12, 461, 081		0		45. 00
	LONG TERM LIABILITIES	1=7.70.77.00				
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48. 00	Unsecured Loans	0	0	0		48. 00
49. 00	Other long term liabilities	26, 709, 584		0	0	49.00
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	26, 709, 584 39, 170, 665		0	-	50. 00 51. 00
31.00	CAPITAL ACCOUNTS	34, 170, 003	<u> </u>		0	31.00
52. 00	General fund balance	127, 963, 057	,			52.00
53.00	Specific purpose fund	,	0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion					58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	127, 963, 057	·	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	167, 133, 722		0	Ö	60.00
	59)					

15.00

16.00 17.00

18.00

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-1329 Peri od: Worksheet G-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/17/2018 8:01 am General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 2.00 3. 00 4.00 1.00 Fund balances at beginning of period 114, 623, 023 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 13, 340, 034 2.00 2.00 127, 963, 057 3.00 Total (sum of line 1 and line 2) ol 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 5.00 0 0 0 0 0 5.00 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 127, 963, 057 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 000000 13.00 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 127, 963, 057 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 0 3.00 3.00 Total (sum of line 1 and line 2) 0 4.00 Additions (credit adjustments) (specify) 4.00 5.00 5.00 6.00 0 6.00 0 7.00 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 0 13.00 14.00 0 14.00

0

0

0

0

15.00

16.00

17.00

18.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

| Peri od: | Worksheet G-2 | From 01/01/2017 | Parts | & II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems MARGA STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-1329

			То	12/31/2017	Date/Time Pre 5/17/2018 8:0	
	Cost Center Description	I npati ent		Outpati ent	Total	ı allı
	oust defiter besett per on	1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00		2.00	0.00	
	General Inpatient Routine Services					İ
1.00	Hospi tal	7, 714,	327		7, 714, 827	1.00
2.00	SUBPROVI DER - I PF				, ,,	2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5. 00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7, 714,	327		7, 714, 827	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	551,	189		551, 189	11. 00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL INTENSI VE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of line	s 551,	189		551, 189	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8, 266,	016		8, 266, 016	17.00
18. 00	Ancillary services	20, 504,	588	126, 035, 717	146, 540, 305	18. 00
19.00	Outpati ent servi ces	389,	367	16, 272, 071	16, 661, 438	19. 00
20.00	RURAL HEALTH CLINIC		0	783, 344	783, 344	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY			1, 879, 747	1, 879, 747	22. 00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE		0	2, 372, 559	2, 372, 559	26. 00
27. 00	NON-PROVI DER BASED		0	19, 220, 551	19, 220, 551	27. 00
27. 01	PROFESSI ONAL FEES	675,		11, 748, 221	12, 423, 478	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to W	kst. 29, 835, 3	228	178, 312, 210	208, 147, 438	28. 00
	G-3, line 1)					
29. 00	PART II - OPERATING EXPENSES			96, 956, 138		29. 00
30.00	Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY)		0	90, 950, 138		30.00
31.00	ADD (SPECIFY)		0			30.00
32.00			0			31.00
32.00			0			32.00
34. 00			0			34.00
35.00			0			35.00
36. 00	Total additions (sum of Lines 20 25)		٥	o		36.00
	Total additions (sum of lines 30-35)		0	U		
37. 00 38. 00	DEDUCT (SPECIFY)		0			37. 00 38. 00
39.00			0			39.00
40.00			0			40.00
41.00			0			40.00
41.00	Total deductions (sum of lines 37-41)		U	0		41.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	ansfer		96, 956, 138		42.00
73.00	to Wkst. G-3, line 4)			70, 730, 130		75.00

	Financial Systems MARGARET MARY COMMU		Period:	u of Form CMS-2	
STATEN	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1329	From 01/01/2017	Worksheet G-3	
			To 12/31/2017	Date/Time Pre 5/17/2018 8:0	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			208, 147, 438	1.00
2.00	Less contractual allowances and discounts on patients' accou	nts		109, 435, 921	2.00
3.00	Net patient revenues (line 1 minus line 2)			98, 711, 517	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		96, 956, 138	
5.00	Net income from service to patients (line 3 minus line 4)			1, 755, 379	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	n services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER INCOME			1, 193, 399	24.00
24. 01	CONTRI BUTI ONS			327, 602	24. 01
24. 02	GAIN ON DISPOSAL			-174, 925	24. 02
04.00	LANGE THEAT DETUDN			/ 470 070	04.00

6, 473, 270 335, 985 24, 04 3, 400, 343 28, 981 24, 05

0 28.00 13, 340, 034 29.00

25.00

34 26.00 0 27.00 0 28.00

11, 584, 655

13, 340, 034

24. 03 I NVESTMENT RETURN

24.04 UNREALIZED GAIN, DERIVATIVE
24.05 UNREALIZED GAIN, INVESTMENTS
24.06 TEMPORARILY RESTRICTED ASSETS

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)

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

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

0

0

1, 790, 151

0

0

1, 790, 151

23.50

24.00

Tel emedi ci ne

24.00 Total (sum of lines 1-23)

23.50

Health Financial Systems	MAR	GARET MARY COM	MMUNITY HOSPITA	AL.	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HHA STATISTICAL BAS	SIS		Provider C		Peri od:	Worksheet H-1	
			HHA CCN:		From 01/01/2017 To 12/31/2017		
					Home Health	PPS	
					Agency I		
	Capital Rel	ated Costs					
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR	Plant Operation & Maintenance	Transportation (MILEAGE)	Reconciliatio n	Administrativ e & General (ACCUM. COST)	

						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	Plant	Transportatio	Reconciliatio	Administrativ	
		Fixtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance	11 (WII EE/10E)	''	(ACCUM. COST)	
		(SQUARE TEET)	VALUE)	(SQUARE FEET)			(1000)	
		1. 00	2. 00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		0			0		2.00
	Equi pment							
3.00	Plant Operation & Maintenance	O	0	0		0		3.00
4.00	Transportation (see	0	0	0	0			4.00
	instructions)							
5.00	Administrative and General	0	0	0	0	-627, 866	1, 162, 285	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	503, 033	6.00
7. 00	Physi cal Therapy	0	0	0	0	0	426, 676	7.00
8. 00	Occupational Therapy	0	0	0	0	0	176, 617	8.00
9. 00	Speech Pathology	0	0	0	0	0	3, 588	9.00
10.00	Medical Social Services	0	0	0	0	0	13, 236	10.00
11.00	Home Health Aide	0	0	0	0	0	38, 944	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respi ratory Therapy	0	0	0	0	0	191	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
	Clinic	0	0	0	0	0	0	18. 00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	o	0	0	0	0	0	22.00
23.00	All Others (specify)	o	0	0	0	0	0	23.00
23. 50	Tel emedi ci ne	o	0	0	0	0	0	23. 50
24.00	Total (sum of lines 1-23)	o	0	0	0	-627, 866	1, 162, 285	24.00
25.00	Cost To Be Allocated (per	o	0	0	0		627, 866	25. 00
	Worksheet H-1, Part I)							
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.000000		0. 540200	26. 00

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Provider CCN: 15-1329 Peri od: Worksheet H-2 From 01/01/2017 Part I 15-7143 То Date/Time Prepared: HHA CCN: 12/31/2017 5/17/2018 8:01 am Home Health Agency I CAPITAL RELATED COSTS NEW BLDG & NEW OFFSITE NEW MVBLE NEW MVBLE **EMPLOYEE** HHA Trial Cost Center Description Bal ance (1) FI XT BLDG EQUI P EQUIP OFFSIT **BENEFITS** DEPARTMENT 0 1. 00 1. 01 2.00 2. 01 4.00 1.00 Administrative and General 947 466, 772 48, 251 2.543 86, 842 1.00 2.00 Skilled Nursing Care 774, 771 0 0 2.00 Physical Therapy 0 0 o 3.00 657, 166 3.00 0 Occupational Therapy 272, 026 0 o 4.00 0 4.00 0 Speech Pathology 0 5.00 C 5, 526 5.00 0 6.00 Medical Social Services 20, 386 0 0 0 6.00 7.00 Home Heal th Aide 59, 982 0 0 0 o 7.00 Supplies (see instructions) 0 0 0 8 00 Ω Ω 8 00 0 9.00 Drugs 0 C 9.00 10.00 DMF 0 10.00 11.00 Home Dialysis Aide Services 0 0 0 0 0 0 11.00 Respiratory Therapy 12 00 12 00 294 Ω 13.00 Private Duty Nursing 0 0 13.00 14.00 0 0 0 0 14.00 Clinic 0 Health Promotion Activities 0 15.00 15.00 0 Day Care Program 0 0 16.00 Ω 16.00 17.00 Home Delivered Meals Program 0 0 C 0 0 17.00 0 18.00 Homemaker Service 0 0 0 18.00 All Others (specify) o 19 00 0 0 O 19 00 C 19.50 Tel emedi ci ne 0 0 19.50 86, 842 Total (sum of lines 1-19) (2) 1, 790, 151 48, 251 2, 543 947 466, 772 20.00 20.00 21.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places ADMINISTRATIV OPERATION OF OPERATION OF OPERATION OF LAUNDRY & Cost Center Description Subtotal F & GENERAL PLANT PLANT PLANT LINEN SERVICE -OFFSITE HOSPITAL & **OFFS** 5.00 7.00 7.01 7. 02 8.00 1.00 Administrative and General 605, 355 124, 933 89, 459 730 17, 173 1.00 Skilled Nursing Care 774, 771 159, 897 2.00 0 0 2.00 0 3.00 Physical Therapy 657, 166 135, 625 C 0 3.00 4.00 Occupational Therapy 272, 026 56, 140 0 0 4.00 0 0 0 Speech Pathology 5, 526 0 5.00 1, 140 5.00 6.00 0 Medical Social Services 20, 386 4, 207 0 6.00 7.00 Home Heal th Aide 59, 982 12, 379 C 0 7.00 8.00 Supplies (see instructions) 0 0 0 8.00 0 0 0 0 9.00 9.00 Druas 10.00 DMF 0 0 C 0 10.00 11.00 Home Dialysis Aide Services 0 0 11.00 12.00 Respiratory Therapy 294 61 0 0 12.00 0 Private Duty Nursing 0 13 00 13 00 0 0 14.00 Clinic 0 14.00 15.00 Health Promotion Activities 0 0 0 15.00 0 ol

0

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494, 382

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C

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89, 459

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O

730

0

0

0

0

17, 173

16.00

17.00

18.00

19.00

19 50

20.00

21.00

(1) Column O, line 20 must agree with Wkst. A, column 7, line 101.

0

0

0

2, 395, 506

0. 000000

16.00

17.00

18.00

19.00

19 50

20.00

Day Care Program

Homemaker Service

6 decimal places.

Tel emedi ci ne

All Others (specify)

Home Delivered Meals Program

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

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

ALLOCATION OF GI	ENERAL SERVICE COSTS ⁻	ГО ННА COST CEN	TERS	Provider C		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
						Home Health	5/17/2018 8: 0 PPS	n alli
Cos	t Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI (Agency I CENTRAL SERVICES & SUPPLY	PHARMACY	
		9. 00	10. 00	11. 00	13.00	14. 00	15.00	
2.00 Skilled M 3.00 Physical 4.00 Cocupatio 5.00 Speech Pa 6.00 Medical S 7.00 Home Heal 8.00 Supplies 9.00 Drugs 10.00 DME 11.00 Heal 12.00 Respirato 14.00 Clinic 15.00 Health Pr 16.00 Day Care 17.00 Home Deli 18.00 Home Deli 18.00 Homemaker 19.00 All Other 19.50 Telemedic 20.00 Unit Cost 26, line of column column 26	onal Therapy athology Social Services th Aide (see instructions) ysis Aide Services bry Therapy Outy Nursing romotion Activities Program vered Meals Program Service To (specify) Sine Im of lines 1-19) (2) To Multiplier: column To divided by the sum To 26, line 20 minus To 11, rounded to	67, 642 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
6 decimal Cos	t 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	
2.00 Skilled M 3.00 Physical 4.00 Occupation 5.00 Speech Pa 6.00 Medical S 7.00 Home Heal 8.00 Supplies 9.00 DME 11.00 Home Dial 12.00 Respirato 13.00 Home Dial 12.00 Respirato 14.00 Clinio 15.00 Health Pr 16.00 Day Care 17.00 Home Deli 18.00 Homemaker 19.00 All Other 19.50 Zo.00 21.00 Unit Cost 26, line of column	onal Therapy athology Social Services th Aide (see instructions) ysis Aide Services bry Therapy Outy Nursing romotion Activities Program vered Meals Program Service ss (specify)	0 0 0 0 0 0 0 0 0 0 0 0	905, 310 934, 668 792, 791 328, 166 6, 666 24, 593 72, 361 0 0 355 0 0 0 0 0 0 0 0 0		905, 31 934, 66 792, 79 328, 16 6, 66 24, 59 72, 36	0 8 391, 816 1 332, 340 6 137, 568 6 2, 794 3 10, 309 1 30, 334 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 326, 484 1, 125, 131 465, 734 9, 460 34, 902 102, 695 0 0 0 504 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

column 26, line 1, rounded to 6 decimal places.

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

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 15-1329 Peri od: Worksheet H-2
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 5/17/2018 8:01 am Peri od: BASIS HHA CCN: 15-7143

					Home Health Agency I	PPS	<u> </u>
		CAPITAL REL	ATED COSTS		Agency I		
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SOUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	
	1. 00	1. 01	2. 00	2. 01	4. 00	5A	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier Cost Center Description	3, 415 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, 415 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	1, 592, 122 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00
	(ACCUM. COST)	(SQUARE FEET)	-OFFSI TE (SQUARE FEET)	HOSPITAL & OFFS (SQUARE FEET)	(POUNDS OF LAUNDRY)	FEET)	
	5. 00	7. 00	7. 01	7. 02	8. 00	9. 00	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier	605, 355 774, 771 657, 166 272, 026 5, 526 20, 386 59, 982 0 0 0 294 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 415 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	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 15-1329 | Peri od: | Worksheet H-2 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/17/2018 8:01 am | Home Health | PPS | BASIS HHA CCN: 15-7143

						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)	SERVICE)	N	SUPPLY	PHARMACY)	LI BRARY	
				(HOURS OF	(COSTED		(TIME	
				SERVI CE)	REQUIS.)		SPENT)	
		10. 00	11. 00	13. 00	14.00	15. 00	16. 00	
1.00	Administrative and General	0	C	0	30, 504	0	0	1.00
2.00	Skilled Nursing Care	0	C	0	0	0	0	2.00
3.00	Physi cal Therapy	0	C	0	0	0	0	3.00
4.00	Occupational Therapy	0	C	0	C	0	0	4.00
5.00	Speech Pathology	0	C	0	C	0	0	5.00
6.00	Medical Social Services	0	C	0	C	0	0	6.00
7.00	Home Health Aide	0	C	0	C	0	0	7.00
8.00	Supplies (see instructions)	0	C	0	C	0	0	8. 00
9.00	Drugs	0	C	0	0	0	0	9.00
10.00	DME	0	C	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	C	0	0	0	0	11.00
12.00	Respiratory Therapy	0	C	0	0	0	0	12.00
13.00	Private Duty Nursing	0	C	0	0	0	0	13.00
14.00	Clinic	0	C	0	0	0	0	14.00
15.00	Health Promotion Activities	0	C	0	0	0	0	15.00
16.00	Day Care Program	0	C	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	C	0	0	0	0	17.00
18.00	Homemaker Service	0	C	0	O	0	0	18.00
19.00	All Others (specify)	0	C	0	O	0	0	19.00
19. 50	Tel emedi ci ne	0	C	0	O	0	0	19. 50
20.00	Total (sum of lines 1-19)	0	C	0	30, 504	0	0	20.00
21.00	Total cost to be allocated	0	C	0	18	o	0	21.00
22.00	Unit cost multiplier	0. 000000	0. 000000	0.000000	0. 000590	0. 000000	0. 000000	22.00

PAPORTI O 1. 00 Si 2. 00 Pi 3. 00 Oi 4. 00 Si 5. 00 Mi 6. 00 He	Cost Center Description Cost Center Description ART I - COMPUTATION OF LESSER OST LIMITATION OST Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Hedical Social Services Home Health Aide Total (sum of lines 1-6)	From, Wkst. H-2, Part I, col. 28, line	1, 326, 484 1, 125, 131 465, 734	Provider C HHA CCN: Title Shared Ancillary Costs (from Part II) 2.00 GGGREGATE OF TI	Total HHA Costs (cols. 1 + 2) 3.00 HE PROGRAM LII	Period: From 01/01/2017 To 12/31/2017 Home Health Agency I Total Visits 4.00 MITATION COST, 0		pared: 1 am
CC Cc 1. 00 SI 2. 00 PI 3. 00 Oc 4. 00 SI 5. 00 Mc 6. 00 He	ART I - COMPUTATION OF LESSER OST LIMITATION OST Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology ledical Social Services Home Health Aide	H-2, Part I, col. 28, line 0 OF AGGREGATE 2.00 3.00 4.00 5.00 6.00	Costs (from Wkst. H-2, Part I) 1.00 PROGRAM COST, A 1,326,484 1,125,131 465,734	Shared Ancillary Costs (from Part II) 2.00 GGREGATE OF TI	15-7143 EXVIII Total HHA Costs (cols. 1 + 2) 3.00 HE PROGRAM LIII 1, 326, 48	To 12/31/2017 Home Heal th Agency I Total Visits 4.00 MITATION COST, 0	Date/Time Preps/17/2018 8:0' PPS Average Cost Per Visit (col. 3 + col. 4) 5.00 R BENEFICIARY	1 am
CC Cc 1. 00 SI 2. 00 PI 3. 00 Oc 4. 00 SI 5. 00 Mc 6. 00 He	ART I - COMPUTATION OF LESSER OST LIMITATION OST Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology ledical Social Services Home Health Aide	H-2, Part I, col. 28, line 0 OF AGGREGATE 2.00 3.00 4.00 5.00 6.00	Costs (from Wkst. H-2, Part I) 1.00 PROGRAM COST, A 1,326,484 1,125,131 465,734	Shared Ancillary Costs (from Part II) 2.00 GGGREGATE OF TI	Total HHA Costs (cols. 1 + 2) 3.00 HE PROGRAM LIII	Agency I Total Visits 4.00 MITATION COST, 0	Average Cost Per Vi si t (col . 3 ÷ col . 4) 5.00 R BENEFI CI ARY	
CC Cc 1. 00 SI 2. 00 PI 3. 00 Oc 4. 00 SI 5. 00 Mc 6. 00 He	ART I - COMPUTATION OF LESSER OST LIMITATION OST Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology ledical Social Services Home Health Aide	H-2, Part I, col. 28, line 0 OF AGGREGATE 2.00 3.00 4.00 5.00 6.00	Costs (from Wkst. H-2, Part I) 1.00 PROGRAM COST, A 1,326,484 1,125,131 465,734	Ancillary Costs (from Part II) 2.00 GGREGATE OF TI	Costs (cols. 1 + 2) 3.00 HE PROGRAM LII	Total Visits 4.00 MITATION COST, 0	Per Visit (col. 3 ÷ col. 4) 5.00 R BENEFICIARY	
CC Cc 1. 00 SI 2. 00 PI 3. 00 Oc 4. 00 SI 5. 00 Mc 6. 00 He	ART I - COMPUTATION OF LESSER OST LIMITATION OST Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology ledical Social Services Home Health Aide	H-2, Part I, col. 28, line 0 OF AGGREGATE 2.00 3.00 4.00 5.00 6.00	Costs (from Wkst. H-2, Part I) 1.00 PROGRAM COST, A 1,326,484 1,125,131 465,734	Costs (from Part II) 2.00 GGREGATE OF TI	1 + 2) 3.00 HE PROGRAM LII	4.00 MITATION COST, C	Per Visit (col. 3 ÷ col. 4) 5.00 R BENEFICIARY	
CC Cc 1. 00 SI 2. 00 PI 3. 00 Oc 4. 00 SI 5. 00 Mc 6. 00 He	OST LIMITATION ost Per Visit Computation skilled Nursing Care Physical Therapy occupational Therapy speech Pathology ledical Social Services dome Health Aide	0 OF AGGREGATE 2.00 3.00 4.00 5.00 6.00	Part I) 1.00 PROGRAM COST, A 1,326,484 1,125,131 465,734	Part II) 2.00 GGREGATE OF TI	3.00 HE PROGRAM LII	MITATION COST, O	col. 4) 5.00 R BENEFICIARY	
CC Cc 1. 00 SI 2. 00 PI 3. 00 Oc 4. 00 SI 5. 00 Mc 6. 00 He	OST LIMITATION ost Per Visit Computation skilled Nursing Care Physical Therapy occupational Therapy speech Pathology ledical Social Services dome Health Aide	2. 00 3. 00 4. 00 5. 00 6. 00	1, 326, 484 1, 125, 131 465, 734	2.00 GGREGATE OF TI	HE PROGRAM LII	MITATION COST, O	5. 00 R BENEFICIARY	
CC Cc 1. 00 SI 2. 00 PI 3. 00 Oc 4. 00 SI 5. 00 Mc 6. 00 He	OST LIMITATION ost Per Visit Computation skilled Nursing Care Physical Therapy occupational Therapy speech Pathology ledical Social Services dome Health Aide	2. 00 3. 00 4. 00 5. 00 6. 00	PROGRAM COST, A 1, 326, 484 1, 125, 131 465, 734	GGREGATE OF TI	HE PROGRAM LII	MITATION COST, O	R BENEFICIARY	
CC Cc 1. 00 SI 2. 00 PI 3. 00 Oc 4. 00 SI 5. 00 Mc 6. 00 He	OST LIMITATION ost Per Visit Computation skilled Nursing Care Physical Therapy occupational Therapy speech Pathology ledical Social Services dome Health Aide	2. 00 3. 00 4. 00 5. 00 6. 00	1, 326, 484 1, 125, 131 465, 734	0	1, 326, 48			
1. 00 SI 2. 00 PI 3. 00 00 4. 00 SI 5. 00 Mo 6. 00 Ho	skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	3. 00 4. 00 5. 00 6. 00	1, 125, 131 465, 734			4 5, 033	242 E4	1
2. 00 PI 3. 00 00 4. 00 SI 5. 00 Mo 6. 00 Ho	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	3. 00 4. 00 5. 00 6. 00	1, 125, 131 465, 734			4 5, 0331		1 00
3. 00 00 4. 00 S _I 5. 00 Mo 6. 00 Ho	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	4. 00 5. 00 6. 00	465, 734		1, 125, 13		374. 05	
4. 00 S ₁ 5. 00 Me 6. 00 He	Speech Pathology Medical Social Services Home Health Aide	5. 00 6. 00		0			356. 61	3.00
5. 00 M 6. 00 H	ledical Social Services Home Health Aide	6. 00		0	9, 46		175. 19	
		7. 00			34, 90		4, 362. 75	
7. 00 T	otal (sum of lines 1-6)		102, 695		102, 69	5 897	114. 49	6.00
			3, 064, 406	0	3, 064, 40			7. 00
					Program Visit	S		
					De	ırt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
	oost center beserretron	0031 211111 13	055/(110: (1)	rui t A	to	Deducti bl es		
					Deductibles	ß		
					Coi nsurance			
l :	imitation Cost Computation	0	1. 00	2. 00	3. 00	4. 00	5. 00	
	imitation Cost Computation Skilled Nursing Care		99915	0	2, 53	6		8.00
	Skilled Nursing Care		17140	0				8. 01
1	Physical Therapy		99915	0				9.00
9. 01 PI	Physical Therapy		17140	0	21	0		9. 01
	Occupational Therapy		99915	0	65			10.00
	Occupational Therapy		17140	0				10. 01
	Speech Pathology		99915	0		1		11.00
	Speech Pathology Medical Social Services		17140 99915	0		5 7		11. 01 12. 00
	ledical Social Services		17140	0		ó		12.00
	Home Health Aide		99915	0				13. 00
	Home Health Aide		17140	0				13. 01
14. 00 T	otal (sum of lines 8-13)			0	5, 94	7		14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges		
		H-2 Part I,	Costs (from	Ancillary	Costs (cols.	(from HHA	÷ 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	
Sı	upplies and Drugs Cost Comput							
	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00		0		0 0	0. 000000 0. 000000	
	or bruge		Program Visits		Cost of	0	0.00000	10.00
			_		Servi ces			
		D	Part		D	Part B	6 11	
	Cost Center Description	Part A	Not Subject to	Subject to Deductibles &	Part A	Not Subject to	Subject to Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance	corrisur ance		Coi nsurance	corrisar aricc	
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
CC	ART I - COMPUTATION OF LESSER OST LIMITATION	OF AGGREGATE	PROGRAM COST, A	GGREGATE OF TI	HE PROGRAM LI	MITATION COST, O	R BENEFICIARY	
	ost Per Visit Computation Skilled Nursing Care	^	2, 827			0 745, 084		1.00
	Physical Therapy	0	1			0 662, 069		2.00
	Occupational Therapy	l n	728			0 259, 612		3.00
	Speech Pathology	0	36		•	0 6, 307		4. 00
	Medical Social Services	0	7			0 30, 539		5. 00
1	Home Health Aide	0	579			0 66, 290		6. 00
	otal (sum of lines 1-6)	Ι 0	5, 947		I	0 1, 769, 901		7.00

near th	Financial Systems	MAR	GARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
APPORT	FIONMENT OF PATIENT SERVICE COST	ΓS		Provi der CO	CN: 15-1329	Period: From 01/01/2017	Worksheet H-3 Part I	3
				HHA CCN:	15-7143	To 12/31/2017	Date/Time Pre 5/17/2018 8:0	pared: 01 am
				Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Limitation Cost Computation							
8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00 13. 01	Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 11. 00 12. 01 13. 00 13. 01
14. 00	Total (sum of lines 8-13)		0		0			14.00
		Progi	ram Covered Cha	irges	Cost of Services			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	Supplies and Drugs Cost Comput							
	Cost of Medical Supplies Cost of Drugs	0	0			0 0	0	15. 00 16. 00
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						_
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TH	HE PROGRAM L	IMITATION COST, O	R BENEFICIARY	
1. 00	Cost Per Visit Computation Skilled Nursing Care	745, 084						1.00
2. 00	Physical Therapy	662, 069						2.00
3.00	Occupational Therapy	259, 612						3.00
4. 00 5. 00	Speech Pathology Medical Social Services	6, 307 30, 539						4.00
6. 00	Home Health Aide	66, 290						6.00
7. 00	Total (sum of lines 1-6)	1, 769, 901						7. 00
	Cost Center Description							
	Limitation Cost Computation	12. 00						
8. 00	Skilled Nursing Care							8.00
8. 01 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01 12. 00 12. 01 13. 00	Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services							8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 12. 01 13. 00 13. 01

Heal t	h Financial Systems	MAR	GARET MARY COM	MUNITY HOSPITA	.L	In Lie	u of Form CMS-2	2552-10
APPOR	TIONMENT OF PATIENT SERVICE COS	ΓS		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7143	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/17/2018 8:0	pared: 1 am
				Title	: 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 Indi cated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED E	BY SHARED HOSPI	TAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 541771	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 515679	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 533905	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 377170	0		0 col. 2, line 1	5. 00	4.00
5. 00	Cost of Drugs	73.00	0. 330068	0		0 col. 2, line 1	6. 00	5. 00

ALCULA	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CO		Peri od:		Worksheet H-4	2552
		HHA CCN:	15-7143	From 01/ To 12/	01/2017 31/2017	Part I-II Date/Time Pre 5/17/2018 8:0	
		Title	XVIII	Home H		PPS	ı aıı
				Agenc	Par	t B	
			Part A		ubj ect	Subject to	
						Deductibles &	
					ibles & urance	Coi nsurance	
			1.00		00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	OMARY CHARGE	S				
	Reasonable Cost of Part A & Part B Services						
1	Reasonable cost of services (see instructions)			0	0	0	
	Total charges Customary Charges			0	0	0	2
	Amount actually collected from patients liable for payment for	r servi ces		0	o	0	3
	on a charge basis (from your records)						
00	Amount that would have been realized from patients liable for	payment		0	0	0	4
	for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)	accordance					
	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	00 0	. 000000	0. 000000	5
	Total customary charges (see instructions)			0	0	0	ı
00	Excess of total customary charges over total reasonable cost	(complete		0	0	0	-
00	only if line 6 exceeds line 1)	: 6 !		0			١,
00	Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	ry ir iine		0	U	0	8
00	Primary payer amounts			0	0	0	9
					t A	Part B	
					vi ces	Servi ces	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			I.	00	2. 00	
	Total reasonable cost (see instructions)				0	0	10
. 00	Total PPS Reimbursement - Full Episodes without Outliers				0	784, 068	1
	Total PPS Reimbursement - Full Episodes with Outliers				0	147, 395	
1	Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes				0	11, 740 5, 429	
	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0	36, 945	
	Total PPS Outlier Reimbursement - PEP Episodes				o	1, 960	
1	Total Other Payments				0	0	1
	DME Payments				0	0	18
	Oxygen Payments Prosthetic and Orthotic Payments				0	0	20
	Part B deductibles billed to Medicare patients (exclude coinst	urance)			ď	0	
. 00	Subtotal (sum of lines 10 thru 20 minus line 21)	,			0	987, 537	2:
	Excess reasonable cost (from line 8)				0	0	
	Subtotal (line 22 minus line 23)				0	987, 537	
	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)				0	0 987, 537	25
	Reimbursable bad debts (from your records)				ď	707, 337	2
	Reimbursable bad debts for dual eligible beneficiaries (see in	nstructions))		İ		28
	Total costs - current cost reporting period (line 26 plus line	e 27)			0	987, 537	
	OTHER ADJUSTMENT	-)			0	0	
	Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration	5)			0	0	
1	Subtotal (see instructions)				0	987, 537	
1	Sequestration adjustment (see instructions)				o	19, 748	
. 02	Demonstration payment adjustment amount after sequestration				0	150	
1	Interim payments (see instructions)				0	967, 638	
3.00	Tentative settlement (for contractor use only)				0	0	33
- 1	Ralance due provider/program (line 21 minus lines 21 01 22 /						
. 00	Balance due provider/program (line 31 minus lines 31.01, 32, a Protested amounts (nonallowable cost report items) in accordan		S Pub. 15-2.		ő	Ö	

Provider CCN: 15-1329 TO PROGRAM BENEFICIARIES

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/17/2018 8:01 am PPS HHA CCN: 15-7143

-				Home Health	PPS	ı aiii
				Agency I		
		Inpatien	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3.00	4. 00	
1.00	Total interim payments paid to provider			0	967, 638	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	, and the second			0	0	3. 01
3. 02			1	0	0	3. 02
3. 03			1	0	0	3. 03
3. 04				0	0	3. 04
3. 05	Dec. 1 Lea La Decembra			0	0	3. 05
2 50	Provider to Program		1	O	1 0	2 50
3. 50 3. 51			l .	0		3. 50 3. 51
3. 51				0		3. 52
3. 53						3. 53
3. 54				Ö	l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			O	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)			0	967, 638	4.00
	(transfer to Wkst. H-4, Part II, column as appropriate,					
	Tine 32)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		I			5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider		•	'		
5. 01				0	0	5. 01
5. 02				0	0	5. 02
5. 03				0	0	5. 03
F F6	Provi der to Program					F F0
5. 50			l .	0	0	5.50
5. 51 5. 52			1	0		5. 51 5. 52
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		1	0		5. 99
3. 77	5. 50-5. 98)				ا	3. 77
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER			0	151	6. 01
6. 02	SETTLEMENT TO PROGRAM		1	0	0	6. 02
7. 00	Total Medicare program liability (see instructions)			0	967, 789	7.00
				Contractor	NPR Date	
		,	0	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		U	1.00	2.00	8. 00
0.00	name of contractor			1		0.00

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1, 066, 739 100. 00

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65.00

68.00

NONREI MBURSABLE COST CENTERS

HOSPICE/PALLIATIVE MEDICINE FELLOWS*

BEREAVEMENT PROGRAM *

PALLIATIVE CARE PROGRAM*

OTHER PHYSICIAN SERVICES*

TELEHEALTH/TELEMONI TORI NG*

71.00 OTHER NONREIMBURSABLE (SPECIFY)*

NURSING FACILITY ROOM & BOARD*

VOLUNTEER PROGRAM *

RESIDENTIAL CARE*

FUNDRAI SI NG*

ADVERTI SI NG*

THRIFT STORE*

60.00

61.00

62.00

63.00

64.00

65.00

66, 00

67 00

68.00

69 00

70.00

100.00 TOTAL

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

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

From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/17/2018 8:01 am Hospi ce CCN: 15-1551

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
	CENEDAL CEDALOF COCT CENTEDO	6. 00	7. 00		
1. 00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT*	ol	0	I	1.00
2. 00	CAP REL COSTS-BLDG & FIXT	0	0	•	2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	•	3.00
4. 00	ADMI NI STRATI VE & GENERAL*	0	338, 529	•	4.00
5. 00	PLANT OPERATION & MAINTENANCE*		11, 815	•	5.00
6. 00	LAUNDRY & LINEN SERVICE*	ام	0		6.00
7. 00	HOUSEKEEPI NG*	ام	Ö	1	7.00
8. 00	DI ETARY*	ام	0	1	8.00
9. 00	NURSING ADMINISTRATION*		Ö	1	9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	l ol	0	1	10.00
11. 00	MEDI CAL RECORDS*	ام	0	1	11.00
12. 00	STAFF TRANSPORTATION*	ol	58, 878	1	12.00
13. 00	VOLUNTEER SERVICE COORDINATION*	ol	0		13.00
14.00	PHARMACY*	o	144, 030		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	ol	0	•	15.00
16.00	OTHER GENERAL SERVI CE*	o	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17. 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	14, 400		26.00
27.00	NURSE PRACTITIONER**	0	194		27. 00
28. 00	REGI STERED NURSE**	0	281, 720		28. 00
29. 00	LPN/LVN**	0	36, 214		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	60, 040	•	33.00
34.00	SPI RI TUAL COUNSELI NG**	0	27, 139	1	34.00
35. 00	DI ETARY COUNSELI NG**	0	0	•	35.00
36. 00	COUNSELING - OTHER**	0	0	1	36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	93, 780	1	37.00
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	0	1	38.00
39.00	PATIENT TRANSPORTATION**	0	0	1	39.00
40.00	I MAGING SERVICES**	0	0	•	40.00
41.00	LABS & DI AGNOSTI CS**	0	0	•	41.00
42. 00 42. 50	MEDICAL SUPPLIES-NON-ROUTINE** DRUGS CHARGED TO PATIENTS**	0	0	1	42. 00 42. 50
43. 00	OUTPATIENT SERVICES**	0	0	1	43. 00
44. 00	PALLIATIVE RADIATION THERAPY**		0	•	44.00
45. 00	PALLIATIVE CHEMOTHERAPY**		0	•	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY) **		0	•	46.00
40.00	NONREI MBURSABLE COST CENTERS	<u> </u>			40.00
60. 00	BEREAVEMENT PROGRAM *	ol	0		60.00
61. 00	VOLUNTEER PROGRAM *	l ol	0	•	61.00
62. 00	FUNDRAI SI NG*	ol	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	o	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	o	0		64. 00
65.00	OTHER PHYSICIAN SERVICES*	ol	0		65. 00
66.00	RESIDENTIAL CARE*	ol	0		66.00
67.00	ADVERTI SI NG*	o	0		67. 00
68.00	TELEHEALTH/TELEMONI TORI NG*	o	0		68. 00
69. 00	THRI FT STORE*	o	0		69. 00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	•	70.00
71. 00	OTHER NONREI MBURSABLE (SPECIFY)*	0	0	1	71.00
100.00	TOTAL	0	1, 066, 739	1	100. 00

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

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512, 394 100. 00

42.00

42.50

44.00

45.00

46.00

100. 00 TOTAL 497.994 * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

LABS & DIAGNOSTICS

OUTPATIENT SERVICES

MEDICAL SUPPLIES-NON-ROUTINE

PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

DRUGS CHARGED TO PATIENTS

PALLIATIVE CHEMOTHERAPY

41.00

42.00

42.50

43.00

44.00

45.00

	·	ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25. 00
26.00	PHYSI CI AN SERVI CES	0	14, 400	26.00
27.00	NURSE PRACTITIONER	0	194	27.00
28.00	REGI STERED NURSE	0	281, 103	28. 00
29.00	LPN/LVN	0	36, 135	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	59, 908	33.00
34.00	SPI RI TUAL COUNSELI NG	0	27, 080	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	93, 574	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39.00	PATIENT TRANSPORTATION	0	0	39. 00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	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	512, 394	100.00

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

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846

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846

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44.00

45.00

46.00

846 100.00

PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

PALLIATIVE CHEMOTHERAPY

		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 PRACTITIONER	0	0	27. 00
28.00	REGI STERED NURSE	0	477	28. 00
29.00	LPN/LVN	0	61	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	102	33.00
34.00	SPIRITUAL COUNSELING	0	46	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	160	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	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	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
	PALLIATIVE CHEMOTHERAPY	0	0	45. 00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	846	100.00

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

44.00

45.00

100. 00 TOTAL

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

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45.00

46.00

247 100. 00

^{100. 00} TOTAL * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5	
		6. 00	± col . 6) 7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25. 00	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	o	26.00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	140	28. 00
29. 00	LPN/LVN	0	18	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	o	32.00
33.00	MEDICAL SOCIAL SERVICES	0	30	33.00
34.00	SPIRITUAL COUNSELING	0	13	34.00
35.00	DI ETARY COUNSELI NG	0	o	35. 00
36.00	COUNSELING - OTHER	0	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	46	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	o	38. 00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	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	247	100.00

247

45.00

PALLIATIVE CHEMOTHERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

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

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-1							
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der C		Peri od:	Worksheet 0-5		
EXPENSES FOR ALLOCATION				From 01/01/2017 Fo 12/31/2017		pared: 1 am	
				Hospi ce I			
	Descri pti ons		HOSPI CE	GENERAL	TOTAL		
			DI RECT	SERVI CE	EXPENSES (sum		
			EXPENSES (see	EXPENSES FROM	of cols. 1 +		
			instructions)	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	1. 00	
2. 00	CAP REL COSTS-MVBLE EQUIP		(0	0	2.00	
3. 00	EMPLOYEE BENEFITS DEPARTMENT		(199, 290		3.00	
4. 00	ADMINISTRATIVE & GENERAL		338, 529	261, 282	599, 811	4.00	
5. 00	PLANT OPERATION & MAINTENANCE		11, 815	5 0	11, 815	5.00	
6. 00	LAUNDRY & LINEN SERVICE		(0	0	6.00	
7. 00	HOUSEKEEPI NG		(0	0	7.00	
8. 00	DIETARY		(0	0	8.00	
9. 00	NURSI NG ADMI NI STRATI ON		(0	0	9.00	
10.00	ROUTINE MEDICAL SUPPLIES		(13	13	10.00	
11.00	MEDI CAL RECORDS		(0	0	11.00	
12 00	CTAFE TRANSPORTATION		F0 070	al .	F0 070	12 00	

		RGARET MARY COM			In Lie	U OF FORM CMS	<u> 2002-10</u>
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provi der C		Peri od:	Worksheet 0-6	·
					From 01/01/2017	Part I	
			Hospi ce CC	N: 15-1551	To 12/31/2017	Date/Time Pre	
					Hospi ce I	5/17/2018 8:0) i aiii
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBLE		SUBTOTAL	
	besci i pti ons	EXPENSES	& FLX	FOUL P	BENEFITS	JUDITOTAL	
		LAI LIVOLO	αιιλ	LQUIT	DEPARTMENT		
		0	1.00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	JA .	
1. 00	CAP REL COSTS-BLDG & FLXT	0	0				1.00
2. 00	CAP REL COSTS-MVBLE EQUIP		0	Ï	0		2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	199, 290	0		0 199, 290		3.00
4. 00	4		0		0 199, 290		
	ADMI NI STRATI VE & GENERAL	599, 811	0	1	0	599, 811	
5.00	PLANT OPERATION & MAINTENANCE	11, 815	0		0	11, 815	
6. 00	LAUNDRY & LINEN SERVICE	0	0	1	0	0	
7. 00	HOUSEKEEPI NG	0	0	1	0	0	1
8.00	DI ETARY	0	0		0 0	0	1
9. 00	NURSI NG ADMI NI STRATI ON	0	0	1	0	0	1
10.00	ROUTINE MEDICAL SUPPLIES	13	0	1	0	13	10.00
11.00	MEDI CAL RECORDS	0	0	1	0	0	11.00
12.00	STAFF TRANSPORTATION	58, 878	0		0	58, 878	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	1	0	0	13.00
14.00	PHARMACY	144, 030	0		0 0	144, 030	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0		0	0	1
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0		0	0	17. 00
	LEVEL OF CARE						1
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	512, 394			198, 853	711, 247	
52. 00	HOSPICE INPATIENT RESPITE CARE	846	0		0 338	1, 184	
53. 00	HOSPICE GENERAL INPATIENT CARE	247	Ö	l .	0 99	346	1
00.00	NONREI MBURSABLE COST CENTERS	2		1	<u> </u>	0.10	1 00.00
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	o	0		o o	0	61.00
62.00	FUNDRAI SI NG	0	0		0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0	Ö		0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES	0	0		0	n	65.00
66. 00	RESI DENTI AL CARE	0	0		0	n	66.00
67. 00	ADVERTI SI NG		0			n	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG		0			0	68.00
69. 00	THRIFT STORE					0	69.00
	NURSING FACILITY ROOM & BOARD					0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)					0	
71.00	NEGATIVE COST CENTER					U	71.00
	TOTAL	1 527 324	0		0 199 290	1 527 324	99.00
1()()	I IVIAI	1 577 3741	()	11	u 199.7901	1 577 374	11()() ()()

0 1, 527, 324 100. 00

71.00 OTHER NONREI MBURSABLE (SPECIFY)
99.00 NEGATI VE COST CENTER
100.00 TOTAL

 Health Financial
 Systems
 MARGARET
 MARY
 COST

 COST ALLOCATION
 - HOSPITAL-BASED HOSPICE GENERAL SERVICE
 COSTS
 In Lieu of Form CMS-2552-10 Peri od: Worksheet 0-6 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/17/2018 8:01 am Provider CCN: 15-1329 Hospi ce CCN: 15-1551

						5/1//2018 8:0	n alli
					Hospi ce I		
	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	OPERATION &	LINEN SERVICE			
			MAI NTENANCE				
		4. 00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	<u>'</u>		•			
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL	599, 811					4.00
5. 00	PLANT OPERATION & MAINTENANCE	7, 641	19, 456				5.00
6. 00	LAUNDRY & LINEN SERVICE	7,041	17, 430	1			6.00
7. 00	HOUSEKEEPI NG	0	0				7.00
8. 00	DIETARY	0	0		0	0	
		0	0		0	U	
9.00	NURSING ADMINISTRATION	0	U	1	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	8	0		0		10.00
11. 00	MEDI CAL RECORDS	0	0	1	0		11.00
12.00	STAFF TRANSPORTATION	38, 076	0	1	0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0	1	0		13.00
14.00	PHARMACY	93, 142	0	1	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	1	0		15.00
16.00	OTHER GENERAL SERVICE	0	0	1	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	459, 954					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	766	15, 063	(0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	224	4, 393	(0	0	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	o	0)	0		61.00
62.00	FUNDRAI SI NG	o	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	O	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	o	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	o	0		0		65.00
66.00	RESI DENTI AL CARE	0	0	(0	0	1
67. 00	ADVERTI SI NG	0	0		0	_	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0		0		68.00
69.00			n		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0			O	1
	NEGATI VE COST CENTER		0				1
	TOTAL	599, 811	19, 456			_	100.00
100.00	71.5	3,7,011	17, 450	1	1 9		1.30.00

		TOAILL WALL COMM	UNITED TOSTETA	<u>L</u>	III LI C	u or rorm cws	2332-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provi der CO Hospi ce CCI		Peri od: From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part I Date/Time Prepared:		
			nospi ce coi	N. 13 1331	10 12/31/2017	5/17/2018 8: 0	on am
				Hospi ce I			
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
	'	ADMI NI STRATI O	MEDI CAL	RECORDS	TRANSPORTATI 0	SERVI CE	
		N	SUPPLI ES		N	COORDI NATI ON	
		9. 00	10. 00	11. 00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7.00
8. 00	DI ETARY						8.00
9. 00	NURSI NG ADMI NI STRATI ON	0					9. 00
10. 00	ROUTINE MEDICAL SUPPLIES		21				10.00
11. 00	MEDI CAL RECORDS		21		0		11.00
12. 00	STAFF TRANSPORTATION				96, 954		12.00
13. 00	VOLUNTEER SERVICE COORDINATION				70, 734	0	
14. 00	PHARMACY				0	0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
	OTHER GENERAL SERVICE	0			0	0	16.00
16. 00 17. 00		١			U	U	17.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES						17.00
EO 00	LEVEL OF CARE HOSPI CE CONTI NUOUS HOME CARE	0	0	1	0 0	0	E0 00
		١			-	_	
51.00	HOSPICE ROUTINE HOME CARE	0	21		0 96, 741 0 165	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0			0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0 48	0	53.00
(0.00	NONREI MBURSABLE COST CENTERS			Γ			
60.00	BEREAVEMENT PROGRAM	0			0	0	
61.00	VOLUNTEER PROGRAM	0			0	_	
62.00	FUNDRAI SI NG	0			0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66. 00	RESI DENTI AL CARE	0			0	0	66.00
67. 00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
	THRI FT STORE	0			0	0	69.00
70. 00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREI MBURSABLE (SPECIFY)	0			0	0	
99. 00	NEGATI VE COST CENTER	0	0		0 0	0	99. 00
100.00	TOTAL	0	21		0 96, 954	0	100.00

 Health Financial
 Systems
 MARGARET
 MARY
 COST

 COST ALLOCATION
 - HOSPITAL-BASED HOSPICE GENERAL SERVICE
 COSTS
 In Lieu of Form CMS-2552-10 Provi der CCN: 15-1329 | Peri od: From 01/01/2017 | Worksheet 0-6 | Part | Hospi ce CCN: 15-1551 | To 12/31/2017 | Date/Time Prepared: 5/17/2018 8:01 am

						5/17/2018 8:0	1 am
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
	·		ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
			E SERVICES		CARE SERVICES		
		14. 00	15. 00	16.00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						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	237, 172					14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	237, 172	0				15.00
16. 00	OTHER GENERAL SERVICE		١	·			16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0			0		17.00
17.00	LEVEL OF CARE				U		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	C	1	0	50.00
51. 00	HOSPICE CONTINUOUS HOME CARE	236, 653		1		1, 504, 616	
52. 00	HOSPICE INPATIENT RESPITE CARE	402				17, 580	
53.00	HOSPICE GENERAL INPATIENT CARE	117				5, 128	
33.00	NONREI MBURSABLE COST CENTERS	117		1	U	3, 120	33.00
60.00	BEREAVEMENT PROGRAM					0	60.00
61.00	VOLUNTEER PROGRAM	0				0	61.00
62.00	FUNDRAI SI NG	0				0	62.00
	4	0				_	1
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	1
64.00	PALLIATIVE CARE PROGRAM	0				0	
65.00	OTHER PHYSICIAN SERVICES	0				0	65.00
66.00	RESI DENTI AL CARE	0	0		0	0	
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		C		0	
70.00	NURSING FACILITY ROOM & BOARD	_	_	_		0	
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		_	0	71.00
99. 00	NEGATI VE COST CENTER	0	0	1		0	
100.00	TOTAL	237, 172	0	() C	0	1, 527, 324	100.00

Health Financial Systems	MARGARET MARY COMMUN	NITY HOSPITAL	In Lieu	ı of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPIC STATISTICAL BASIS	E GENERAL SERVICE COSTS	Provider CCN: 15-1329	From 01/01/2017	
		Hospi ce CCN: 15-1551	10 12/31/2017	Date/Time Prepared:

P REL MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Hospi ce I RECONCI LI ATI O N	ADMI NI STRATI V E & GENERAL	
EQUI P (DOLLAR VALUE)	BENEFITS DEPARTMENT (GROSS			
2.00	SALARLES)		(ACCUMULATED COSTS)	
2.00 I		4A	4. 00	
	7.77			
0 0 0 0 0 0 0 0 0 0	199, 476 0 0 0 0 0 0 0 0 0 0	-599, 811 0 0 0 0 0 0 0 0 0	0 144, 030 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
<u> </u>		<u> </u>	0	17.00
	0	0	0	50.00
_		0		51.00
- 1		-1		52.00
υĮ	99	U	346	53.00
0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0		
	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SALARI ES) 2.00 3.00 199, 476 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SALARI ES) 2.00 3.00 4A 0 199, 476 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SALARIES) 2.00 3.00 4A 4A 4.00 0 199, 476 0 0 0 0 0 11, 815 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

Health Financial Systems	M	MARGARET MA	ARY COMMUN	ITY HOSPIT	AL	In Lieu	ı of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED	HOSPI CE GENERAL	SERVICE CO	0STS	Provi der	CCN: 15-1329		Worksheet 0-6
STATI STI CAL BASI S						From 01/01/2017	Part II

STATI S	TICAL BASIS		Hospi ce CC		rom 01/01/201/ o 12/31/2017	Date/Time Pre 5/17/2018 8:0	
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMI NI STRATI O	
		MAI NTENANCE	(IN-FACILITY		DAYS)	N	
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
						HRS.)	
		5. 00	6.00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE	20, 783					5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0				6. 00
7. 00	HOUSEKEEPI NG	0)				7. 00
8. 00	DI ETARY	0)		0		8. 00
9.00	NURSING ADMINISTRATION	0)			0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0)			0	10.00
11.00	MEDICAL RECORDS	0)			0	11. 00
12.00	STAFF TRANSPORTATION	0)			0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0)			0	13.00
14.00	PHARMACY	0)			0	14.00
	PHYSICIAN ADMINISTRATIVE SERVICES	0	,			0	ı
16. 00	OTHER GENERAL SERVICE	0)			0	16.00
	PATIENT/RESIDENTIAL CARE SERVICES	0)				17.00
	LEVEL OF CARE		•		'		
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	16, 090	0		0	0	52.00
	HOSPICE GENERAL INPATIENT CARE	4, 693	•			0	
	NONREI MBURSABLE COST CENTERS	.,	-	-			1
60.00	BEREAVEMENT PROGRAM	0)	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	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)			Ö	69.00
70.00	NURSING FACILITY ROOM & BOARD					_	70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	ol o	ol o	0	0	
	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part	19, 456	o n	ol o	n	n	100.00
	UNIT COST MULTIPLIER	0. 936150		0. 000000	0. 000000		
	· · · · · · · · · · · · · · · · · · ·	1 2	1 2.22000	1 2.220000	1 2:223000	1 2:223000	

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CM:							2552-10
COST ALLOCATION STATISTICAL BASI	- HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provi der C		Period: From 01/01/2017	Worksheet 0-6 Part II	
STATISTICAL DASIS		Hospi ce CC	N: 15-1551	To 12/31/2017	Date/Time Pre 5/17/2018 8:0	pared: 1 am	
					Hospi ce I		
Cost	Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATI C	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 SE	ERVICE COST CENTERS						
1.00 CAP REL CO	OSTS-BLDG & FLXT						1.00

	COST CERTER DESCRIPTIONS	MEDI CAL SUPPLI ES (PATI ENT DAYS)	RECORDS (PATI ENT DAYS)	TRANSPORTATIO N (MI LEAGE)	SERVI CE COORDI NATI ON (HOURS OF SERVI CE)	(CHARGES)	
	CENEDAL CEDVICE COST CENTEDS	10. 00	11. 00	12.00	13. 00	14. 00	
1 00	GENERAL SERVICE COST CENTERS	T		I	I		1 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 16. 00	MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES	14, 162	0	103, 570 0 0 0	0 0 0	253, 356 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							17. 00
50. 00	HOSPICE CONTINUOUS HOME CARE	O	0	0	ol	0	50.00
51. 00		14, 131	0	_	ő	252, 802	
52. 00		24	0		o	429	52.00
53. 00		7	0		Ö	125	
	NONREI MBURSABLE COST CENTERS				-1		
100.0	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES RESIDENTIAL CARE ADVERTISING TELEHEALTH/TELEMONITORING THRIFT STORE NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER D COST TO BE ALLOCATED (per Wkst. 0-6, Part I		0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	
101. 0	OUNIT COST MULTIPLIER	0. 001483	0. 000000	0. 936120	0. 000000	0. 936122	101. 00

Health Financial Systems	MARGARET MARY COMMUN	NITY HOSPITAL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE	GENERAL SERVICE COSTS	Provider CCN: 15-1329	Peri od:	Worksheet 0-6
STATISTICAL BASIS			From 01/01/2017	

From 01/01/2017 To 12/31/2017 Part II Date/Time Prepared: Hospi ce CCN: 15-1551 5/17/2018 8:01 am Hospi ce I Cost Center Descriptions PHYSI CI AN OTHER GENERAL PATI ENT/ ADMI NI STRATI V SERVI CE RESI DENTI AL E SERVICES (SPECI FY CARE SERVICES (PATIENT BASIS) (IN-FACILITY DAYS) DAYS) 15. 00 16. 00 17.00 GENERAL SERVICE COST CENTERS 1 00 CAP REL COSTS-BLDG & FIXT 1 00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 PLANT OPERATION & MAINTENANCE 5.00 5.00 6.00 LAUNDRY & LINEN SERVICE 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 8.00 DIFTARY NURSING ADMINISTRATION 9.00 9.00 10.00 ROUTINE MEDICAL SUPPLIES 10.00 MEDICAL RECORDS 11.00 11.00 STAFF TRANSPORTATION 12.00 12.00 13.00 VOLUNTEER SERVICE COORDINATION 13.00 PHARMACY 14.00 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 0 15.00 16.00 OTHER GENERAL SERVICE C 16.00 17.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 0 50.00 0 51.00 HOSPICE ROUTINE HOME CARE 0 51.00 HOSPICE INPATIENT RESPITE CARE 0 52.00 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 53.00 NONREIMBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 60.00 VOLUNTEER PROGRAM 0 61.00 61.00 FUNDRAI SI NG 62 00 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00

0

0.000000

64.00

65.00

66.00

67.00

68.00

69.00

70.00

71.00

99.00

100.00

101.00

0

0

0.000000

0

0

0.000000

64.00

65.00

66.00

67.00

68.00

69.00

70.00

PALLIATIVE CARE PROGRAM

OTHER PHYSICIAN SERVICES

TELEHEALTH/TELEMONI TORI NG

71.00 OTHER NONREIMBURSABLE (SPECIFY)

NURSING FACILITY ROOM & BOARD

100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)

RESIDENTIAL CARE

ADVERTI SI NG

THRIFT STORE

99. 00 NEGATI VE COST CENTER

101.00 UNIT COST MULTIPLIER

Health Financial Systems	MARGARET MARY COMMU	NITY HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPIC	E SHARED SERVICE COSTS BY	Provider CCN: 15-1329	Peri od: From 01/01/2017	Worksheet 0-7
LEVEL OF CARE		Hospi ce CCN: 15-1551		Date/Time Prepared:

LEVEL OF CARE	Hospi ce CCI		o 12/31/2017	Date/Time Pre 5/17/2018 8:0	pared: 1 am	
				Hospi ce I		
			Charges by L	OC (from Provi	der Records)	
Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	HCHC	HRHC	HI RC	
	0	1. 00	2. 00	3. 00	4. 00	
ANCILLARY SERVICE COST CENTERS						
1.00 PHYSICAL THERAPY 2.00 OCCUPATIONAL THERAPY 3.00 SPEECH PATHOLOGY 4.00 DRUGS CHARGED TO PATIENTS 5.00 DURABLE MEDICAL EQUIP-RENTED 6.00 LABORATORY 6.01 BLOOD LABORATORY 7.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 8.00 OTHER OUTPATIENT SERVICE COST CENTER 9.00 RADIOLOGY-THERAPEUTIC 10.00 OTHER ANCILLARY SERVICE COST CENTERS 11.00 Totals (sum of lines 1-11)	66. 00 67. 00 68. 00 73. 00 96. 00 60. 01 71. 00 93. 00 55. 00 76. 00	0. 515679 0. 533905 0. 330068 0. 200348 0. 000000 0. 377170	000000000000000000000000000000000000000	0000	0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 6. 01
Cost Center Descriptions	LOC (from Provi der Records) HGI P	HCHC (col. 1 x col. 2) 6.00	HRHC (col. 1 x col. 3) 7.00	HIRC (col. 1 x col. 4) 8.00	HGIP (col. 1 x col. 5) 9.00	
ANCILLARY SERVICE COST CENTERS						
1.00 PHYSICAL THERAPY 2.00 OCCUPATIONAL THERAPY 3.00 SPEECH PATHOLOGY 4.00 DRUGS CHARGED TO PATIENTS 5.00 DURABLE MEDICAL EQUIP-RENTED 6.00 LABORATORY 6.01 BLOOD LABORATORY 7.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 8.00 OTHER OUTPATIENT SERVICE COST CENTER 9.00 RADIOLOGY-THERAPEUTIC 10.00 OTHER ANCILLARY SERVICE COST CENTERS 11.00 Total's (sum of lines 1-11)	000000000000000000000000000000000000000	Ō	000000000000000000000000000000000000000	000000000000000000000000000000000000000	0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 6. 01 7. 00 8. 00 9. 00 10. 00

Health Financial Systems	MARGARET MARY COMMUN	IITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DI	EM COST	Provider CCN: 15-1329	Peri od:	Worksheet 0-8

					5/17/2018 8:0	1 am
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2.00	3. 00	
	HOSPICE CONTINUOUS HOME CARE			_		
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	7, col. 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	e 10)		0		4.00
5.00	Program cost (line 3 times line 4)			0		5.00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	7, col. 7,			1, 504, 616	6.00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				14, 131	7.00
8.00	Total average cost per diem (line 6 divided by line 7)				106. 48	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ne 11)	12, 38	5 265		9.00
10.00	Program cost (line 8 times line 9)		1, 318, 75	5 28, 217		10.00
	HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7	7, col. 8,			17, 580	11.00
	line 11)					
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				24	12.00
13.00	Total average cost per diem (line 11 divided by line 12)				732. 50	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ne 12)	1	5 0		14.00
15.00	Program cost (line 13 times line 14)		11, 72	0		15.00
	HOSPI CE GENERAL I NPATI ENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	7, col. 9,			5, 128	16.00
	line 11)					
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				7	17.00
18.00	Total average cost per diem (line 16 divided by line 17)				732. 57	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ne 13)		5 0		19.00
20.00	Program cost (line 18 times line 19)		4, 39	5 0		20.00
	TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				1, 527, 324	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				14, 162	
23.00	Average cost per diem (line 21 divided by line 22)				107. 85	23.00
			•	•	. '	

						6.5	
	Financial Systems MAR SIS OF HOSPITAL-BASED RHC/FOHC COSTS	GARET MARY COM	Provider C		In Lie Period:	u of Form CMS-2 Worksheet M-1	
711071213	NO OF HOSEL THE BROED WILD, FAIR COOLS				From 01/01/2017		
			Component	CCN: 15-8511	Γο 12/31/2017	Date/Time Pre 5/17/2018 8:0	
					RHC I	Cost	i aiii
		Compensation	Other Costs	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
		·		+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS				-1		
1.00	Physi ci an	291, 018	0	291, 01		2,.,0.0	1.00
2.00	Physician Assistant	118, 798	0	118, 79			
3.00	Nurse Practitioner	63, 354	0	63, 35			3.00
4.00	Visiting Nurse	5, 470	0	F, 47	0	0	4.00
5.00	Other Nurse	56, 479	0	56, 47		,	
6. 00 7. 00	Clinical Psychologist Clinical Social Worker	0			0 0	0	6.00 7.00
	· ·	0			0 0	1	
8. 00 9. 00	Laboratory Technician Other Facility Health Care Staff Costs	116, 942		116, 94	-	_	
10.00	Subtotal (sum of lines 1 through 9)	646, 591		646, 59		646, 591	10.00
11. 00	Physician Services Under Agreement	040, 391		040, 39	0		
12. 00	Physician Supervision Under Agreement	0				-	1
13. 00	Other Costs Under Agreement	0				-	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0				0	14.00
15. 00	Medical Supplies	0				0	15. 00
16. 00	Transportation (Health Care Staff)	0				1	1
17. 00	Depreciation-Medical Equipment	0	Ö			0	17.00
18. 00	Professional Liability Insurance	0	Ö		0	0	18. 00
19. 00	Other Health Care Costs	0	Ö		0	0	
20.00	Allowable GME Costs	_					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	0		0	0	21.00
22.00	Total Cost of Health Care Services (sum of	646, 591	O	646, 59	1 0	646, 591	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0	0	23. 00
24.00	Dental	0	0	(0	0	24. 00
25.00	Optometry	0	0		0	0	25. 00
25. 01	Tel eheal th	0	0	1	0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	1	0	0	28. 00

154, 455

154, 455

801, 046

103, 581

103, 581

103, 581

103, 581

154, 455

258, 036

904, 627

103, 581

154, 455

258, 036

904, 627

0

29.00

30.00

31.00

32.00

through 27)
FACILITY OVERHEAD
29.00 Facility Costs

31.00

30.00 Administrative Costs

Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	MARGARET MARY COMMUN	IITY HOSPITAL	In Lieu of Form CMS-2552-1			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-1329		Worksheet M-1		
		Component CCN: 15-8511	From 01/01/2017 To 12/31/2017			

			Component	CCN: 15-8511	То	12/31/2017	Date/Time Pro 5/17/2018 8:0	epared: 01 am
						RHC I	Cost	<u> </u>
		Adjustments	Net Expenses					
		,	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	291, 01	8				1.00
2.00	Physician Assistant	0	118, 79	8				2.00
3.00	Nurse Practitioner	0	63, 35	4				3.00
4.00	Visiting Nurse	0		0				4.00
5.00	Other Nurse	0	56, 47	9				5.00
6.00	Clinical Psychologist	0		0				6.00
7.00	Clinical Social Worker	0		0				7.00
8.00	Laboratory Techni ci an	0		0				8. 00
9.00	Other Facility Health Care Staff Costs	0	116, 94	2				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	646, 59	1				10.00
11.00	Physician Services Under Agreement	0		ol				11.00
12.00	Physician Supervision Under Agreement	0		ol				12.00
13.00	Other Costs Under Agreement	0		ol				13.00
14.00	Subtotal (sum of lines 11 through 13)	0		ol				14.00
15.00	Medical Supplies	o		ol				15.00
16.00	Transportation (Health Care Staff)	o		ol				16, 00
17.00		o		ol				17.00
18. 00	Professional Liability Insurance	o		ol				18.00
	Other Health Care Costs	0		o				19.00
20.00	Allowable GME Costs							20.00
21. 00	Subtotal (sum of lines 15 through 20)	o		ol				21.00
22. 00	Total Cost of Health Care Services (sum of	o	646, 59	1				22.00
	lines 10, 14, and 21)	٦						
	COSTS OTHER THAN RHC/FQHC SERVICES	'		·				
23.00	Pharmacy	0		ol				23.00
24.00	Dental	o		ol				24.00
25.00	Optometry	o		ol				25. 00
25. 01	Tel eheal th	o		ol				25. 01
25. 02	4	o		ol				25. 02
26.00	All other nonreimbursable costs	o		ol				26.00
27. 00	Nonallowable GME costs]		-				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0		ol				28. 00
	through 27)	٦						
	FACILITY OVERHEAD							1
29. 00	Facility Costs	0	103, 58	1				29. 00
30. 00	Administrative Costs	o	154, 45					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-1	258, 03					31.00
	30)	٦						
32.00	Total facility costs (sum of lines 22, 28	o	904, 62	7				32.00
	and 31)]	,					
	1 /	Į.		'				•

Heal th	Financial Systems MAF	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/17/2018 8:0	
					RHC I	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	T	T	T			
1. 00	Physi ci an	1. 13					1.00
2.00	Physician Assistant	0. 87	,				2.00
3.00	Nurse Practitioner	0. 47					3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 47			7, 560		
5. 00	Visiting Nurse	0.00		•		0	
6.00	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. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
8. 00	only)	2. 47	4 110			7, 560	8.00
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.47	4, 113			7,560	8.00
9. 00	Physician Services Under Agreements		0			0	9. 00
9.00	Priysi ci air sei vi ces under Agreements					U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	0 HOSPI TAL-BASI	ED RHC/FQHC SEI	RVICES			
	Total costs of health care services (from Wk					646, 591	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			646, 591	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet.	M-1, col. 7, l	ine 31)		258, 036	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			587, 674	15.00
16.00	Total overhead (sum of lines 14 and 15)					845, 710	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16					845, 710	18.00
	Overhead applicable to hospital-based RHC/FC					845, 710	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 1	0 and 19)		1, 492, 301	20.00

	Systems MARGARET MARY COMMUN REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CES			From 01/01/2017		
		Component CCN: 15-8511	To 12/31/2017	Date/Time Pre	
		Title XVIII	RHC I	5/17/2018 8:0 Cost	ı allı
·					
				1. 00	
	TION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1, 492, 301	1.0	
1	Cost of vaccines and their administration (from Wkst. M-4, line 15) Total allowable cost excluding vaccine (line 1 minus line 2)		76, 864 1, 415, 437	2. C	
4	its (from Wkst. M-2, column 5, line 8)			7, 560	1
•	s visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.0
1 7	usted visits (line 4 plus line 5)			7, 560	
	cost per visit (line 3 divided by line 6)			187. 23	7.0
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1)	Period 2)	
00 00 10 10 10 10 10 10			1.00	2. 00	
	payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	81. 32 187. 23	82. 30	
	Program covered visits (see instructions) ON OF SETTLEMENT		107. 23	187. 23	9.0
	overed visits excluding mental health services (from	contractor records)	0	1, 261	10.0
_	ost excluding costs for mental health services (line		0	236, 097	11. (
2.00 Program o	overed visits for mental health services (from contr	actor records)	0	0	12. (
	Program covered cost from mental health services (line 9 x line 12)		0		
,	Limit adjustment for mental health services (see instructions)			0	
	3 ,	•		236, 097	15.0
	Graduate Medical Education Pass Through Cost (see instructions) Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) * Total program charges (see instructions)(from contractor's records)		171, 044	1	
	gram preventive charges (see instructions)(from prov	•		12, 414	
	gram preventive costs ((line 16.02/line 16.01) times	*		17, 135	1
16.04 Total Pro	gram non-preventive costs ((line 16 minus lines 16.0	03 and 18) times .80)		160, 594	16. (
	and XIX see instructions.)		_		
	gram cost (see instructions)		0	177, 729	
	ayer amounts	(from contractor		10 210	
records)	eneficiary deductible for RHC only (see instructions)	(Troili contractor		18, 219	10.0
,	ry coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		28, 082	19.0
,	are cost excluding vaccines (see instructions)			177, 729	20.0
	ost of vaccines and their administration (from Wkst.	M-4, line 16)		51, 756	1
2.00 Total rei	Total reimbursable Program cost (line 20 plus line 21)			229, 485	22.
	bad debts (see instructions)			0	23.
1 -	reimbursable bad debts (see instructions)			0	
	bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	USTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ne)		0	
	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	1	
	sursable amount (see instructions)			229, 485	
4	tion adjustment (see instructions)			4, 590	1
	tion payment adjustment amount after sequestration			0	
	Interim payments			194, 105	1
1	e settlement (for contractor use only)	00 07		0	1
1				30, 790	1
30.00 Protested	lamounts (nonallowable cost report items) in accorda , §115.2	ince with CMS Pub. 15-11	,	0	30.0

Health Financial Systems	MARGARET MARY COMMUN	NITY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC VACCINE COST	FOHC PNEUMOCOCCAL AND INFLUENZA		Period: From 01/01/2017	Worksheet M-4
VACCINE COST		Component CCN: 15-8511		
		Ti +1 o V/// / /	DUC I	Coct

Title XVIII RHC I Cost Pneumococcal Influenza 1.00 Leal th care staff cost (from Wkst. M-1, col. 7, line 10) 2.00 Ratio of pneumococcal and influenza vaccine staff time to total health care staff time 0.001717 0.006562 2.00 3.00 Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) 1.110 4.243 3.00 4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 14, 452 13, 499 4.00 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 15, 562 17, 742 5.00 7.00 Total direct cost of the hospital-based RHC/FOHC (from Worksheet M-1, col. 7, line 22) 646, 591 646, 591 6.00 7.00 Total overhead (from Wkst. M-2, line 19) 845, 710 7.00 8.00 Ratio of pneumococcal and influenza vaccine direct cost total direct cost (line 5 divided by line 6) 0.024068 0.027439 8.00 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 20,355 23,205 9.00 10.00 Total pneumococcal and influenza vaccine injections (from your records) 56 214 11.00 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 56 214 11.00 12.00 Cost per pneumococcal and influenza vaccine injections administration (sum of line 10/line 11) 641.38 191.34 12.00 13.00 Number of pneumococcal and influenza vaccine injections administration (sum of line 12 x line 13) 76,864 15.00 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 15.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 15.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)					5/1//2018 8:0	ı am
1.00 Heal th care staff cost (from Wkst. M-1, col. 7, line 10) 1.00 2.00 1.00 Ratio of pneumococcal and influenza vaccine staff time to total heal th care staff time 0.001717 0.006562 2.00 3.00 Pneumococcal and influenza vaccine heal th care staff cost (line 1 x line 2) 1, 110 4, 243 3.00 4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 14, 452 13, 499 4.00 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 15, 562 17, 742 5.00 7.00 Total direct cost of the hospital-based RHC/FOHC (from Worksheet M-1, col. 7, line 22) 646, 591			Title XVIII	RHC I	Cost	
1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 2.00 Ratio of pneumococcal and influenza vaccine staff time to total health care staff time 3.00 Pneumococcal and influenza vaccine staff time to total health care staff time 4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 6.00 Total direct cost of the hospital -based RHC/FOHC (from Worksheet M-1, col. 7, line 22) 6.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine injections (from your records) 11.00 Total pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injections (from your records) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 13) 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)				Pneumococcal	l nfl uenza	
2.00 Ratio of pneumococcal and influenza vaccine staff time to total health care staff time 3.00 Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) 4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 6.00 Total direct cost of the hospital -based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total number of pneumococcal and influenza vaccine injections (from your records) 7.00 Total number of pneumococcal and influenza vaccine injections (from your records) 7.00 Number of pneumococcal and influenza vaccine injections (from your records) 7.00 Number of pneumococcal and influenza vaccine injections (from your records) 7.00 Number of pneumococcal and influenza vaccine injections (from your records) 7.00 Number of pneumococcal and influenza vaccine injections (from your records) 7.00 Number of pneumococcal and influenza vaccine injections (from your records) 7.00 Number of pneumococcal and influenza vaccine injections (from your records) 7.00 Number of pneumococcal and influenza vaccine injections (from your records) 7.00 Number of pneumococcal and influenza vaccine injections (from your records) 7.00 Number of pneumococcal and influenza vaccine and its (their) administration 7.00 Number of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 7.00 Number of pneumococcal and influenza vaccine and its (their) 7.00 Number of pneumococcal and influenza vaccine and its (their) 7.00 Number of pneumococcal and influenza vaccine and its (their) 7.00 Number of pneumococcal and influenza vaccine and its (their)				1. 00	2. 00	
3.00 Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) 4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 6.00 Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injections (from your records) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		646, 591	646, 591	1.00
4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 6.00 Total direct cost of the hospital -based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injections (from your records) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	2.00	Ratio of pneumococcal and influenza vaccine staff time to tota	al health care staff time	0. 001717	0. 006562	2.00
5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 6.00 Total direct cost of the hospital -based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 9.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injections (from your records) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	1, 110	4, 243	3.00
Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections administered to Program beneficiaries 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)	4.00	Medical supplies cost - pneumococcal and influenza vaccine (fi	rom your records)	14, 452	13, 499	4.00
Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injections (from your records) 13.00 Number of pneumococcal and influenza vaccine injections administration 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	15, 562	17, 742	5.00
Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injections (from your records) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshop)	eet M-1, col. 7, line 22)	646, 591	646, 591	6.00
divided by line 6) 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) 17.00 administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	7.00	Total overhead (from Wkst. M-2, line 19)		845, 710	845, 710	7.00
9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	8. 00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 024068	0. 027439	8.00
Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) Total number of pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injection (line 10/line 11) Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,		divided by line 6)				
lines 5 and 9) Total number of pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injection (line 10/line 11) Sumber of pneumococcal and influenza vaccine injections administered to Program beneficiaries Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	20, 355	23, 205	9.00
11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 12.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	35, 917	40, 947	10.00
12.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11) 13.00 Number of pneumococcal and influenza vaccine injections administered to Program 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13) 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,		lines 5 and 9)				
13.00 Number of pneumococcal and influenza vaccine injections administered to Program 44 123 13.00 beneficiaries 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13) 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	56	214	11.00
beneficiaries 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration 28,221 23,535 14.00 (line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	12.00	Cost per pneumococcal and influenza vaccine injection (line 10	D/line 11)	641. 38	191. 34	12.00
14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	44	123	13.00
(line 12 x line 13) 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,						
15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	14.00		neir) administration	28, 221	23, 535	14.00
of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,		(line 12 x line 13)				
16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) 51,756 16.00 administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	15. 00				76, 864	15.00
administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,						
	16. 00				51, 756	16. 00
line 21)			amount to Wkst. M-3,			
		line 21)			l	

Health Financial Systems	MARGARET MARY COM	MMUNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER FOR	Provider CCN: 15-1329 Component CCN: 15-8511	Peri od: From 01/01/2017 To 12/31/2017	Worksheet M-5 Date/Time Prepared: 5/17/2018 8:01 am

		Component CCN: 15-8511	10 12/31/2017	5/17/2018 8: 01	
			RHC I	Cost	
	· · · · · · · · · · · · · · · · · · ·		Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			194, 105	1.0
. 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	2.0
00	List separately each retroactive lump sum adjustment amount 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	Frogram to Frovider			0	3. (
02				0	3. (
03				0	3. (
04				0	3.
05				0	3.
05	Provider to Program			J	٥.
50	11 ovi dei 10 11 ogi din			0	3.
51				ol	3.
52				o	3.
53				0	3.
54				0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)			194, 105	4.
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date o	of		5.
	Program to Provider				
01				0	5.
02				0	5.
03	Dec. 1 Lea Le Decessor			0	5.
F0	Provider to Program			0	5.
50 51				0	5. 5.
51 52				0	5. 5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5. 5.
77 00	Determined net settlement amount (balance due) based on the cost report. (1)				6.
00 01	SETTLEMENT TO PROVIDER			30, 790	6.
02	SETTLEMENT TO PROGRAM			30, 790	6.
02 00	Total Medicare program liability (see instructions)			224, 895	7.
00	Total medicale program trability (see instructions)		Contractor	NPR Date	7.
			Number	(Mo/Day/Vr)	
		0	Number 1.00	(Mo/Day/Yr) 2.00	