Health Financia	al Systems	MARGARET MARY COMMUN	NITY HOSPITAL	In Li€	eu of Form CMS-2552-1
This report is	required by law (42 USC 139	5g; 42 CFR 413.20(b)). Fai	Ture to report can re	esult in all interi	m FORM APPROVED
payments made	since the beginning of the c	ost reporting period being	g deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
					EXPIRES 03-31-2022
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX SUMMARY	COST REPORT CERTIFICATION	Provider CCN: 15-1329	From 01/01/2018	Worksheet S Parts I-III Date/Time Prepared: 2/13/2020 2:38 pm
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed	cost report		Date: 2/13/20	020 Time: 2:38 p
use only	2. [] Manually submitted of	ost report			
	3. [1] If this is an amende 4. [F] Medicare Utilization	d report enter the number . Enter "F" for full or "I	of times the provider L" for low.	r resubmitted this	cost report
Contractor use only	5. [5]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened		or this Provider CCN 12		dor Code: 4 olumn 1 is 4: Enter mes reopened = 0-9.

PART II - CERTIFICATION

(5) Amended

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 01/01/2018 and ending 12/31/2018 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)
D. I.	
Date	

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	-276, 965	265, 217	0	17, 110	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
200. 00 Total	0	-276, 965	265, 217	0	17, 110	200.00

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

	I Financial Systems FAL AND HOSPITAL HEALTH CARE COMPLEX		RET MARY COMM ION DATA		SPITAL der CCN: 1		Ir Period: From 01/01/ To 12/31/	2018 2018	Workshe Part I Date/Ti	m CMS-2 eet S-2 me Pre 020 2:3	pared:
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	Hospital and Hospital Health Care Co	omplex Addre									
1.00	Street: 321 MITCHELL		Box:								1.00
2.00	City: BATESVILLE	Sta	ate: IN	Zip Cod	e: 47006-	Count	y: RIPLEY				2.00
	<u> </u>		ent Name	CCN	CBSA	Provi der		Paymer	nt Syst	em (P	
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4. 00	Subprovi der - IPF										4.00
5. 00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
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11. 00	Hospi tal -Based OLTC										11. 00
12.00	Hospi tal -Based HHA	MARGARET MA	ARY COMMUNITY	157143	99915		03/01/1985	N	P	N	12.00
		HOSPI TAL									
13.00	Separately Certified ASC										13.00
14.00	Hospi tal -Based Hospi ce	MARGARET MA	ARY COMMUNITY	151551	99915		12/31/2003		İ		14.00
11.00	nospi tai Basea nospi ce	HOSPI TAL	uti oommonii ii	101001	,,,,,		127 017 2000				11.00
15. 00	Hospital-Based Health Clinic - RHC	MARGARET MA	ARY COMMUNITY	158511	99915		09/03/2013	N	0	N	15. 00
		HOSPI TAL									
16. 00	Hospital -Based Health Clinic - FQHC										16. 00
17. 00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis				İ	1					18.00
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20.00	Cook Donortino Donied (mar/dd/(mar))						1.00		2. (20.00
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21. 00 22. 00 22. 01 22. 02 22. 03	Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adjugate. S412.106? In column 1, enter "Y" for facility subject to 42 CFR Section Shospital?) In column 2, enter "Y" for Did this hospital receive interim uncost reporting period? Enter in column 2, "Y" for yes or "Noreporting period occurring on or aft is this a newly merged hospital that payments to be determined at cost resenter in column 1, "Y" for yes or "Noreporting period prior to Octobor "N" for no, for the portion of the Cost reporting period prior to Octobor 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Mebelow? In column 1, enter 1 if date	ustment, in pryes or "N yes or no for the cer October 100 but not 12.105)? Entedical days of admission.	accordance w "for no. Is 2) (Pickle am "for no. Is accordance w "le for no. Is care paymen for yes or "N ing prior to or the portion 1. (see inst inal uncomper in column 2 orting period fication from neating stat "for yes or if or to Octobe portion of ti 1. (see inst the more than 4 if or in column 2 in column 3 in or the portion in column 4 in or than 4 in or than 4 in or than 4 in or the column is on lines 24 in, 2 if censor	th 42 CF this endment ts for the for no October n of the ructions) assted can struction or af the stical a "N" for er 1. Enthe cost ructions) beds (3, "Y" fand/or 2 us days,	R is for 1. cost re ns) yes ter o reas no er as for 5 or 3	N N N	01/01/2i 2 2.00	018	3. (/2018 00	22. 00 22. 01 22. 02 22. 03
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		Medicaid paid days	Medi cai d el i gi bl e unpai d	State Medicaid paid days	State Medicaid eligible	HMO day		li cai d lays	
		1.00	days 2. 00	2.00	unpai d 4. 00	F 00		00	
24. 00	If this provider is an IPPS hospital, enter the	1.00		3.00		5. 00	0	0. 00	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.								
25. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state	0	0	0	0		0		25. 00
	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.								
					Urban/R				
26. 00	Enter your standard geographic classification (not w		at the be	ginning of	the 1.0	2	2. (00	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o	age) status			st	2			27. 00
35. 00	enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter th	ication in	column 2.		n	O			35. 00
	effect in the cost reporting period.				Begi nr		Endi		
36. 00	Enter applicable beginning and ending dates of SCH s		cript line	36 for num	ber 1. (00	2. (00	36.00
37. 00	of periods in excess of one and enter subsequent dates. 7.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status								37. 00
37. 01	accordance with FY 2016 OPPS final rule? Enter "Y" f			,					37. 01
38. 00	<pre>instructions) If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.</pre>								38. 00
					1. (Y/ 2. (
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? En requireme	ter in colu nts in	mn		N		39.00
40. 00	Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for				N		40.00
	Ü					V 1.00	XVIII 2. 00		
						_			
45 00	Prospective Payment System (PPS)-Capital	nt for disr	roporti ona	to share in	accordance	N	N	N	45.00
	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)					· N	N N	N N	45. 00 46. 00
46. 00	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	eption for t. L, Pt. I	extraordin II and Wks	ary circums t. L-1, Pt.	tances I through	N		N	46. 00
46. 00 47. 00	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen	eption for t. L, Pt. I capital? E	extraordin II and Wks inter "Y fo	ary circums t. L-1, Pt. r yes or "N	tances I through				
46. 00 47. 00 48. 00	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in	eption for t. L, Pt. I capital? E t? Enter "	extraordin II and Wks inter "Y fo Y" for yes	ary circums t. L-1, Pt. r yes or "N or "N" for	tances I through for no.	N N	N N	N N	46. 00 47. 00
46. 00 47. 00 48. 00 56. 00	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals	eption for t. L, Pt. I capital? E t? Enter " approved C period duri r yes or "N th of this Y", complet	extraordin II and Wks Inter "Y fo Y" for yes ME program ng which r " for no i cost repor e Workshee	ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter " esidents in n column 1. ting period	tances I through " for no. no. Y" for yes approved If column ? Enter "Y	N N N N	N N	N N	46. 00 47. 00 48. 00
46. 00 47. 00 48. 00 56. 00 57. 00	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	eption for t. L, Pt. I capital? E t? Enter " approved C period duri r yes or "N th of this Y", complet I, if appli bursement f	extraordin II and Wks Inter "Y fo Y" for yes ME program ng which r " for no i cost repor e Workshee cable. For physici	ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter " esidents in n column 1. ting period t E-4. If c	tances I through " for no. no. Y" for yes approved If column ? Enter "Y	N N N N	N N	N N	46. 00 47. 00 48. 00 56. 00

				10	12/31/2010	Date/lime Pre 2/13/2020 2:3	
			1	NAHE 413. 85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion	о рііі
				1.00	2. 00	Code 3. 00	
	g nursing and allied health education			N		21.22	60.00
any programs that	at meet the criteria under §413.85? (see in	structions) IME	Direct GME	IME	Direct GME	
61 00 Did your hospita	al receive FTE slots under ACA	1.00	2. 00	3. 00	4. 00	5.00	61. 00
section 5503? Er column 1. (see i 61.01 Enter the averag FTEs from the ho	nter "Y" for yes or "N" for no in				0.00	0.00	61. 01
FTE count (excl	nt year total unweighted primary care uding OB/GYN, general surgery FTEs, e FTEs added under section 5503 of ructions)						61. 02
and/or general s determining comp instructions)	ine FTE count for primary care surgery residents, which is used for pliance with the 75% test. (see						61.03
surgery allopath current cost rep	of unweighted primary care/or nic and/or osteopathic FTEs in the porting period.(see instructions).						61.04
and/or general s primary care and 61.04 minus line 61.06 Enter the amount	rence between the baseline primary surgery FTEs and the current year's d/or general surgery FTE counts (line e 61.03). (see instructions) t of ACA §5503 award that is being						61. 05
	<pre>ief and/or FTEs that are nonprimary surgery. (see instructions)</pre>						
par o or general		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
61 10 Of the FTFs in I	ine 61.05, specify each new program		1. 00	2. 00	3. 00	4.00	61. 10
specialty, if ar for each new procolumn 1, the program code. Er unweighted countiff the unweighted of the FTEs in I program special residents for each instructions) Er Enter in column 3, the IME FTEs.	ny, and the number of FTE residents ogram. (see instructions) Enter in rogram name. Enter in column 2, the nter in column 3, the IME FTE t. Enter in column 4, the direct GME				0.00		61. 20
						1. 00	
	Affecting the Health Resources and Ser of FTE residents that your hospital				ind for which	0.00	62. 00
your hospital re 62.01 Enter the number	ceeived HRSA PCRE funding (see instructions) of FTE residents that rotated from a cost reporting period of HRSA THC process	ctions) a Teach	ing Health Cen	nter (THC) into			62. 01
Teaching Hospita	als that Claim Residents in Nonprovide	er Sett	ings	•	noni od 2 Frata	NI NI	42.00
	ty trained residents in nonprovider se 'N" for no in column 1. If yes, comple					N	63. 00
			<u>.</u>	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of	the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 -This base year	2.00	3.00	
period that begi 64.00 Enter in column in the base year resident FTEs at settings. Enter resident FTEs th	ns on or after July 1, 2009 and before 1, if line 63 is yes, or your facility period, the number of unweighted nor ttributable to rotations occurring in in column 2 the number of unweighted nat trained in your hospital. Enter invided by (column 1 + column 2)). (see	re June ty trai n-prima all no d non-p n colum	e 30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00		. 0	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1329 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 2/13/2020 2:38 pm 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"

	HOSPITAL ovider CCN: 15-1329	Peri od:		Workshe	n+ S 2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		From 01/01/	2018	Part I	et 3-2	
				Date/Ti		
				2/13/20	20 2: 3	8 pm
			1 00	2.00	3. 00	
76.00 If line 75 is yes: Column 1: Did the facility have an approved GM	ME teaching program in	the most	1.00	2.00	0	76. 00
recent cost reporting period ending on or before November 15, 200						
no. Column 2: Did this facility train residents in a new teaching						l
CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Colu						l
indicate which program year began during this cost reporting peri	od. (see instructions	5)				
			-	1. C	10	
Long Term Care Hospital PPS				1. 0	<i>,</i>	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and	"N" for no.		I	N		80.00
81.00 Is this a LTCH co-located within another hospital for part or all		ng period? E	nter	N		81.00
"Y" for yes and "N" for no.	•	3 1				
TEFRA Provi ders						
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFR			no.	N		85.00
86.00 Did this facility establish a new Other subprovider (excluded uni	t) under 42 CFR Secti	on				86.00
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital cla	esified under section	,	-	N		87. OC
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	issi i eu unuer secti or	'		IV		87.00
1000(u)(1)(b)(v1): Eliter 1 101 yes of 10 101 iio.		V		XL	X	
		1.00		2.0		
Title V and XIX Services						
90.00 Does this facility have title V and/or XIX inpatient hospital ser	rvices? Enter "Y" for	N		Υ		90.00
yes or "N" for no in the applicable column.				.,		
91.00 Is this hospital reimbursed for title V and/or XIX through the co- full or in part? Enter "Y" for yes or "N" for no in the applicabl		N		Υ		91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual ce				N		92.00
instructions) Enter "Y" for yes or "N" for no in the applicable of	column.					/2.00
93.00 Does this facility operate an ICF/IID facility for purposes of ti		N		N		93.00
"Y" for yes or "N" for no in the applicable column.						l
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "	'N" for no in the	N		N		94.00
applicable column.		0.00		0.0		05.00
95.00 If line 94 is "Y", enter the reduction percentage in the applicab 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "		0. 00 N		O. C N		95.00 96.00
applicable column.	N TOT NO THE THE	IN IN		IN		96.00
97.00 If line 96 is "Y", enter the reduction percentage in the applicab	ole column	0.00		0. 0	00	97.00
98.00 Does title V or XIX follow Medicare (title XVIII) for the interns		Y		Y		98.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for ye						l
column 1 for title V, and in column 2 for title XIX.						1
98.01 Does title V or XIX follow Medicare (title XVIII) for the reporti				Υ		98. 01
C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V	/, and in column 2 for	-				l
title XIX.	ation of observation	Υ		Υ		98. 02
98.02 Does title V or XIX follow Medicare (title XVIII) for the calcula bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N"		"		Y		90.02
for title V, and in column 2 for title XIX.	151 110 111 COLUMN I					
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical	access hospital (CAH)	N		N		98. 03
reimbursed 101% of inpatient services cost? Enter "Y" for yes or						
for title V, and in column 2 for title XIX.						

i n				
			1. 00	
	ng Term Care Hospital PPS this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.0
81.00 Is "Y	this a LTCH co-located within another hospital for part or all of the cost reporting "for yes and "N" for no.	period? Enter	N	81. 0
	FRA Providers this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes o	r "N" for no	N	85. 0
86. 00 Di	d this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 13.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		14	86.0
	this hospital an extended neoplastic disease care hospital classified under section		N	87. 0
18	86(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	V	XI X	
		1. 00	2. 00	
	tle V and XIX Services	NI I		
	es this facility have title V and/or XIX inpatient hospital services? Enter "Y" for s or "N" for no in the applicable column.	N	Υ	90.0
91.00 lís	this hospital reimbursed for title V and/or XIX through the cost report either in II or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Υ	91.0
	e title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see structions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.0
93. 00 Do	" for yes or "N" for no in the applicable column.	N	N	93.0
94.00 Do	es title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the plicable column.	N	N	94.0
95.00 I f	line 94 is "Y", enter the reduction percentage in the applicable column.	0. 00	0.00	95.0
	es title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the plicable column.	N	N	96.0
	line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.0
st	es title V or XIX follow Medicare (title XVIII) for the interns and residents post epdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in lumn 1 for title V, and in column 2 for title XIX.	Y	Υ	98.0
98. 01 Do C,	es title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for	Y	Υ	98. 0
98. 02 Do	tle XIX. es title V or XIX follow Medicare (title XVIII) for the calculation of observation d costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	Y	Υ	98. (
	r title V, and in column 2 for title XIX.			
re	es title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) imbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 r title V, and in column 2 for title XIX.	N	N	98.0
98. 04 Do ou	es title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of tpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	N	N	98.0
98. 05 Do	column 2 for title XIX. es title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on st. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	Y	Υ	98.
98. 06 Do	lumn 2 for title XIX. es title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, s. I through IV2 Enter "Y" for yes or "N" for no in column 1 for title V, and in	Υ	Υ	98.
со	s. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in lumn 2 for title XIX. ral Providers			
	es this hospital qualify as a CAH?	Υ		105.
	this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N		106.0
107.00 f tr	r outpatient services? (see instructions) this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R aining programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If	N		107.
re	s, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost imbursed. If yes complete Wkst. D-2, Pt. II.			
08.00 I s	this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 R Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.

Health Financial Systems MARGARET MARY COMM HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 15-1329	Ir Period: From 01/01/ To 12/31/	2018		et S- me Pr	2 epared:
	Physi cal	Occupati onal	Speec	h	2/13/20 Respi ra		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1. 00 N	2. 00 N	3. 00 N		4. C		109. 00
					1. 0	10	_
110.00 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 Worapplicable.	Y" for yes o	r "N" for no.	If yes,	6	N N		110.00
111.00 f 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 act for tele-health services.	ost reporting Dlumn 1 is Y, Tticipating in	period? Enter enter the n column 2.	1.00 N		2.0	0	111.00
				1. 00	2.00	3. 00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insur	If column 2 at for long to rs) based on for yes or "I	is "E", enter erm care (incl the definition N" for no.	in column udes in CMS	N N N		0	115. 00 116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence pol	icv? Enter 1	if the policy	is	1			118.00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losse		Insura	nnco	
		Pi eiiii uiiis	Losse	5	HISUL	ance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 469, 43	2.00	0	3.0		0118.01
The organisation of marginative premitals and para rosses.		1 407, 43					0110.01
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schece and amounts contained therein. 119.00D0 NOT USE THIS LINE			1. 00 N		2.0	0	118. 02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, "` ualifies for	Y" for yes or the Outpatient			N		120. 00
121.00 Did this facility incur and report costs for high cost impla	ntable devic	es charged to	Y				121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain heal theare related taxes as def					5. 0	0	122. 00
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.							
the Worksheet A line number where these taxes are included. Transplant Center Information	or yes and "N	" for no. If	N				126. 00
the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" foyes, enter certification date(s) (mm/dd/yyyy) below.	,						
the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2	nter the cert	ification date					
the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ere in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2	nter the cert 2. er the certi	ification date fication date					127. 00
the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ere in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2	nter the cert 2. cer the certi 2. cer the certi	ification date fication date					127. 00
the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2 and termination date, if applicable, in column 3 and termination date, if applicable, in column 3 and termination date, if applicable, in column 3 and termination date, if applicable, in column 3 and termination date, if applicable, in column 3 and termination date, if applicable, in column 3 and 4 and 5 a	nter the cert 2. Ser the certi 2. Ser the certi	ification date fication date fication date					127. 00 128. 00
the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, end in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 1 129.00 If this is a Medicare certified lung transplant center, end column 1 and termination date, if applicable, in column 2.	nter the certical certhe certical certhe certical certhe certificant certifica	ification date fication date fication date ication date i					127. 00 128. 00 129. 00
the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, end in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col und 2. 131.00 If this is a Medicare certified intestinal transplant center.	nter the certical certical certhe certical certhe certifical certi	ification date fication date fication date ication date i rtification					127. 00 128. 00 129. 00 130. 00
the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, end in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 1 129.00 If this is a Medicare certified lung transplant center, end column 1 and termination date, if applicable, in column 2.	enter the certical certification and the cer	ification date fication date fication date ication date i rtification certification					127. 00 128. 00 129. 00 130. 00 131. 00
the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, end in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col 131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified islet transplant center, enter date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified islet transplant center, enter date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified islet transplant center, enter date in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 2	er the certical certical certification and certi	ification date fication date fication date ication date i rtification certification fication date					127. 00 128. 00 129. 00 130. 00 131. 00 132. 00
the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col 131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified is let transplant center, entermination date, if applicable, in col 132.00 If this is a Medicare certified is let transplant center, entermination date, if applicable, in col 132.00 If this is a Medicare certified is let transplant center, entermination date, if applicable, in col 132.00 If this is a Medicare derified is let transplant center, entermination date, if app	er the certical certical certification and the certification and t	ification date fication date fication date ication date irtification certification fication date fication date					127. 00 128. 00 129. 00 130. 00 131. 00

Health Financial Systems MARGARET MARY COM	MUNITY HOSPITAL			In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCI			1/01/2018	Worksheet S-2	epared:
				1 00	2.00	
140.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. If are claimed, enter in column 2 the home office chain number	yes, and home	office cost		1. 00 N	2.00	140. 00
1.00 2.0	00			3. 00		
If this facility is part of a chain organization, enter on office and enter the home office contractor name and contra		ugh 143 the	name an	d address	of the home	
141.00 Name: Contractor's Name: 142.00 Street: PO Box: 143.00 Ci ty: State:	actor Humber.	Contrac Zip Code	tor's Nu	mber:		141. 00 142. 00 143. 00
State.		Zi p cou	J			143.00
444 00 4	40				1. 00	111 00
144.00 Are provider based physicians' costs included in Worksheet	A?				Y	144.00
				1. 00	2. 00	
 145.00 If costs for renal services are claimed on Wkst. A, line 74 inpatient services only? Enter "Y" for yes or "N" for no in no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Publyes, enter the approval date (mm/dd/yyyy) in column 2. 	n column 1. If on for this cost ously filed cost	column 1 is reporting report?	f	N		145. 00
147.00 Was there a change in the statistical basis? Enter "Y" for	vos or "N" for	no			1. 00 N	147.00
148.00 Was there a change in the order of allocation? Enter "Y" for					N N	147.00
149.00 Was there a change to the simplified cost finding method? E	,		or no.		N	149.00
	Part A	Part B	T	itle V	Title XIX	-
Does this facility contain a provider that qualifies for an	1.00	2.00	cation o	3.00	4.00	
or charges? Enter "Y" for yes or "N" for no for each compor						
155. 00 Hospi tal	N	N		N	N	155.00
156.00 Subprovi der - IPF 157.00 Subprovi der - IRF	N N	N N		N N	N N	156. 00 157. 00
158. 00 SUBPROVI DER	14	14		14		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	161. 00
					1. 00	
Multicampus 165.00 s this hospital part of a Multicampus hospital that has or	or more compl	icoc in diff	Foront C	DCAc2	l N	165. 00
Enter "Y" for yes or "N" for no.	ie di illoi e callipo	ises ili ui i	erent c	DSAS !	IN IN	165.00
Name	County		ip Code	CBSA	FTE/Campus	
166.00 f line 165 is yes, for each	1. 00	2.00	3. 00	4. 00	5. 00	166.00
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)					0.00	7166.00
					1.00	
Health Information Technology (HIT) incentive in the Americ			ent Act			
167.00 s this provider a meaningful user under §1886(n)? Enter "168.00 o lf this provider is a CAH (line 105 is "Y") and is a meaningful user under §1886(n)?	ngful user (line		'), ente	r the	Y	167. 00 168. 00
reasonable cost incurred for the HIT assets (see instruction 168.01 of this provider is a CAH and is not a meaningful user, does		gualify fo	or a har	dshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" 169.00 If this provider is a meaningful user (line 167 is "Y") and transition factor. (see instructions)	' for no. (see i	nstructions	s)		0.00	169. 00
pri diristi ti oli Taletoi . (See Tristi deti olis)			Be	gi nni ng	Endi ng	
470 00 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1			1. 00	2.00	170
170.00 Enter in columns 1 and 2 the EHR beginning date and ending period respectively (mm/dd/yyyy)	date for the re	eporti ng	01/	01/2018	12/31/2018	170. 00

Health Financial Systems MARGARET MARY COMM	UNITY HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1329	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Pre 2/13/2020 2:3	epared:
			27 107 2020 2. 0	J piii
		1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for inc	lividuals enrolled in	N	C	171.00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt.	I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes,	enter the number of secti	on		
1876 Medicare days in column 2. (see instructions)				

SPI T	Financial Systems MARGARET MARY COMM AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C			eriod: rom 01/01/2018 o 12/31/2018	Date/Time Pre 2/13/2020 2:3	2 epare
					Y/N 1. 00	<u>Date</u> 2. 00	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO r	esponses. En	ter			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS						-
	Provider Organization and Operation						
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			s)	N		1
			Y/N		Date	V/I	
00	Has the provider terminated participation in the Medicare F	Program? If	1. 00 N		2. 00	3. 00	2
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	s, enter in column 2 the date of termination and in column 3, "V" for untary or "I" for involuntary.					
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 relationships? (see instructions)					3	
	refutionships: (see matructions)		Y/N		Туре	Date	
	Financial Data and Reports		1.00		2. 00	3. 00	
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avaicolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y		А		4
00	Are the cost report total expenses and total revenues differentiation that the cost report total statements? If yes, submit recommendations are total recommendations and total revenues differentiations are total recommendations.		N				5
	those on the fired financial statements: If yes, submit fee	oner i rati on.			Y/N	Legal Oper.	
	Approved Educational Activities				1. 00	2. 00	
00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is t	he provi der	is	N		1 6
00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	setructions			N		7
00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the		N		8
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of	is.		n	N N		10
00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I				N		11
	Teaching Program on Worksheet A? If yes, see instructions.					Y/N	
						1. 00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s see instruc	tions			Υ	12
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			COS	st reporting	N	13
00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	f yes, see i	nst	ructions.	N	14
00	Did total beds available change from the prior cost reporti	ng period? If	yes, see in	str		N	15
		Y/N	t A Date		Par Y/N	t B Date	
		1. 00	2.00		3. 00	4. 00	
00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	02/26/2019)	Y	02/26/2019	16
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N			N		17
00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N			N		18
	cost report? If yes, see instructions.	N	1		N		19

Heal th	Financial Systems MARGARET MARY CO	MMUNITY HOSPITA	AL	In Lie	u of Form CM	S-2552-10
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	_	CCN: 15-1329	Period: From 01/01/2018 To 12/31/2018	Date/Time F 2/13/2020 2	Prepared:
			iption	Y/N	Y/N	
20.00	If line 1/ on 17 is yes were adjustments made to DCOD		0	1.00	3.00	20.00
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
	report data for other. Beserve the other day detiments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS	HOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, se				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	e due to apprai	sals made du	ring the cost	N	23. 00
24.00	reporting period? If yes, see instructions.		. 46:4		, ,	24.00
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	rea into auring	j this cost r	eporting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during	g the cost reno	orting period	? If yes, see	N	25. 00
	instructions.	,	3 1	3 ,		
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	the cost report	ing period?	lf yes, see	N	26. 00
	instructions.					
27. 00	Has the provider's capitalization policy changed during th	ne cost reporti	ng period? I	f yes, submit	N	27. 00
	copy. Interest Expense					_
28. 00	Were new Loans, mortgage agreements or Letters of credit e	entered into du	uring the cos	t reporting	N	28.00
	period? If yes, see instructions.		3			
29. 00	Did the provider have a funded depreciation account and/or		Debt Service	Reserve Fund)	N	29. 00
	treated as a funded depreciation account? If yes, see inst					
30. 00	Has existing debt been replaced prior to its scheduled mat	turity with new	w debt? If ye	s, see	N	30.00
31. 00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of new	w deht2 lf ve	200	N	31.00
31.00	instructions.	SSuarice of flev	debt: II ye	5, 300	IN IN	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se	ervi ces furni sh	ned through c	ontractual	N	32. 00
	arrangements with suppliers of services? If yes, see instr					
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	oplied pertaini	ng to compet	itive bidding? If	N	33.00
	no, see instructions. Provider-Based Physicians					
34 00	Are services furnished at the provider facility under an a	arrangement wit	h provider_h	ased physicians?	Y	34.00
34.00	If yes, see instructions.	arrangement wr	in provider b	asca physicians:	'	34.00
35.00	If line 34 is yes, were there new agreements or amended ex	kisting agreeme	ents with the	provi der-based	Υ	35.00
	physicians during the cost reporting period? If yes, see i	nstructi ons.		·		
				Y/N	Date	
	U 066: 0			1.00	2. 00	
24 00	Home Office Costs Were home office costs claimed on the cost report?			N		36.00
36. 00 37. 00	If line 36 is yes, has a home office cost statement been p	prepared by the	home office			37.00
57.00	If yes, see instructions.	opar oa by the	011106	. 14		37.00
38. 00	If line 36 is yes , was the fiscal year end of the home of			f N		38. 00
	the provider? If yes, enter in column 2 the fiscal year er	nd of the home	offi ce.			
39. 00	If line 36 is yes, did the provider render services to oth	ner chain compo	onents? If ye	s, N		39. 00
40.00	see instructions.	homo office?	If was as-	NI		40.00
40. 00	If line 36 is yes, did the provider render services to the instructions.	e nome office?	ii yes, see	N		40.00
	That detroils.					
		1.	. 00	2.	00	
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position	KYLE		SMI TH		41.00
	held by the cost report preparer in columns 1, 2, and 3,					
42 OO	respectively. Enter the employer/company name of the cost report	BLUE & CO., LI	1.0			42.00
42. 00	preparer.	DEUL & CU., LI	LU			42.00
43.00	Enter the telephone number and email address of the cost	317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43.00
	report preparer in columns 1 and 2, respectively.					
		•		•		

Heal th	Financial Systems MARGARET MARY	COM	MUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1329	Peri od: From 01/01/2018	Worksheet S-2 Part II	!
				To 12/31/2018		pared: 8 pm
			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	١,				
	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	it				43.00
	report preparer in columns 1 and 2, respectively.					

 Heal th Fi nancial
 Systems
 MARGARET MAD

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provi der CCN: 15-1329

					To	12/31/2018	Date/Time Pre 2/13/2020 2:3	
							1/P Days /	O pili
							0/P Visits /	
							Trips	
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Available	CAH Hours	Title V	
		1. 00		2. 00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and			18	6, 570	105, 216. 00	0.00	1.00
	8 exclude Swing Bed, Observation Bed and	55.55			0,070	100,210.00	ŭ	
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			18	6, 570	105, 216. 00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		7	2, 555	5, 208. 00	0	
9. 00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						_	12.00
13.00	NURSERY	43. 00		0.5	0.405	440 404 00	0	
14.00	Total (see instructions)			25	9, 125	110, 424. 00	0	
15.00	CAH visits						0	
16.00	SUBPROVIDER - I PF							16.00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER							17. 00 18. 00
	SKILLED NURSING FACILITY							19.00
20. 00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY	101.00					0	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	101.00					O	23. 00
24. 00	HOSPI CE	116. 00		0	0			24.00
24. 10	HOSPICE (non-distinct part)	30.00		Ü	Ü			24. 10
25. 00	CMHC - CMHC	50.00						25. 00
26. 00	RURAL HEALTH CLINIC	88. 00					0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)			25				27. 00
28.00	Observation Bed Days						0	28. 00
29.00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges					l		33. 01

33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1329

Peri od: Worksheet S-3 From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

2/13/2020 2:38 pm 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, 384 Hospital Adults & Peds. (columns 5, 6, 7 and 51 1. 00 1,631 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) 226 431 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 7.00 Total Adults and Peds. (exclude observation 51 4, 384 7.00 1.631 beds) (see instructions) INTENSIVE CARE UNIT 8 00 176 217 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 1,049 13.00 607.80 14.00 Total (see instructions) 1,807 55 5,650 0.00 14.00 CAH visits 15.00 15.00 16.00 SUBPROVIDER - IPF 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 22.00 HOME HEALTH AGENCY 5.562 619 10 560 0.00 23.80 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 24.00 HOSPI CE 0 0 0.00 14.24 24.00 24. 10 HOSPICE (non-distinct part) 0 24.10 CMHC - CMHC 25.00 25.00 26.00 RURAL HEALTH CLINIC 1, 429 1, 308 7, 281 0.00 16. 29 26.00 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 0.00 0.00 26.25 Total (sum of lines 14-26) 27 00 0 00 662.13 27 00 Observation Bed Days 28.00 23 829 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 C 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

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN Provi der CCN: 15-1329

				To	12/31/2018	Date/Time Pre 2/13/2020 2:3	
		Full Time	_	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	574	13	1, 598	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)			77	164		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						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	0	574	13	1, 598	14.00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0. 00					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 Tri ps						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22 00	outpatient days (see instructions)						22.00
33.00	LTCH site poutral days and discharges			0			33.00
33.01	LTCH site neutral days and discharges			0			33. 01

Heal th	Financial Systems MAF	RGARET MARY COMM	MUNITY HOSPITA	AI	In lie	u of Form CMS-2	2552-10
	HEALTH AGENCY STATISTICAL DATA	CONTROL INFINITION	Provi der C	CN: 15-1329 CCN: 15-7143	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-4 Date/Time Pre	pared:
					Home Health	2/13/2020 2: 3 PPS	8 pm
					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 Home Health Aide Hours	O	C	sl.	0 0	0	1, 00
2. 00	Unduplicated Census Count (see instructions)	0.00	241. 00	0. (0.00	0.00	
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the number	or of hours in	Staff	Contract	Total	
		your normal		Starr	Contract	Total	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0		1.00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		40.00				1
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0. (
6. 00	Direct Nursing Service			8.		8. 15	
7.00	Nursi ng Supervi sor			0.0		0.00	
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			4. 4 0. 0		4. 47 0. 00	
10.00	Occupational Therapy Service			1. 0			10.00
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0.0			1
13.00	Speech Pathology Supervisor			0.0	0. 00	0.00	13.00
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0. 0		0. 17 0. 00	1
16. 00	Home Heal th Ai de			0.0			
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0.0			
16.00	HOME HEALTH AGENCY CBSA CODES			0.0	0.00	0.00	18.00
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost				2		19. 00
	reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			99915			20.00
	contains the first code).						
20. 01		Full En	isadas	17140			20. 01
		Full Ep Without	With Outliers	LUPA Episode	s PEP Only	Total (cols.	
		Outliers 1.00	2. 00	3.00	Epi sodes 4. 00	1-4) 5. 00	
	PPS ACTIVITY DATA	1.00	2.00	3.00	4.00	5.00	
21. 00 22. 00	Skilled Nursing Visits	1, 843 309, 624	709	1	72 29 96 4, 872	2, 653 445, 704	1
23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	1, 108	119, 112 430	1	24 4, 872	1, 571	1
24.00	Physical Therapy Visit Charges	223, 816	86, 860		1, 818		
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	346 74, 520	298 64, 368	1	2 / 32 1, 512	653 140, 832	1
27. 00	Speech Pathology Visits	8	34		0 0	42	27. 00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	1, 308 0	7, 194 4		0 0	8, 502 4	28. 00 29. 00
30.00	Medical Social Service Visit Charges	0	1, 280		0 0	1, 280	30.00
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	237 23, 463	393 38, 907		2 7 98 693	639 63, 261	1
33. 00	Total visits (sum of lines 21, 23, 25, 27,	3, 542	1, 868	1	52	5, 562	1
34. 00	29, and 31) Other Charges	0	C		0 0	0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	632, 731	317, 721				1
36. 00	30, 32, and 34)	257			34 1		
JU. UU	Total Number of Episodes (standard/non outlier)	25/		,	J-+I	292	30.00
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	40, 485	49 27, 633	1	2 30 600	51 70,098	37. 00 38. 00
30.00	Trotal Mon-Noutrine medical supply charges	40, 400	27,033	η 1, 30	501 800	1 70,090	1 30.00

		GARET MARY COM	MUNITY HOSPITA	\L		<u>eu of Form CM</u>	15-2	552-1
USPIT	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1329	Peri od: From 01/01/2018	Worksheet S	S-8	
			Component	CCN: 15-8511	To 12/31/2018	8 Date/Time F		
					RHC I	2/13/2020 2		pm
					KHC I	Cos		
					1	. 00		
	Clinic Address and Identification							
. 00	Street		0.		112 N. BUCKEY		_	1. (
				ty	State	ZIP Code 3.00		
. 00	City, State, ZIP Code, County		OSGOOD 1.	00	2. 00	N 47037	-	2. (
. 00	orty, State, 211 code, county		030000			11 47037		۷. ۱
	Lucopi Tili Bross Solio Oni V D. I. I. I. S.	"B" 6				1.00		
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for		a+ Award	Doto	0	3. (
					nt Award 1.00	2.00		
	Source of Federal Funds				1.00	2.00		
00	Community Health Center (Section 330(d), PHS	Act)						4.
00	Migrant Health Center (Section 329(d), PHS A	ct)						5. (
00	Health Services for the Homeless (Section 34)	O(d), PHS Act)						6.
. 00	Appalachian Regional Commission							7. (
00	Look-Alikes							8.
00	OTHER (SPECIFY)							9.
					1.00	2. 00	\dashv	
0. 00	Does this facility operate as other than a he	ospi tal -based F	RHC or FQHC? E	nter "Y" for		2.00	0	10.
	yes or "N" for no in column 1. If yes, indica							
	2. (Enter in subscripts of line 11 the type or	f other operati	on(s) and the	operati ng				
	hours.)					 		
		Sun		-	londay	Tuesday	\rightarrow	
		from 1.00	2. 00	from 3.00	4. 00	5. 00	-	
	Facility hours of operations (1)		2.00	0.00	11.00	1 0.00		
1.00	CLINIC			08: 00	16: 30	08: 00		11. (
					4 00	0.00	\rightarrow	
2 00	Have you received an approval for an exception	on to the produ	ictivity stand	ard?	1. 00	2. 00		12
2. 00					N	2.00	0	
2. 00 3. 00	1	d in CMS Pub. 1	100-04, chapte	r 9, section	N	2.00	0	
	Is this a consolidated cost report as define	d in CMS Pub. ´ umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N	2.00	0	
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu	d in CMS Pub. ´ umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the ders and	N N			
	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. ´ umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the ders and	N N ider name	CCN number		
3. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	d in CMS Pub. ´ umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the ders and	N N			13.
3. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. ´ umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the ders and	N N ider name	CCN number	-	12. (13. (
3. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes, List the names	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and	N N ider name	CCN number	-	13.
1. 00	Is this a consolidated cost report as define 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	d in CMS Pub. 7 umn 1. If yes, List the names	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Prov	N N ider name 1.00	CCN number 2.00 Total Visit	-	13.
1. 00	Is this a consolidated cost report as define 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	d in CMS Pub. 7 umn 1. If yes, List the names	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Prov	N N ider name 1.00	CCN number 2.00 Total Visit	-	13.
1. 00	Is this a consolidated cost report as define 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	d in CMS Pub. 7 umn 1. If yes, List the names	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Prov	N N ider name 1.00	CCN number 2.00 Total Visit	-	14.
1. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FOHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	d in CMS Pub. 7 umn 1. If yes, List the names	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Prov	N N ider name 1.00	CCN number 2.00 Total Visit	-	13.
1. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FOHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	d in CMS Pub. 7 umn 1. If yes, List the names	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Prov	N N ider name 1.00	CCN number 2.00 Total Visit	-	13.
1. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FOHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	d in CMS Pub. 7 umn 1. If yes, List the names	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Prov	N N ider name 1.00	CCN number 2.00 Total Visit	-	13.
. 00	Is this a consolidated cost report as define 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	d in CMS Pub. 7 umn 1. If yes, List the names	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Prov	N N ider name 1.00	CCN number 2.00 Total Visit	-	14.
. 00	Is this a consolidated cost report as define 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.	d in CMS Pub. 7 umn 1. If yes, List the names	V 2.00	r 9, section mn 2 the ders and Prov XVIII 3.00	N N ider name 1.00	CCN number 2.00 Total Visit	-	14.
H. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FOHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	d in CMS Pub. 7 umn 1. If yes, List the names	V 2.00	r 9, section mn 2 the ders and Prov XVIII 3.00	N N ider name 1.00	CCN number 2.00 Total Visit	-	14.
1.00	Is this a consolidated cost report as define 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.	d in CMS Pub. Aumn 1. If yes, List the names Y/N 1.00	V 2.00	r 9, section mn 2 the ders and Prov XVIII 3.00	N N N i der name 1.00	CCN number 2.00 Total Visit 5.00	-	14.
3. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FOHC 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)	y/N 1.00 Tuesday	V 2.00 Cou	r 9, section mn 2 the ders and Prov XVIII 3.00	N N N ider name 1.00 XIX 4.00	CCN number 2.00 Total Visit	-	13. (
4. 00 5. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FOHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	d in CMS Pub. Aumn 1. If yes, List the names Y/N 1.00	V 2.00	r 9, section mn 2 the ders and Prov XVIII 3.00 unty 00 esday	N N N i der name 1.00	CCN number 2.00 Total Visit 5.00	-	13.

Health Financial Systems MA	RGARET MARY COM	MMUNITY HOSPITA	AL .	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Peri od:	Worksheet S-8	
		Component		From 01/01/2018 To 12/31/2018	Date/Time Pre 2/13/2020 2:3	
				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	07: 00	06: 00	08: 00	12: 00		11.00

IOSPI T	AL-BASED HOSPICE IDENTIFICATION	DATA		Provi der CC Hospi ce CCI	CN: 15-1329 N: 15-1551	Peri od: From 01/01/2018 To 12/31/2018		GH IV pared:
						Hospi ce I	2/13/2020 2: 3	8 pm
		Unduplicated				поѕргсе г		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility			ŕ	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING I	PERIODS BEGINN	ING BEFORE OCTO	DBER 1, 2015			
. 00	Hospice Continuous Home Care							1.0
2. 00	Hospice Routine Home Care							2.0
3. 00	Hospice Inpatient Respite Care							3.0
. 00	Hospice General Inpatient Care							4.0
. 00	Total Hospice Days							5.0
	Part II - CENSUS DATA FOR COST	REPORTING PER	ODS BEGINNING	BEFORE OCTOBER	R 1, 2015			l
. 00	Number of patients receiving							6.0
	hospi ce care							
. 00	Total number of unduplicated							7.0
	Continuous Care hours billable to Medicare							
. 00	Average Length of Stay (line 5			-				8.0
. 00	/ line 6)							0.0
. 00	Unduplicated census count							9.0
	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			7.0
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1. 00	2. 00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERIODS BEGI	NNING ON OR AFT	FER OCTOBER 1	I, 2015		1
0. 00	Hospice Continuous Home Care			0		0 0		10.0
1. 00	Hospice Routine Home Care			9, 441	2	11 1, 603	11, 255	
2.00	Hospice Inpatient Respite Care			0		0 4	4	1
	Hospice General Inpatient Care			0	_	0 6	11 2/5	
4. 00	Total Hospice Days	N DATA FOR CO.	CT DEDODTING D	9, 441		1, 613	11, 265] 14. (
E 00	PART IV - CONTRACTED STATISTICA	AL DATA FUR COS	SI KEPUKIING P				-	1
5.00	Hospice Inpatient Respite Care Hospice General Inpatient Care			0 0		0 0	0	15. 0 16. 0

Heal th	Financial Systems MARGARET MARY	COMMUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CO	CN: 15-1329	Peri od:	Worksheet S-1	
				From 01/01/2018	Doto/Time Dro	narad.
				To 12/31/2018	Date/Time Pre 2/13/2020 2:3	
					1. 00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 colu	mn 3 divided by li	ne 202 colum	n 8)	0. 383314	1.00
	Medicaid (see instructions for each line)					
2. 00	Net revenue from Medicaid				6, 842, 908	2.00
3.00	Did you receive DSH or supplemental payments from Medic		<i>-</i> M1: -	-: -10	N	3.00
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or su If line 4 is no, then enter DSH and/or supplemental pay			ai u ?	0	4. 00 5. 00
6. 00	Medical d charges	ments from wedicar	u		17, 483, 441	6. 00
7. 00	Medicaid cost (line 1 times line 6)				6, 701, 648	
8. 00	Difference between net revenue and costs for Medicaid p	rogram (line 7 mir	nus sum of li	nes 2 and 5; if	0	8. 00
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instruc	tions for each lir	ne)			
9.00	Net revenue from stand-alone CHIP				0	9.00
10.00	Stand-alone CHIP charges				0	10. 00 11. 00
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone	o CUID (lino 11 mi	nue lino 0:	if < zoro thon	0	12.00
12.00	enter zero)	e Chir (iille ii IIII	nus ime 9,	i < zero tilen	U	12.00
	Other state or local government indigent care program (see instructions f	or each line)		
13.00	Net revenue from state or local indigent care program (0	13.00
14.00	Charges for patients covered under state or local indig	ent care program ((Not included	in lines 6 or	0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times			45 1 11	0	15.00
16. 00	Difference between net revenue and costs for state or I	ocai indigent care	e program (II	ne 15 minus iine	. 0	16. 00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medica	aid CHIP and stat	te/Local indi-	gent care progra	ms (see	
	instructions for each line)			gent care progre		
	Private grants, donations, or endowment income restrict					17.00
18.00	Government grants, appropriations or transfers for supp				0	18.00
19. 00	Total unreimbursed cost for Medicaid, CHIP and state a 8, 12 and 16)	nd Local Indigent	care program	s (sum or lines	0	19. 00
			Uni nsured	Insured	Total (col. 1	
			patients 1.00	pati ents 2.00	+ col . 2) 3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the en	tire facility	1, 146, 25	3 0	1, 146, 253	20.00
	(see instructions)					
21. 00	Cost of patients approved for charity care and uninsure	d discounts (see	439, 37	5 0	439, 375	21.00
22. 00	instructions) Payments received from patients for amounts previously	written off as		o	0	22. 00
22.00	charity care	mireton orr us			o l	22.00
23. 00	Cost of charity care (line 21 minus line 22)		439, 37	5 0	439, 375	23.00
					1 00	
24 00	Does the amount on line 20 column 2, include charges fo	r natient days hev	und a Length	of stay limit	1. 00 N	24. 00
24.00	imposed on patients covered by Medicaid or other indige		yona a rengtii	or stay rriiir t	14	24.00
25. 00	If line 24 is yes, enter the charges for patient days b stay limit		t care progra	m's length of	0	25.00
26. 00	Total bad debt expense for the entire hospital complex	(see instructions))		8, 085, 181	26. 00
27. 00	Medicare reimbursable bad debts for the entire hospital	•			588, 029	27. 00
27. 01	Medicare allowable bad debts for the entire hospital co				904, 661	
28. 00	Non-Medicare bad debt expense (see instructions)				7, 180, 520	28.00
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad	, ,	instructions)	3, 069, 026	29.00
	Cost of uncompensated care (line 23 column 3 plus line	•			3, 508, 401	30.00
	Total unreimbursed and uncompensated care cost (line 19)	prus rine 30)			3, 508, 401	31.UU

Heal th	Financial Systems MAR	GARET MARY COMMU			In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		Period: From 01/01/2018 Fo 12/31/2018	Worksheet A Date/Time Pre	nared:
					10 12/31/2010	2/13/2020 2: 3	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
	'			+ col . 2)	ions (See	Trial Balance	
				,	A-6)	(col. 3 +-	
						col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT		3, 247, 141	3, 247, 14	1 0	3, 247, 141	1.00
1. 01	00101 NEW CAP REL COSTS-OFFSITE BLDG		832, 756			832, 756	1
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		4, 928, 773			4, 572, 643	1
2. 01	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0		356, 130	356, 130	
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	204, 975	12, 816, 127	1		13, 021, 101	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	6, 417, 583	9, 429, 764			16, 281, 640	1
7. 00	00700 OPERATION OF PLANT	0, 117, 000	1, 436, 222			1, 435, 981	1
7. 01	00701 OPERATION OF PLANT -OFFSITE	0	287, 365			287, 365	1
7. 01	00702 OPERATION OF PLANT - HOSPITAL & OFFS	530, 986	16, 693			547, 679	1
8. 00	00800 LAUNDRY & LI NEN SERVI CE	96, 884	67, 078			151, 817	1
9. 00	00900 HOUSEKEEPI NG			1			1
		1, 018, 349	340, 600				1
10.00	01000 DI ETARY	860, 570	575, 530				
11.00	01100 CAFETERI A	0	0	1		1, 229, 562	1
13.00	01300 NURSI NG ADMI NI STRATI ON	561, 423	8, 959	1		570, 366	
14.00	01400 CENTRAL SERVI CES & SUPPLY	0	132, 765			-5, 011	1
15. 00	01500 PHARMACY	764, 443	3, 752, 534			4, 484, 463	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 484, 462	327, 060	1, 811, 522	2 -71	1, 811, 451	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 887, 879	306, 844			3, 682, 349	1
31. 00	03100 INTENSIVE CARE UNIT	304, 739	21, 686			311, 280	
43.00	04300 NURSERY	0	4, 255	4, 25!	700, 391	704, 646	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 498, 820	2, 851, 821			1, 951, 790	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 346, 536	299, 024			148, 483	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 974, 774	7, 897, 777			10, 599, 489	•
60.00	06000 LABORATORY	1, 626, 035	2, 409, 898	4, 035, 933	-160, 604	3, 875, 329	•
60. 01	06001 BLOOD LABORATORY	0	0)	0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	568, 968	170, 456	739, 42	-27, 120	712, 304	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 143, 408	61, 521			1, 181, 825	66.00
67.00	06700 OCCUPATI ONAL THERAPY	373, 187	15, 029	388, 216	-11, 623	376, 593	67.00
68.00	06800 SPEECH PATHOLOGY	203, 397	2, 726	206, 123		205, 276	
69. 00	06900 ELECTROCARDI OLOGY	673, 842	344, 383	1, 018, 22	-39, 062	979, 163	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)		3, 428, 834	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0)	1, 005, 152	1, 005, 152	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0)	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	1, 091, 383	97, 322	1, 188, 70			
90.00	09000 CLI NI C	1, 625, 969	862, 262	2, 488, 23	-225, 876		
90. 01	09001 WOUND CLINC	330, 219	250, 607	580, 820	-243, 544	337, 282	90. 01
91.00	09100 EMERGENCY	2, 265, 827	2, 549, 576	4, 815, 403	-179, 088	4, 636, 315	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1, 753, 398	233, 842	1, 987, 240	-66, 658	1, 920, 582	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE		0)	0	0	113.00
116.00	11600 HOSPI CE	778, 497	387, 628	1, 166, 12	-14, 579	1, 151, 546	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	33, 386, 553	56, 966, 024	90, 352, 57	647, 481	91, 000, 058	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	10, 526, 041	1, 781, 597	12, 307, 638	-143, 875	12, 163, 763	192.00
192. 01	19201 PEDI ATRI CS	655, 122	59, 137	714, 259	-24, 681	689, 578	192.01
192.02	19202 BR00KVI LLE	1, 222, 324	94, 090	1, 316, 414	-18, 014	1, 298, 400	192.02
192.03	19203 RADI OLOGY - OSGOOD	93, 079	0	93, 079	el ol	93, 079	192.03
	19204 ENT	232, 285	23, 157	255, 442	-11, 014	244, 428	1
	07950 COMMUNITY RELATIONS	385, 183	910, 706			858, 818	1
	07951 COMMUNITY BENEFITS	475, 570	223, 166			686, 900	1
	07952 OTHER NON-REIMBURSABLE	0	0		0		194. 02
	07953 EMS	47, 928	56, 208	1	-	103, 146	
	07954 BATESVILLE TOOL & DIE CLINIC	71, 736	5, 139			76, 875	
194.05	07955 MMHCB RHC	112, 374	4, 182			116, 556	
200.00		47, 208, 195	60, 123, 406				
_55.50	1 1.5 (55 5. 2 110 till bagil 177)	, 200, 170	55, .25, 100	1 .5., 551, 66	۰, ۷	, ,	,_00.00

 Health Financial
 Systems
 MARGARET MARY

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 15-1329

Peri od: Worksheet A From 01/01/2018 Date/Time Prepared: 2/13/2020 2:38 pm

				2/13/2020 2:	
	Cost Center Description	Adjustments	Net Expenses	27 107 2020 21	
		(See A-8)	For		
		, ,	Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	-861, 668	2, 385, 473	3	1.00
1. 01	00101 NEW CAP REL COSTS-OFFSITE BLDG	0	,		1. 01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-149, 877	4, 422, 766		2.00
2. 01	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	356, 130		2. 01
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	13, 021, 101		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-3, 251, 614			5. 00
7. 00	00700 OPERATION OF PLANT	-10, 916	,		7. 00
7. 01	00701 OPERATION OF PLANT -OFFSITE	0	287, 365		7. 01
7. 02	00702 OPERATION OF PLANT - HOSPITAL & OFFS	0			7. 02
8. 00	00800 LAUNDRY & LI NEN SERVI CE	-912	150, 905	l control of the cont	8.00
9.00	00900 HOUSEKEEPI NG	0	1, 356, 809		9.00
10.00	01000 DI ETARY	-18, 995			10.00
11. 00	01100 CAFETERI A	-364, 891	864, 671	l control of the cont	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	570, 366		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	-5, 011		14.00
15.00	01500 PHARMACY	-126, 564			15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-18, 003	1, 793, 448	3	16. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 440 004	0 570 040	,	
30.00	03000 ADULTS & PEDIATRICS	-1, 110, 031	2, 572, 318		30.00
31.00		0	311, 280		31.00
43. 00		0	704, 646	0	43.00
EO 00	ANCILLARY SERVICE COST CENTERS	75 000	1 07/ 700		F0 00
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	-75, 000 0	1		50.00 52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-1, 163, 181	9, 436, 308		54.00
60.00	06000 LABORATORY	-1, 103, 161			60.00
60. 00	06001 BL00D LABORATORY	0	3,075,329	l e e e e e e e e e e e e e e e e e e e	60.00
65. 00	06500 RESPIRATORY THERAPY	0	712, 304		65.00
66. 00	06600 PHYSI CAL THERAPY	-7, 499	l '		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	-525			67.00
68. 00	06800 SPEECH PATHOLOGY	0	205, 276		68.00
69. 00	06900 ELECTROCARDI OLOGY	-193, 810			69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1		72.00
73. 00		0	0		73.00
	OUTPATIENT SERVICE COST CENTERS			1	1
88. 00	08800 RURAL HEALTH CLINIC	0	1, 188, 705		88.00
90.00	09000 CLI NI C	-979, 362			90.00
90. 01	09001 WOUND CLINC	0	337, 282	l control of the cont	90. 01
91.00		-1, 904, 837			91.00
92.00					92.00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>	<u> </u>		
101.00	10100 HOME HEALTH AGENCY	0	1, 920, 582		101.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	0	0		113.00
116.00	11600 H0SPI CE	0	1, 151, 546		116.00
118.00		-10, 237, 685	80, 762, 373	3	118. 00
	NONREI MBURSABLE COST CENTERS				
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	12, 163, 763		192. 00
	1 19201 PEDI ATRI CS	0	689, 578	3	192. 01
	2 19202 BROOKVI LLE	0	,		192. 02
	3 19203 RADI OLOGY - OSGOOD	0	93, 079	•	192. 03
	4 19204 ENT	0	244, 428		192. 04
	07950 COMMUNITY RELATIONS	0	858, 818		194. 00
	1 07951 COMMUNITY BENEFITS	0	686, 900	1	194. 01
	2 07952 OTHER NON-REI MBURSABLE	0	0		194. 02
	3 07953 EMS	0			194. 03
	4 07954 BATESVILLE TOOL & DIE CLINIC	0	76, 875		194.04
	507955 MMHCB RHC	0			194.05
200.00	TOTAL (SUM OF LINES 118 through 199)	-10, 237, 685	97, 093, 916)	200.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-1329

						To	12/31/2018	B Date/Time Prepared: 2/13/2020 2:38 pm
A - GAFETERIA			Increases			<u> </u>		27 107 2020 2: 00 piii
A - CAFETERIA								
1.00			3. 00	4. 00	5. 00			
Color	1 00		11 00	763 909	465 653			1 00
Company Comp	1.00	0						1.00
A		B - OB RECLASS						
1.00								
C - COMMUNITY RELATIONS 1,00	2. 00		43.00					2.00
1.00		-		1, 202, 781	140, 448			
1.00 0	1 00		5.00	134 814	301 681			1 00
1.00	1.00	0						1.00
COLOR COLO		D - OFFSITE BUILDING DEPR REC	CLASS	,	22.7.22.1			
2.00 0	1.00		2. 01	0	356, 130			1.00
1.00		EQUIP OFFSIT			_			
Color Implication Implic	2.00							2.00
1. 00		-	224	U	330, 130			
PATIENT	1. 00			0	1, 005, 152			1.00
3.00 0.00 0.00 0 0 0 0 0				1	.,,			
4. 00 5. 00 6. 00 6. 00 7. 00 8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00			O	0			
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7. 00 8. 00 0 0 0 0 0 0 0 0 0				~	-			•
8.00								
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1. 00 PATIENTS 0. 00 0.		0 — — — — —			1, 005, 152			
PATIENTS								
2 00	1. 00		71. 00	0	3, 438, 941			1.00
3.00 4.00 5.00 6.00 7.00 6.00 7.00 8.00 8.00 9.00 9.00 9.00 9.00 10.00 9.00 10.00 11.00 11.00 11.00 12.00 13.00 14.00 15.00 11.00 12.00 13.00 14.00 15.00 15.00 16.00 17.00 18.00 18.00 19.00 10.00 10.00 10.00 10.00 11	2 00	PATTENTS	0.00	0	0			3 00
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30.00 31.00 32.00 33.00 0 30.00 0 0 0 0 0 0 0 0 0 0 0				0				
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33.00				0				
0 3, 438, 941				ol				•
500.00 Grand Total: Increases 2, 101, 504 5, 708, 005 500.00		0						
	500.00	Grand Total: Increases		2, 101, 504	5, 708, 005			500.00

		Dooroooo				
	2 . 2 .	Decreases		0.11		
	Cost Center	Li ne #	Sal ary		kst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
	A - CAFETERIA					
1.00	DI ETARY	10. 00	763, 909	465, 653	0	1.00
	0 — — — — —		763, 909	465, 653		
	B - OB RECLASS		7007707	1007 000		
1 00		E2 00	1 202 701	140 449	0	1 00
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 202, 781	140, 448		1.00
2.00	L — — — — — —	0.00		0	0	2.00
	0		1, 202, 781	140, 448		
	C - COMMUNITY RELATIONS					
1.00	COMMUNITY RELATIONS	194. 00	134, 814	301, 681	0	1.00
00	0		134, 814	301, 681	4	1.00
	D OFFICIAL DINC DEDD DE	CL ACC	134, 014	301,001		
	D - OFFSITE BUILDING DEPR REC					
1. 00	NEW CAP REL COSTS-MVBLE	2. 00	0	356, 130	9	1.00
	EQUI P					
2.00		0.00	0	0	9	2. 00
	0 — — — — —			356, 130		
	E - IMPLANTABLE SUPPLIES RECI	221				
1 00	ADULTS & PEDIATRICS	30.00	0	23, 246	O	1.00
1.00	•					•
2. 00	INTENSIVE CARE UNIT	31. 00	0	1, 011	0	2.00
3.00	OPERATING ROOM	50.00	0	935, 413	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	15, 161	ol	4.00
5. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	10, 107	ol	5.00
5.00	1	71.00	٥	10, 107	٩	3.00
,	PATIENTS			0.507		
6. 00	CLINIC	90. 00	0	2, 527	0	6.00
7. 00	WOUND CLINC	90. 01	0	17, 182	0	7.00
8.00	EMERGENCY	91.00	0	505	О	8.00
	0		— — 	1, 005, 152		1 2.22
	G - CENTRAL SUPPLY RECLASS		<u> </u>	1,003,132		
4 00		4 00				1.00
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	2, 202	0	2.00
3.00	OPERATION OF PLANT	7. 00	O	241	ol	3.00
4.00	LAUNDRY & LINEN SERVICE	8. 00	0	12, 145		4.00
5. 00		9. 00	o		0	5.00
	HOUSEKEEPI NG		-	2, 140	-	· · · · · · · · · · · · · · · · · · ·
6. 00	DI ETARY	10. 00	0	47, 671	0	6.00
7. 00	NURSING ADMINISTRATION	13. 00	0	16	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14. 00	O	137, 776	ol	8.00
9. 00	PHARMACY	15. 00	0	32, 514	o	9.00
	•		0		0	10.00
10.00	MEDICAL RECORDS & LIBRARY	16. 00		71	-1	•
11. 00	ADULTS & PEDIATRICS	30. 00	0	131, 966	0	11.00
12.00	INTENSIVE CARE UNIT	31. 00	0	14, 134	0	12.00
13.00	OPERATING ROOM	50.00	O	1, 463, 438	ol	13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	o	138, 687	o	14.00
			0		0	
15. 00	RADI OLOGY-DI AGNOSTI C	54. 00	-1	273, 062	٩	15. 00
16. 00	LABORATORY	60. 00	0	160, 604	0	16.00
17.00	RESPI RATORY THERAPY	65. 00	0	27, 120	0	17. 00
18.00	PHYSI CAL THERAPY	66. 00	ol	23, 104	o	18.00
19. 00	OCCUPATIONAL THERAPY	67. 00	o	11, 623	o	19.00
	•					•
20.00	SPEECH PATHOLOGY	68.00	و	847	O	20.00
21. 00	ELECTROCARDI OLOGY	69. 00	0	39, 062	0	21.00
22.00	CLINIC	90. 00	0	223, 349	0	22.00
23.00	WOUND CLINC	90. 01	O	226, 362	o	23.00
24. 00	EMERGENCY	91.00	o	178, 583	Ö	24.00
25.00	HOME HEALTH AGENCY	101.00	و	66, 658	0	25. 00
26.00	HOSPI CE	116. 00	0	14, 579	0	26. 00
27.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	143, 875	0	27. 00
28.00	PEDI ATRI CS	192. 01	ol	24, 681	ol	28. 00
29. 00	BROOKVI LLE	192. 02	٥	18, 014	Ŏ	29.00
	1				O O	
30.00	ENT	192. 04	이	11, 014	0	30.00
31.00	COMMUNITY RELATIONS	194. 00	0	576	0	31.00
32.00	COMMUNITY BENEFITS	194. 01	ol	11, 836	o	32.00
33. 00	EMS	194. 03	أم	990	ام	33.00
55. 55			— — 升	3, 438, 941	— —	33.00
E00 00	Crand Total: Decrees	+	2 101 504			500.00
500.00	Grand Total: Decreases	l l	2, 101, 504	5, 708, 005		500.00

MARGARET MARY COMMUNITY HOSPITAL Health Financial Systems In Lieu of Form CMS-2552-10 RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-1329 Worksheet A-7 Peri od: From 01/01/2018 To 12/31/2018 Part I Date/Time Prepared: 2/13/2020 2:38 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Disposals and Retirements Bal ances 1.00 2.00 3.00 4.00 5.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 2, 553, 658 1.00 1.00 Land 0 0 0 557, 745 285, 701 2.00 Land Improvements 2.00 80, 587, 989 3.00 Buildings and Fixtures 2, 245, 692 2, 245, 692 2, 937, 416 3.00 4.00 Building Improvements 4.00 5.00 Fixed Equipment 6, 340, 280 1,094,512 5.00 0 0 0 6.00 Movabl e Equi pment 58, 892, 305 16, 365, 009 16, 365, 009 17, 929, 882 6.00 HIT designated Assets 7.00 7.00 8.00 Subtotal (sum of lines 1-7) 148, 931, 977 18, 610, 701 18, 610, 701 22, 247, 511 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 148, 931, 977 0 18, 610, 701 10.00 18, 610, 701 22, 247, 511 10.00 Endi ng Ful I y Bal ance Depreciated Assets

			6.00	7.00	
_		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES		
	1. 00	Land	2, 553, 658	0	1.00
	2. 00	Land Improvements	272, 044	0	2.00
	3.00	Buildings and Fixtures	79, 896, 265	0	3.00
	4.00	Building Improvements	0	0	4.00
	5. 00	Fixed Equipment	5, 245, 768	0	5.00
	6. 00	Movable Equipment	57, 327, 432	0	6.00
	7. 00	HIT designated Assets	0	0	7.00
	8. 00	Subtotal (sum of lines 1-7)	145, 295, 167	0	8.00
	9. 00	Reconciling Items	0	0	9.00
	10.00	Total (line 8 minus line 9)	145, 295, 167	0	10.00

In Lieu of Form CMS-2552-10
Period: Worksheet A-7
From 01/01/2018 Part II Provi der CCN: 15-1329

				Ť	o 12/31/2018	Date/Time Pre 2/13/2020 2:3	
			SU	MMARY OF CAPIT	AL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
		9. 00	10. 00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	2, 222, 174	0	1, 024, 967	0	0	1.00
1. 01	NEW CAP REL COSTS-OFFSITE BLDG	832, 756		0	0	0	1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4, 928, 773	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, 983, 703		1, 024, 967	0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Coat Contan Decarintian	Other	Total (1)				
	Cost Center Description	Capi tal -Rel at	` '				
		ed Costs (see					
		instructions)	7 till ough 14)				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1. 00	NEW CAP REL COSTS-BLDG & FLXT	0	3, 247, 141				1.00
1. 01	NEW CAP REL COSTS-OFFSITE BLDG	0	832, 756				1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	4, 928, 773				2.00
2. 01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0				2. 01
3.00	Total (sum of lines 1-2)	0	9, 008, 670				3.00

Heal th	n Financial Systems MAF	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part III Date/Time Pre 2/13/2020 2:3	pared:
		COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			10 (00 (1	0 447045		
1.00	NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-OFFSITE BLDG	60, 623, 612					1.00
1. 01 2. 00	NEW CAP REL COSTS-OFFSITE BLDG	20, 177, 119 64, 494, 436		,,		0	1. 01 2. 00
2. 00	NEW CAP REL COSTS-MVBLE EQUIP	04, 494, 430	0		0. 000000	0	2.00
3. 00	Total (sum of lines 1-2)	145, 295, 167	0	145, 295, 16		-	3.00
3.00	Total (Sum of Titles 1.2)		TION OF OTHER (F CAPITAL	3.00
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Rel at				
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			ı	0 000 174		
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		2, 222, 174		1.00
1. 01	NEW CAP REL COSTS-OFFSITE BLDG NEW CAP REL COSTS-MVBLE EQUIP	0	0		832, 756		1. 01 2. 00
2. 00 2. 01	NEW CAP REL COSTS-MVBLE EQUIP	0	0		4, 422, 766 356, 130		2.00
3. 00	Total (sum of lines 1-2)	0	0		7, 833, 826		3.00
3.00	Total (Sull of Titles 1-2)	U	SI	I' JMMARY OF CAPI		U	3.00
			30	JIVIIVIAKT OF CAFT	IAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Rel at	(sum of cols.	
			instructions)	ĺ	ed Costs (see	9 through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			Т			
1.00	NEW CAP REL COSTS-BLDG & FIXT	163, 299			0	2, 385, 473	1.00
1. 01	NEW CAP REL COSTS AND E FOULD	0	0		0	832, 756	1.01
2. 00 2. 01	NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0		0 0	4, 422, 766 356, 130	2. 00 2. 01
2. 01 3. 00	Total (sum of lines 1-2)	163, 299				7, 997, 125	
3.00	Total (Sum Of TITIES 1-2)	103, 299	0	'	J ₁ 0	1, 771, 125	3.00

	MENTS TO EXPENSES			Provider CCN: 15-1329	Peri od:	Worksheet A-8	
					From 01/01/2018 To 12/31/2018	Date/Time Pre 2/13/2020 2:3	pared:
				Expense Classification o			J
				To/From Which the Amount is	s 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		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1. 01	2) Investment income - NEW CAP		0	NEW CAP REL COSTS-OFFSITE	1. 01	0	1.01
	REL COSTS-OFFSITE BLDG (chapter 2)			BLDG		-	
2. 00	Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2. 00	0	2. 00
	REL COSTS-MVBLE EQUIP (chapter 2)			EQUI P			
2. 01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2. 01	0	2. 01
	(chapter 2)				0.00		
3. 00	Investment income - other (chapter 2)		0		0.00	0	3.00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	О	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	o	7.00
	stations excluded) (chapter 21)						
8. 00	Television and radio service		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10.00	Provider-based physician adjustment	A-8-2	-5, 009, 174			0	10.00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11.00
12. 00	Related organization	A-8-1	0			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		0		0. 00 0. 00		
	and others		0				
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
	abstracts						
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20.00
	Income from imposition of interest, finance or penalty		0		0. 00		1
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23.00
23.00	therapy costs in excess of	A-0-3	0	RESTINATORY THERAFT	05.00		23.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24.00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted **	114.00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG &	1.00	0	26. 00
26. 01	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-OFFSITE	1. 01	0	26. 01
	COSTS-OFFSITE BLDG			BLDG	I	I	I

Health Financial Systems ADJUSTMENTS TO EXPENSES Provi der CCN: 15-1329 Peri od: Worksheet A-8

					0 12/31/2018	Date/IIme Pre 2/13/2020 2:3	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)	0.00		4 00	Ref.	
27. 00	Depreciation - NEW CAP REL	1. 00	2. 00	3.00 NEW CAP REL COSTS-MVBLE	4. 00	5. 00	27. 00
27.00	COSTS-MVBLE EQUIP		0	EQUI P	2.00	O	27.00
27. 01	Depreciation - NEW CAP REL			NEW CAP REL COSTS-MVBLE	2. 01	0	27. 01
20.00	COSTS-MVBLE EQUIP OFFSIT			EQUIP OFFSIT *** Cost Center Deleted ***	10.00		20.00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	Cost Center Deleted AAA	19. 00 0. 00	0	28. 00 29. 00
30.00	Adjustment for occupational	A-8-3	Ö	OCCUPATIONAL THERAPY	67. 00	Ŭ	30.00
	therapy costs in excess of						
30. 99	limitation (chapter 14)		0	ADULTO O DEDLATRICO	30.00		30. 99
30. 99	Hospice (non-distinct) (see instructions)		U	ADULTS & PEDIATRICS	30. 00		30. 99
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
32. 00	limitation (chapter 14) CAH HIT Adjustment for	А	_149 877	NEW CAP REL COSTS-MVBLE	2. 00	9	32. 00
32.00	Depreciation and Interest	A	· ·	EQUI P	2.00	,	32.00
33.00	OTHEROPERATING GIRLS ON THE	В	-37, 005	ADMINISTRATIVE & GENERAL	5. 00	0	33.00
24.00	RUN REVE	Б	2.047	ADMINISTRATIVE & CENEDAL	F 00		24.00
34. 00	OTHEROPERATING OTHOP - INTERNAL SALE	В	3, 907	ADMINISTRATIVE & GENERAL	5. 00	0	34. 00
35.00	MMCH OTHER OPERATING	В	-5, 651	ADMINISTRATIVE & GENERAL	5. 00	0	35.00
0, 00	COMMBENEFITS SC		10 171				0, 00
36. 00	OTHEROPERATING DIABETES PROGRAM	В	-10, 1/4	ADMINISTRATIVE & GENERAL	5. 00	0	36. 00
37.00	OTHEROPERATING OTHOP-COMMUNITY	В	-5, 942	ADMINISTRATIVE & GENERAL	5. 00	0	37. 00
20.00	CLASS	5	10.01/	ODERATION OF BLANT	7.00		20.00
38. 00	OTHEROPERATING OTHOP - MISC REVENUE	В	-10, 916	OPERATION OF PLANT	7. 00	0	38. 00
40.00	OTHEROPERATING OTHOP - LAUNDRY	В	-912	LAUNDRY & LINEN SERVICE	8. 00	0	40. 00
41 00	SERVI	D	2.057	DI ETADY	10.00	0	41 00
41. 00	OTHEROPERATING OTHOP - VENDING SALES	В	-3, 956	DI ETARY	10. 00	0	41. 00
43.00	OTHEROPERATING OTHOP - DIET	В	-6, 347	DI ETARY	10. 00	0	43.00
44.00	SUPP/INS	5	0/4 004	OAFETER! A	11 00		44.00
44. 00 45. 00	CAFETERIA OFFSET OTHEROPERATING OTHOP - MEDRED	B B		CAFETERIA MEDICAL RECORDS & LIBRARY	11. 00 16. 00	0	44. 00 45. 00
43.00	TRANSC	В	10,003	MEDIONE RECORDS & EIDINANT	10.00	Ü	43.00
45. 01	OTHEROPERATING OTHOP-PHYSICAL	В	-7, 499	PHYSI CAL THERAPY	66. 00	0	45. 01
45. 02	THERAP OTHEROPERATING OTHOP-	В	525	OCCUPATIONAL THERAPY	67. 00	0	45. 02
45.02	OCCUPATI ONAL T	В	-323	CCCO ATTONAL THERAIT	07.00	O	45.02
45.03	INTEREST OFFSET	Α	-861, 668	NEW CAP REL COSTS-BLDG &	1. 00	11	45.03
45. 04	LOBBYING EXPENSE	Λ	E 400	FIXT ADMINISTRATIVE & GENERAL	5. 00	0	45. 04
45. 05	MEDICAL STAFF RETENTION COST	A A		ADMINISTRATIVE & GENERAL	5.00	0	45. 05
45. 06	MEDICAL STAFF PLACEMENT FEE	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 06
45. 07	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 07
45. 08	HAF	A		ADMINISTRATIVE & GENERAL	5.00	0	45.08
45. 09 45. 10	TELEPHONE & TV OFFSET BOUTIQUE OFFSET	A A		ADMINISTRATIVE & GENERAL RADIOLOGY-DIAGNOSTIC	5. 00 54. 00	0	45. 09 45. 10
45. 10	HOSPI TALI ST OFFSET	Ä		ADULTS & PEDIATRICS	30.00	0	45. 10
45. 12	340B EXPENSE	A	-126, 564	l e e e e e e e e e e e e e e e e e e e	15. 00	0	45. 12
45. 13	DIETARY REVENUE	В		DI ETARY	10. 00	0	45. 13
50. 00	TOTAL (sum of lines 1 thru 49)		-10, 237, 685				50.00
	(Transfer to Worksheet A, column 6, line 200.)						
	COLUMNIC O, TITHE 200. J				1		

⁽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

Provi der CCN: 15-1329

Peri od: Worksheet A-8-2 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

						0 12/31/2018	2/13/2020 2:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	4, 796	C	4, 796	0	0	1.00
2.00	30. 00	ADULTS & PEDIATRICS	778, 728	693, 728	85, 000	0	0	2.00
3.00	50. 00	OPERATING ROOM	130, 000	75, 000	55, 000	0	0	3.00
4.00	54. 00	RADI OLOGY-DI AGNOSTI C	1, 220, 437	1, 162, 437	58, 000	0	0	4.00
5.00	60.00	LABORATORY	71, 094	.l c	71, 094	0	0	5.00
6.00	69. 00	ELECTROCARDI OLOGY	205, 810	193, 810	12,000	0	0	6.00
7. 00	90.00	CLINIC	979, 362	979, 362	0	0	0	7. 00
8. 00	91. 00	EMERGENCY	2, 315, 904			0	0	8. 00
9. 00	0.00		0		0	0	0	9. 00
10.00	0.00		0		0	0	0	10.00
200.00			5, 706, 131	5, 009, 174	696, 957	·	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12.00	13. 00	14.00	
1. 00	5. 00	ADMINISTRATIVE & GENERAL	0	C	0	0	0	1.00
2.00	30. 00	ADULTS & PEDIATRICS	0) C	0	0	0	2.00
3.00	50. 00	OPERATING ROOM	0) C	0	0	0	3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0	C	0	0	0	4.00
5.00	60. 00	LABORATORY	0	C	0	0	0	5. 00
6.00		ELECTROCARDI OLOGY	0) c	0	0	0	6. 00
7. 00	90. 00	CLINIC	0	ol c	0	0	0	7. 00
8.00	91. 00	EMERGENCY	0	C	0	0	0	8. 00
9. 00	0. 00		0	ol c	0	0	0	9. 00
10.00	0. 00		0	ol c	0	0	0	10.00
200.00			0	C	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMINISTRATIVE & GENERAL	0	-	_	0		1.00
2.00		ADULTS & PEDIATRICS	0	1		693, 728		2.00
3. 00		OPERATING ROOM	0	1	Ü	75, 000		3. 00
4. 00		RADI OLOGY-DI AGNOSTI C	0	C	0	1, 162, 437		4.00
5. 00		LABORATORY	0	l c	0	0		5. 00
6. 00		ELECTROCARDI OLOGY	0	C	0	193, 810	•	6. 00
7. 00		CLINIC	0	l c	0	979, 362		7. 00
8. 00		EMERGENCY	0	C	0	1, 904, 837		8. 00
9. 00	0. 00		0	l c	0	0		9. 00
10.00	0. 00		0	l c	0	0		10.00
200.00			0) C	0	5, 009, 174		200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1329

Peri od: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 2/13/2020 2:38 pm

						2/13/2020 2: 3	8 pm
				CAPITAL REL	ATED COSTS		
	Cost Center Description	Net Expenses	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE	
	cost center bescription	for Cost	FLXT	BLDG	EQUI P	EQUIP OFFSIT	
		Allocation	1171	DEDO	2011	24011 011011	
		(from Wkst A					
		col. 7)					
		0	1.00	1. 01	2. 00	2. 01	
GENI	ERAL SERVICE COST CENTERS						
	OO NEW CAP REL COSTS-BLDG & FIXT	2, 385, 473	2, 385, 473				1.00
	01 NEW CAP REL COSTS-OFFSITE BLDG	832, 756	0	832, 756			1. 01
4	OO NEW CAP REL COSTS-MVBLE EQUIP	4, 422, 766			4, 422, 766		2.00
	01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	356, 130	40.047		10 570	356, 130	2. 01
	OO EMPLOYEE BENEFITS DEPARTMENT OO ADMINISTRATIVE & GENERAL	13, 021, 101 13, 030, 026	10, 016 365, 729	0	18, 570	0	4.00
	00 OPERATION OF PLANT	1, 425, 065	305, 729 395, 778	1	678, 077 733, 787	0	5. 00 7. 00
	01 OPERATION OF PLANT -OFFSITE	287, 365	373, 778	0	/33, /6/ O	0	
	02 OPERATION OF PLANT - HOSPITAL & OFFS	547, 679	0	0	0	0	
	OO LAUNDRY & LINEN SERVICE	150, 905	26, 585	0	49, 290	0	
	00 HOUSEKEEPI NG	1, 356, 809	30, 313		56, 202	Ö	
	00 DI ETARY	139, 872	10, 282		19, 063	0	10.00
	OO CAFETERI A	864, 671	79, 519		147, 432	0	11.00
13. 00 013	OO NURSING ADMINISTRATION	570, 366	902	0	1, 673	0	13.00
14. 00 014	00 CENTRAL SERVICES & SUPPLY	-5, 011	11, 199	0	20, 764	0	14.00
15. 00 015	OO PHARMACY	4, 357, 899	12, 472	0	23, 123	0	15. 00
	00 MEDICAL RECORDS & LIBRARY	1, 793, 448	43, 125	0	79, 956	0	16. 00
	ATIENT ROUTINE SERVICE COST CENTERS						
	00 ADULTS & PEDIATRICS	2, 572, 318	211, 233	0	391, 634	0	
	00 INTENSIVE CARE UNIT	311, 280	20, 549		38, 099	0	31.00
	00 NURSERY	704, 646	10, 903	0	20, 215	0	43.00
	ILLARY SERVICE COST CENTERS OO OPERATING ROOM	1 074 700	40.000		120 444	0	FO 00
	OO DELIVERY ROOM & LABOR ROOM	1, 876, 790 148, 483	69, 829 17, 502		129, 466 32, 449	0	50.00 52.00
4	00 RADI OLOGY-DI AGNOSTI C	9, 436, 308	283, 059	1	524, 803	0	54.00
	00 LABORATORY	3, 875, 329	51, 484	0	95, 454	0	
4	01 BLOOD LABORATORY	0,075,527	0 0	0	75, 454	0	60.01
4	00 RESPI RATORY THERAPY	712, 304	39, 368		72, 989	Ö	65.00
	00 PHYSI CAL THERAPY	1, 174, 326	82, 434	0	152, 835	0	66.00
	OO OCCUPATI ONAL THERAPY	376, 068	17, 295	0	32, 065	0	67.00
68. 00 068	00 SPEECH PATHOLOGY	205, 276	15, 800	0	29, 294	0	68. 00
69. 00 069	00 ELECTROCARDI OLOGY	785, 353	35, 654	0	66, 104	0	69. 00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 428, 834	0	0	0	0	71.00
72. 00 072	00 I MPL. DEV. CHARGED TO PATIENT	1, 005, 152	43, 495	l	80, 642	0	72.00
73. 00 073	00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	PATIENT SERVICE COST CENTERS	4 400 705		F 4 00/	ما	00.000	00.00
	OO RURAL HEALTH CLINIC	1, 188, 705	207, 386	54, 326 22, 563	384, 502	23, 232	88.00
	00 CLI NI C 01 WOUND CLI NC	1, 282, 993 337, 282	207, 386 9, 986	22, 563	384, 502 18, 515	9, 649 0	90. 00 90. 01
	OO EMERGENCY	2, 731, 478	135, 634		251, 471	0	91.00
-	OO OBSERVATION BEDS (NON-DISTINCT PART)	2, 731, 470	133, 034		231, 471	O	92.00
	ER REIMBURSABLE COST CENTERS						72.00
	OO HOME HEALTH AGENCY	1, 920, 582	50, 522	2, 345	93, 671	1.003	101.00
	CIAL PURPOSE COST CENTERS	., ., ., ., .,	27, 122	_, _,		.,,	
	00 INTEREST EXPENSE						113.00
116. 00 116	00 HOSPI CE	1, 151, 546	0	0	0	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	80, 762, 373	2, 288, 053	79, 234	4, 242, 145	33, 884	118. 00
	REIMBURSABLE COST CENTERS						
4	00 PHYSICIANS' PRIVATE OFFICES	12, 163, 763	47, 445		87, 965	258, 264	
	01 PEDI ATRI CS	689, 578	27, 650		51, 265		192. 01
	02 BROOKVI LLE	1, 298, 400	0	143, 626	0		192. 02
	03 RADI OLOGY - OSGOOD	93, 079	0	3, 405	0		192.03
192. 04 192		244, 428	4 400	0	0 211		192.04
	50 COMMUNITY RELATIONS 51 COMMUNITY BENEFITS	858, 818	4, 483	l	8, 311		194. 00 194. 01
-	l e e e e e e e e e e e e e e e e e e e	686, 900	17, 842	0	33, 080		194.01
194. 02 079	52 OTHER NON-REIMBURSABLE	103, 146	0	0	0		194. 02
	54 BATESVILLE TOOL & DIE CLINIC	76, 875	0		٥		194.03
	55 MMHCB RHC	116, 556	0	2, 581	n		194. 04
200.00	Cross Foot Adjustments	110,000	O	2,001	Ĭ	1, 104	200.00
201.00	Negative Cost Centers		0	o	o	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	97, 093, 916	2, 385, 473	832, 756	4, 422, 766		
"	•		-	. "			

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

| Peri od: | Worksheet B | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-1329

				1	0 12/31/2018	2/13/2020 2:3	
	Cost Center Description	EMPLOYEE BENEFITS	Subtotal	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT	O piii
		DEPARTMENT				-OFFSITE	
	I	4. 00	4A	5. 00	7. 00	7. 01	
1 00	GENERAL SERVICE COST CENTERS			1			1 00
1. 00 1. 01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-OFFSITE BLDG						1. 00 1. 01
2. 00	00200 NEW CAP REL COSTS-OFFSITE BLDG						2.00
2. 00	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	13, 049, 687					4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 819, 168	15, 893, 000	15, 893, 000			5. 00
7. 00	00700 OPERATION OF PLANT	0	2, 554, 630		3, 054, 632		7.00
7. 01	00701 OPERATION OF PLANT -OFFSITE	0	287, 365				7. 01
7.02	00702 OPERATION OF PLANT - HOSPITAL & OFFS	147, 420	695, 099	136, 048	0	0	7. 02
8. 00	00800 LAUNDRY & LINEN SERVICE	26, 898	253, 678	49, 651	50, 316	0	8. 00
9.00	00900 HOUSEKEEPI NG	282, 728	1, 726, 052			0	9. 00
10.00	01000 DI ETARY	26, 836	196, 053				10.00
11. 00	01100 CAFETERI A	212, 087	1, 303, 709		150, 501	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	155, 870	728, 811				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	212 225	26, 952				14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	212, 235 412, 137	4, 605, 729 2, 328, 666			0	15. 00 16. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	412, 137	2, 320, 000	455,770	01,021	0	10.00
30. 00	03000 ADULTS & PEDIATRICS	961, 586	4, 136, 771	809, 665	399, 788	0	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	84, 606	454, 534				31.00
43. 00	04300 NURSERY	174, 120	909, 884				43.00
	ANCILLARY SERVICE COST CENTERS		·		·		
50.00	05000 OPERATING ROOM	416, 123	2, 492, 208	487, 785	132, 161	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	39, 911	238, 345			0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	825, 898	11, 070, 068			0	54.00
60. 00	06000 LABORATORY	451, 443	4, 473, 710			0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	1	_	0	60. 01
65.00	06500 RESPI RATORY THERAPY	157, 965	982, 626				65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY	317, 449	1, 727, 044		156, 017	0	66. 00 67. 00
68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	103, 609 56, 470	529, 037 306, 840			0	68.00
69. 00	06900 ELECTROCARDI OLOGY	187, 081	1, 074, 192			0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 428, 834			_	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 129, 289			Ö	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			0	73.00
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		•			
88. 00	08800 RURAL HEALTH CLINIC	303, 005	1, 569, 268	307, 143	0		88. 00
90.00	09000 CLI NI C	451, 424	2, 358, 517				90.00
90. 01	09001 WOUND CLINC	91, 680	457, 463				90. 01
91. 00	09100 EMERGENCY	629, 071	3, 747, 654		256, 706	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0)			92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	486, 803	2, 554, 926	500, 060	95, 621	040	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	400, 003	2, 334, 920	300,000	75, 021	700	101.00
113.00	11300 I NTEREST EXPENSE						113. 00
	11600 H0SPI CE	216, 137	1, 367, 683	267, 688	0		116. 00
118.00		9, 249, 760	75, 608, 637			32, 694	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	2, 922, 386	16, 083, 733			•	
	19201 PEDI ATRI CS	181, 884	950, 377	•			192. 01
	19202 BROOKVI LLE	339, 359	1, 842, 807				
	19203 RADI OLOGY - OSGOOD	25, 842	123, 782		0		192. 03
	19204 ENT	64, 490	308, 918				192.04
	07950 COMMUNITY RELATIONS	69, 511	941, 123				194.00
	07951 COMMUNITY BENEFITS 07952 OTHER NON-REIMBURSABLE	132, 034	869, 856 0	1	33, 768 0		194. 01 194. 02
	07952 OTHER NON-RETWINDURSABLE	13, 306	116, 452	1			194. 02
	07954 BATESVILLE TOOL & DIE CLINIC	19, 916	96, 791				194. 03
	07955 MMHCB RHC	31, 199	151, 440				194. 05
200.00	1 1	3.,.,,	0		Ŭ		200.00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	13, 049, 687	97, 093, 916	15, 893, 000	3, 054, 632	343, 609	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 Peri od: Worksheet B
From 01/01/2018 Part I
To 12/21/2019 Pate/Time Pr Provider CCN: 15-1329

				To	12/31/2018	Date/Time Pre	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	2/13/2020 2: 3 CAFETERI A	8 piii
		PLANT -	LINEN SERVICE				
		HOSPITAL & OFFS					
		7. 02	8. 00	9. 00	10.00	11. 00	
1 00	GENERAL SERVICE COST CENTERS	T	I				1 1 00
1. 00 1. 01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-OFFSITE BLDG						1. 00 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 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
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	831, 147					7. 02
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	8, 909 10, 158					8. 00 9. 00
10.00	01000 DI ETARY	3, 446		13, 202	270, 837		10.00
11. 00	01100 CAFETERI A	26, 648	2, 351	102, 103	0	1, 840, 479	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	302		1, 159	0	45, 290	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	3, 753 4, 179	•	14, 380 16, 013	0	0 53, 299	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	14, 452	l e	55, 373	0	141, 184	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	70, 786				322, 040	30.00
31. 00 43. 00	O3100 NTENSI VE CARE UNIT O4300 NURSERY	6, 886 3, 654		26, 385 14, 000	14, 481 0	31, 965 64, 977	31. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS	3,034	10, 737	14,000	<u> </u>	04, 777	73.00
50.00	05000 OPERATING ROOM	23, 400		89, 660	0	167, 459	50.00
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM	5, 865			0	11, 678	52.00
60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	94, 856 17, 253		363, 446 66, 105	0	150, 691 208, 108	54. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0		0	o	0	60. 01
65.00	06500 RESPIRATORY THERAPY	13, 192			0	54, 198	65. 00
66.00	06600 PHYSI CAL THERAPY	27, 624			0	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	5, 796 5, 295		22, 206 20, 288	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	11, 948			o	69, 694	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	14, 576		55, 848 0	0	0	72. 00 73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	0	0	<u> </u>	υĮ	0	73.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
90.00	09000 CLI NI C	79, 943	•	266, 283	0	0	90.00
90. 01 91. 00	O9001 WOUND CLINC O9100 EMERGENCY	3, 346 45, 452		12, 822 174, 154	0	0 237, 153	90. 01 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	45, 452	22, 673	174, 134	O ₁	237, 133	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	18, 016	0	69, 031	0	0	101. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	0	0	0	0	116.00
118. 00		519, 735	351, 448	1, 878, 325	270, 837	1, 557, 736	118. 00
100.00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES	224 077	11 104	272 025	ما	1/2 0/0	102.00
	19200 PHYSICIANS PRIVATE OFFICES	226, 977 9, 266		273, 825 35, 503	0	162, 968 41, 921	
192. 02	19202 BR00KVI LLE	66, 493			Ö		192. 02
	19203 RADI OLOGY - OSGOOD	0	1	0	0		192. 03
	19204 ENT 07950 COMMUNITY RELATIONS	0 1, 502	,	0 5, 756	0	0 22, 383	192.04
	07951 COMMUNITY BENEFITS	5, 979		22, 909	0	48, 359	
194. 02	07952 OTHER NON-REIMBURSABLE	0		0	ō	0	194. 02
	07953 EMS	0	0	0	0		194.03
	07954 BATESVILLE TOOL & DIE CLINIC 07955 MMHCB RHC	1, 195	0	0	0		194. 04 194. 05
200.00	1	1, 175			٩	O	200.00
201.00	Negative Cost Centers	0	_	0	О		201. 00
202.00	TOTAL (sum lines 118 through 201)	831, 147	362, 554	2, 216, 318	270, 837	1, 840, 479	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-1329

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Ti me Prepared: 2/13/2020 2:38 pm

			"	12/31/2010	2/13/2020 2: 3	
Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	р
	13. 00	14. 00	15. 00	16. 00	24. 00	
GENERAL SERVICE COST CENTERS						
1. 00						1. 00 1. 01 2. 00 2. 01 4. 00 5. 00 7. 00
7. 01 00701 OPERATION OF PLANT -OFFSITE 7. 02 00702 OPERATION OF PLANT - HOSPITAL & OFFS 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01100 DI ETARY 11. 00 01100 CAFETERIA	010 014					7. 01 7. 02 8. 00 9. 00 10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	919, 916 0 41, 258	75, 205 0	5, 645, 534	0 077 070		13. 00 14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	3, 077, 072		16.00
30. 00 03000 ADULTS & PEDIATRICS	249, 283	o	0	2, 024, 389	8, 598, 303	30.00
31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY	24, 755 50, 303	0	0	0	689, 249 1, 258, 297	31. 00 43. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	O	ol	O	226, 732	3, 648, 172	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	9, 045	ol	0	220, 732	369, 551	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	116, 669	o	0	412, 975	14, 955, 049	
60. 00 06000 LABORATORY	161, 086	0	0	0	5, 899, 315	60.00
60. 01 06001 BL00D LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	41, 968	0	0	0	1, 413, 539	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	2, 384, 780	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	693, 316	
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	422, 383	
69. 00 06900 ELECTROCARDI OLOGY	36, 477	75 005	0	24, 293	1, 543, 436	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	75, 205	0	0	4, 175, 144	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1, 520, 666	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	5, 645, 534	O _I	5, 645, 534	73.00
OUTPATIENT SERVICE COST CENTERS		ما		ما	1 000 007	00.00
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC	0	0	0	112 244	1, 898, 827	88.00
90. 00 09000 CLI NI C 90. 01 09001 WOUND CLI NC	0	0	0	113, 366	3, 706, 936	1
91. 00 09100 EMERGENCY	183, 573	0	0	251, 024	586, 488 5, 652, 097	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	103, 373	o _l	U	231, 024	5, 052, 047	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
101. 00 10100 HOME HEALTH AGENCY	O	0	0	0	3, 238, 622	101.00
SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	- 1	- 1	- "	.,,	
113. 00 11300 NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	o	0	0	O	1, 635, 371	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	914, 417	75, 205	5, 645, 534	3, 052, 779	69, 935, 075	
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	24, 293	20, 269, 890	
192. 01 19201 PEDI ATRI CS	0	0	0	0	1, 275, 411	
192. 02 19202 BROOKVI LLE	0	0	0	0	2, 329, 244	
192. 03 19203 RADI OLOGY - OSGOOD	0	0	0	0	149, 414	
192. 04 19204 ENT	0	0	0	0	369, 381	
194.00 07950 COMMUNITY RELATIONS	0	0	0	0	1, 163, 448	
194. 01 07951 COMMUNITY BENEFITS	0	0	0	O	1, 151, 123	194.01
194. 02 07952 0THER NON-REIMBURSABLE 194. 03 07953 EMS	5, 499	o o	0	0	151, 855	1
194. 04 07954 BATESVILLE TOOL & DIE CLINIC	5, 499	0	0	0	115, 735	
194. 05 07955 MMHCB RHC		0	0	0	183, 340	
200.00 Cross Foot Adjustments		٩	J	٩		200.00
201.00 Negative Cost Centers	ol	o	0	ol		201.00
202.00 TOTAL (sum lines 118 through 201)	919, 916	75, 205	5, 645, 534	3, 077, 072	97, 093, 916	
			- 1			•

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1329 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 2/13/2020 2:38 pm Cost Center Description Intern & Total 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 00101 NEW CAP REL COSTS-OFFSITE BLDG 1.01 1 01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 7.01 00701 OPERATION OF PLANT -OFFSITE 7.01 00702 OPERATION OF PLANT - HOSPITAL & OFFS 7 02 7.02 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13.00 | 01300 | NURSI NG ADMI NI STRATI ON 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 8, 598, 303 30.00 03100 INTENSIVE CARE UNIT 31.00 0 689, 249 31.00 43.00 04300 NURSERY 0 1, 258, 297 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 3 648 172 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 369, 551 52.00 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 14, 955, 049 54.00 06000 LABORATORY 60.00 00000000 5, 899, 315 60.00 06001 BLOOD LABORATORY 60 01 60 01 06500 RESPIRATORY THERAPY 65.00 1, 413, 539 65.00 06600 PHYSI CAL THERAPY 2, 384, 780 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 693, 316 67.00 68.00 06800 SPEECH PATHOLOGY 422, 383 68 00 69.00 06900 ELECTROCARDI OLOGY 1, 543, 436 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 175, 144 71.00 71.00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 1, 520, 666 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 5, 645, 534 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 1, 898, 827 88.00 09000 CLI NI C 0 3, 706, 936 90.00 90.00 09001 WOUND CLINC 90.01 586, 488 90.01 91.00 09100 EMERGENCY 0 5, 652, 097 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 3, 238, 622 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 1,635,371 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 69, 935, 075 118.00 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192.00 20, 269, 890 0 192. 01 19201 PEDI ATRI CS 0 1, 275, 411 192.01 192. 02 19202 BROOKVI LLE 2, 329, 244 192.02 0000000000 192. 03 19203 RADI OLOGY - OSGOOD 149, 414 192.03 192. 04 19204 ENT 192. 04 369, 381 194. 00 07950 COMMUNITY RELATIONS 1, 163, 448 194.00 194. 01 07951 COMMUNITY BENEFITS 194.01 1, 151, 123 194. 02 07952 OTHER NON-REIMBURSABLE 194.02 0 194, 03 07953 FMS 194. 03 151, 855 194. 04 07954 BATESVILLE TOOL & DIE CLINIC 115, 735 194.04 194. 05 07955 MMHCB RHC 194. 05 183, 340 Cross Foot Adjustments 200 00 200.00 0 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 97, 093, 916 202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | 2/13/2020 2:38 pm

				CAPITAL REL	ATED COSTS	2/13/2020 2: 3	8 pm
	Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUI P	NEW MVBLE EQUIP OFFSIT	
		0	1. 00	1. 01	2. 00	2. 01	
1. 00 00100 1. 01 00101 2. 00 00200 2. 01 00201 4. 00 00400	AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-OFFSITE BLDG NEW CAP REL COSTS-MVBLE EQUIP NEW CAP REL COSTS-MVBLE EQUIP OFFSIT EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	0	10, 016 365, 729		18, 570 678, 077	0	1. 00 1. 01 2. 00 2. 01 4. 00 5. 00
7. 01 00701 7. 02 00702 8. 00 00800 9. 00 00900 10. 00 01000 11. 00 01100	OPERATION OF PLANT OPERATION OF PLANT -OFFSITE OPERATION OF PLANT - HOSPITAL & OFFS LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	395, 778 0 0 26, 585 30, 313 10, 282 79, 519	0 0 0 0 0	733, 787 0 0 49, 290 56, 202 19, 063 147, 432	0 0 0 0 0 0	7. 01 7. 02 8. 00 9. 00 10. 00 11. 00
14. 00 01400 15. 00 01500 16. 00 01600	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY IENT ROUTINE SERVICE COST CENTERS	0 0	902 11, 199 12, 472 43, 125	0	1, 673 20, 764 23, 123 79, 956	0 0	15. 00
30. 00 03000 31. 00 03100 43. 00 04300	ADULTS & PEDIATRICS INTENSIVE CARE UNIT NURSERY LARY SERVICE COST CENTERS	0 0 0	211, 233 20, 549 10, 903	0	391, 634 38, 099 20, 215	0 0 0	31.00
50. 00 05000 52. 00 05200 54. 00 05400 60. 01 06001 65. 00 06500 66. 00 06600 67. 00 06700 68. 00 06800 69. 00 06900 71. 00 07100	OPERATI NG ROOM DELI VERY ROOM & LABOR ROOM RADI OLOGY-DI AGNOSTI C LABORATORY BLOOD LABORATORY RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY ELECTROCARDI OLOGY MEDI CAL SUPPLIES CHARGED TO PATIENTS	0 0 0 0 0 0 0 0	69, 829 17, 502 283, 059 51, 484 0 39, 368 82, 434 17, 295 15, 800 35, 654	0 0 0 0 0 0 0 0	129, 466 32, 449 524, 803 95, 454 0 72, 989 152, 835 32, 065 29, 294 66, 104	0 0 0 0 0 0 0 0	52. 00 54. 00 60. 00 60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00
73. 00 07300 OUTPA	IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0 0	43, 495	0	80, 642	23, 232	1
90. 01 09001 91. 00 09100 92. 00 <u>09200</u>	CLINIC WOUND CLINC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS	0 0	207, 386 9, 986 135, 634	0	384, 502 18, 515 251, 471	9, 649 0 0	90. 01
101. 00 10100	HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	50, 522	2, 345	93, 671	1, 003	101.00
113. 00 11300 116. 00 11600 118. 00	INTEREST EXPENSE	0	0 2, 288, 053	0 79, 234	0 4, 242, 145		113. 00 116. 00 118. 00
192. 01 19201 192. 02 19202 192. 03 19203 192. 04 19204 194. 00 07950 194. 01 07951 194. 02 07952 194. 03 07953	BROOKVILLE RADIOLOGY - OSGOOD ENT COMMUNITY RELATIONS COMMUNITY BENEFITS OTHER NON-REIMBURSABLE EMS BATESVILLE TOOL & DIE CLINIC	0 0 0 0 0 0 0 0	47, 445 27, 650 0 0 0 4, 483 17, 842 0 0	0 143, 626 3, 405 0 0	87, 965 51, 265 0 0 0 8, 311 33, 080 0 0	61, 422 1, 456 0 0 0 0 0	192. 00 192. 01 192. 02 192. 03 192. 04 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 200. 00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0	0 2, 385, 473	0 832, 756	0 4, 422, 766		201.00

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1329 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 2/13/2020 2:38 pm Cost Center Description Subtotal **EMPLOYEE** ADMINISTRATIV OPERATION OF OPERATION OF **BENEFITS** PLANT E & GENERAL **PLANT** DEPARTMENT -OFFSITE 2A 5.00 7. 00 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 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 28, 586 28, 586 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 1,043,806 3, 984 1, 047, 790 5.00 00700 OPERATION OF PLANT 7.00 1, 129, 565 32, 965 1, 162, 530 7 00 C 00701 OPERATION OF PLANT -OFFSITE 7.01 3,708 3,708 7.01 7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS 0 323 8,970 0 7.02 00800 LAUNDRY & LINEN SERVICE 75.875 59 3.273 19.149 8.00 8.00 0 00900 HOUSEKEEPI NG 9 00 86, 515 619 22.273 21, 835 0 9 00 10.00 01000 DI ETARY 29, 345 59 2,530 7, 406 0 10.00 11.00 01100 CAFETERI A 226, 951 464 16, 823 57, 278 0 11.00 01300 NURSING ADMINISTRATION 9, 405 13.00 650 2.575 0 13.00 341 14.00 01400 CENTRAL SERVICES & SUPPLY 31, 963 348 8,067 0 14.00 01500 PHARMACY 59, 432 15.00 15 00 35, 595 465 8, 983 0 01600 MEDICAL RECORDS & LIBRARY
INPATIENT ROUTINE SERVICE COST CENTERS 123, 081 16.00 903 30, 049 31, 063 0 16.00 30.00 03000 ADULTS & PEDIATRICS 602, 867 152, 151 30.00 2, 106 53, 381 0 03100 INTENSIVE CARE UNIT 31.00 58, 648 185 5, 865 14, 802 0 31.00 04300 NURSERY 31, 118 11,741 7,854 43.00 381 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 199, 295 911 32, 159 50, 298 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 49, 951 87 3,076 12,606 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 203, 887 54 00 807.862 1 809 142, 848 0 54 00 60.00 06000 LABORATORY 146, 938 989 57, 729 37,084 0 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 65.00 06500 RESPIRATORY THERAPY 112.357 12.680 28. 356 0 65.00 346 06600 PHYSI CAL THERAPY 59, 377 66.00 235, 269 695 22, 286 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 49, 360 227 6,827 12, 457 0 67.00 06800 SPEECH PATHOLOGY 3, 959 68.00 45,094 124 11, 381 0 68.00 69 00 06900 ELECTROCARDI OLOGY 101, 758 410 13, 861 25, 682 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 C 44, 246 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 124, 137 0 14, 572 31, 330 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 77, 558 664 20, 250 242 09000 CLI NI C 989 149, 380 100 90.00 90.00 624, 100 30, 434 90.01 09001 WOUND CLINC 28, 501 201 5. 903 7, 193 Ω 90.01 09100 EMERGENCY 91.00 387, 105 1, 378 48, 360 97,697 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 147, 541 1, 066 32, 969 36, 391 10 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 473 17, 649 0 116.00 0 0 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 6, 643, 316 20, 258 770, 571 1, 092, 357 352 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 997, 584 207. 517 2, 690 192. 00 6, 407 34, 175 0 192.01 192. 01 19201 PEDI ATRI CS 78, 915 19, 917 398 12, 264 192. 02 19202 BROOKVI LLE 640 192.02 205, 048 743 23.780 0 192. 03 19203 RADI OLOGY - OSGOOD 4, 861 57 1, 597 0 15 192.03 192. 04 19204 ENT 0 141 3, 986 0 0 192.04 194. 00 07950 COMMUNITY RELATIONS 0 194.00 12.794 12.144 3, 229 152 194. 01 07951 COMMUNITY BENEFITS 50, 922 289 11, 225 12, 852 0 194 01 194. 02 07952 OTHER NON-REIMBURSABLE 0 194. 02 0 0 194. 03 07953 EMS 0 194.03 0 29 1,503 0

0

3,685

7, 997, 125

1, 249

1, 954

1, 047, 790

0

0

1, 162, 530

0 194, 04

11 194. 05

200.00

0 201.00

3, 708 202. 00

44

68

C

28, 586

194. 05 07955 MMHCB RHC

200.00

201.00

202.00

194. 04 07954 BATESVILLE TOOL & DIE CLINIC

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1329 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 2/13/2020 2:38 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A PLANT -LINEN SERVICE HOSPITAL & **OFFS** 8.00 9.00 10.00 11.00 7.02 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 1 01 00101 NEW CAP REL COSTS-OFFSITE BLDG 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 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5 00 00700 OPERATION OF PLANT 7.00 7.00 7.01 00701 OPERATION OF PLANT -OFFSITE 7.01 00702 OPERATION OF PLANT - HOSPITAL & OFFS 7.02 9. 293 7.02 00800 LAUNDRY & LINEN SERVICE 98, 456 8.00 100 8.00 9.00 00900 HOUSEKEEPI NG 114 23,060 154, 416 9.00 10.00 01000 DI ETARY 39 82 920 40, 381 10.00 01100 CAFETERI A 298 7, 114 11.00 638 309, 566 11.00 0 01300 NURSING ADMINISTRATION 13.00 3 r 81 0 7, 618 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 991 14.00 42 1.002 0 0 15.00 01500 PHARMACY 47 0 8, 965 15.00 C 1, 116 01600 MEDICAL RECORDS & LIBRARY 16.00 162 3,858 23, 747 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 15, 751 18. 897 38, 222 54, 168 30.00 03100 INTENSIVE CARE UNIT 1,838 5, 376 31.00 77 2.159 31.00 648 04300 NURSERY 43.00 41 4,550 975 10, 929 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 262 7, 812 6, 247 28, 166 50.00 o 1, 964 52.00 05200 DELIVERY ROOM & LABOR ROOM 1 566 52 00 66 644 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 1,061 11, 931 25, 320 25, 346 54.00 60.00 06000 LABORATORY 193 0 35,003 60.00 4,606 06001 BLOOD LABORATORY 60.01 0 0 60.01 0 C 0 0 06500 RESPIRATORY THERAPY 9, 116 65.00 148 1, 134 3,522 65.00 66.00 06600 PHYSI CAL THERAPY 309 8, 208 7,374 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 65 C 1,547 0 0 0 67.00 68 00 06800 SPEECH PATHOLOGY 59 1 413 68 00 C 0 06900 ELECTROCARDI OLOGY 69.00 134 903 3, 190 11, 722 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 4, 780 ol 163 3,891 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 Ω 0 73.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 90.00 09000 CLI NI C 894 6,895 18, 553 0 0 90.00 09001 WOUND CLINC 90 01 0 90 01 37 1. 201 893 0 91.00 09100 EMERGENCY 508 6, 212 12, 134 0 39,889 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 4, 810 101.00 10100 HOME HEALTH AGENCY 201 0 0 0 101, 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 0 116.00 0 0 SUBTOTALS (SUM_OF_LINES_1 through 117) 5, 814 95, 440 130, 867 40, 381 262, 009 118. 00 118.00 NONREIMBURSABLE COST CENTERS 27, 411 192. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 2, 535 3, 016 19, 078 7, 051 192. 01 192. 01 19201 PEDI ATRI CS 0 104 C 2,474 0 192.02 192. 02 19202 BROOKVI LLE 743 C 0 192. 03 19203 RADI OLOGY - OSGOOD 0 0 0 0 0 192.03 192. 04 19204 ENT 0 0 192.04 0 0 0 194. 00 07950 COMMUNITY RELATIONS 17 0 401 0 3, 765 194.00 194. 01 07951 COMMUNITY BENEFITS 1, 596 0 8, 134 194. 01 67 194. 02 07952 OTHER NON-REIMBURSABLE 0 0 194. 02 0 0 0 194. 03 07953 EMS 1, 196 194. 03 0 0 0 0 194. 04 07954 BATESVILLE TOOL & DIE CLINIC 0 C 0 0 0 194.04 0 194.05 194. 05 07955 MMHCB RHC 13 0 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 0 201, 00 201.00

9.293

98, 456

154, 416

40, 381

309, 566 202. 00

TOTAL (sum lines 118 through 201)

202.00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1329

				To	12/31/2018	Date/Time Pre 2/13/2020 2:3	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal) piii
		ADMI NI STRATI O	SERVICES &		RECORDS &		
		N 13. 00	14. 00	15. 00	16. 00	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01 2. 00	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. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5. 00 7. 00
7. 00 7. 01	00700 OPERATION OF PLANT -OFFSITE						7.00
7. 02	00702 OPERATION OF PLANT - HOSPITAL & OFFS						7. 02
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION	20, 673					13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	39, 764				14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	927	0		212, 863		15. 00 16. 00
16.00	INPATIENT ROUTINE SERVICE COST CENTERS	l o	0	<u> </u>	212, 003		10.00
30.00	03000 ADULTS & PEDIATRICS	5, 603	0	0	140, 043	1, 083, 980	30.00
31. 00	03100 INTENSIVE CARE UNIT	556	0		0	90, 154	1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 130	0	0	0	68, 719	43.00
50.00	05000 OPERATING ROOM	l ol	0	0	15, 685	340, 835	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	203	0	0	0	70, 163	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 622	0	0	28, 568	1, 251, 254	1
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	3, 620	0	0	0	286, 162 0	1
65. 00	06500 RESPIRATORY THERAPY	943	0	0	0	168, 602	1
66.00	06600 PHYSI CAL THERAPY	0	0	0	0	333, 518	1
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	70, 483	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	820	0	0	0 1, 680	62, 030 160, 160	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39, 764		0	84, 010	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	o	0		0	178, 873	1
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	115, 530	0	115, 530	73. 00
88. 00		O	0	0	O	98, 714	88. 00
90.00	09000 CLINIC	O	0		7, 842	839, 187	1
90. 01	09001 WOUND CLINC	0	0	I "I	0	43, 929	1
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 125	0	0	17, 365	614, 773	1
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	222, 988	101.00
	SPECIAL PURPOSE COST CENTERS	1					
) 11300 NTEREST EXPENSE) 11600 HOSPI CE		0	0	0	10 122	113. 00 116. 00
118. 0	1	20, 549	0 39, 764		211, 183		
	NONREI MBURSABLE COST CENTERS				,		
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		1, 680	1, 302, 093	192.00
	19201 PEDI ATRI CS 2 19202 BROOKVI LLE	0	0		0	121, 123 230, 954	
	3 19203 RADI OLOGY - OSGOOD	0	0		0		192.03
192.0	1 19204 ENT	0	0		o	4, 127	192. 04
	07950 COMMUNITY RELATIONS	0	0		0		194.00
	I O7951 COMMUNITY BENEFITS 2 O7952 OTHER NON-REIMBURSABLE		0	0	0		194. 01 194. 02
	307953 EMS	124	0		ő		194. 03
	107954 BATESVILLE TOOL & DIE CLINIC	0	0		0	•	194. 04
	507955 MMHCB RHC	0	0	0	0		194. 05
200. 00 201. 00		0	2, 649	0	0		200. 00 201. 00
202. 00		20, 673	42, 413		212, 863		

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1329 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 2/13/2020 2:38 pm Cost Center Description Intern & Total 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 00101 NEW CAP REL COSTS-OFFSITE BLDG 1.01 1 01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 7.01 00701 OPERATION OF PLANT -OFFSITE 7.01 00702 OPERATION OF PLANT - HOSPITAL & OFFS 7 02 7.02 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13.00 | 01300 | NURSI NG ADMI NI STRATI ON 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 083, 980 30.00 03100 INTENSIVE CARE UNIT 31.00 0 90, 154 31.00 43.00 04300 NURSERY 0 68, 719 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 340, 835 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 70, 163 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 251, 254 54.00 06000 LABORATORY 60.00 00000000 286, 162 60.00 06001 BLOOD LABORATORY 60 01 60 01 0 06500 RESPIRATORY THERAPY 65.00 168, 602 65.00 06600 PHYSI CAL THERAPY 333, 518 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 70, 483 67.00 68.00 06800 SPEECH PATHOLOGY 62, 030 68 00 69.00 06900 ELECTROCARDI OLOGY 160, 160 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 84,010 71.00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 178.873 72.00 07300 DRUGS CHARGED TO PATIENTS 115, 530 73.00 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 98, 714 88.00 09000 CLI NI C 0 90.00 839. 187 90.00 09001 WOUND CLINC 90.01 43, 929 90.01 91.00 09100 EMERGENCY 0 614, 773 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 222, 988 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 0 18, 122 116. 00 11600 HOSPI CE 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 202, 186 118.00 118.00 0 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192.00 00 1, 302, 093 192. 01 19201 PEDI ATRI CS 121, 123 192.01 192. 02 19202 BROOKVI LLE 230, 954 192.02 00000000000 192. 03 19203 RADI OLOGY - OSGOOD 6, 530 192.03 192. 04 19204 ENT 192. 04 4, 127 194. 00 07950 COMMUNITY RELATIONS 32, 502 194.00 194. 01 07951 COMMUNITY BENEFITS 194.01 85,085 194. 02 07952 OTHER NON-REIMBURSABLE 0 194. 02 194, 03 07953 FMS 2,852 194. 03 194. 04 07954 BATESVILLE TOOL & DIE CLINIC 1, 293 194.04 194. 05 07955 MMHCB RHC 194. 05 5, 731 Cross Foot Adjustments 200 00 200.00 0 201.00 Negative Cost Centers 2,649 201.00 202.00 TOTAL (sum lines 118 through 201) 7, 997, 125 202.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-1329

			T	o 12/31/2018	Date/Time Pre 2/13/2020 2:3	
		CAPI TAL REI	LATED COSTS		127 107 2020 210	ļ
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	
	1. 00	1. 01	2.00	2. 01	SALARI ES) 4. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT O0101 NEW CAP REL COSTS-OFFSITE BLDG 2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP O0201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT	161, 243 0	77, 764	161, 243 0	77, 764 O	47, 003, 220	1. 00 1. 01 2. 00 2. 01 4. 00
5.00	24, 721 26, 752 0	0 0	24, 721 26, 752 0 0	0	6, 552, 397 0 0 530, 986	5. 00 7. 00 7. 01
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	1, 797 2, 049 695 5, 375	0 0 0 0	1, 797 2, 049 695 5, 375	0 0 0	96, 884 1, 018, 349 96, 661 763, 909	9. 00 10. 00
13. 00	61 757 843 2, 915	0 0 0 0	843	0 0 0 0	561, 423 0 764, 443 1, 484, 462	14. 00 15. 00
INPATIENT ROUTINE SERVICE COST CENTERS	14, 278 1, 389 737	0	1, 389	0 0 0	3, 463, 502 304, 739 627, 158	31.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	4, 720	0	4, 720	0	1, 498, 820	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06001 BLOOD LABORATORY	1, 183 19, 133 3, 480	0	19, 133 3, 480	0	143, 755 2, 974, 774 1, 626, 035 0	54.00
65. 00 06500 RESPI RATORY THERAPY 066. 00 06600 PHYSI CAL THERAPY 067. 00 06700 0CCUPATI ONAL THERAPY 068. 00 06800 SPEECH PATHOLOGY	2, 661 5, 572 1, 169 1, 068	0	2, 661 5, 572 1, 169 1, 068	0 0 0	568, 968 1, 143, 408 373, 187 203, 397	65. 00 66. 00 67. 00
69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENTS 74.00 07300 DRUGS CHARGED TO PATI ENTS 75.00 07300	2, 410 0 2, 940	0	2, 410 0 2, 940	0 0 0	673, 842 0 0	69. 00 71. 00 72. 00
OUTPATIENT SERVICE COST CENTERS	0	E 072	0	E 072	1 001 202	00.00
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC 90. 01 09001 WOUND CLINC 91. 00 09100 EMERGENCY 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)	14, 018 675 9, 168	2, 107	14, 018 675	2, 107 0	1, 091, 383 1, 625, 969 330, 219 2, 265, 827	90. 00 90. 01
OTHER REIMBURSABLE COST CENTERS						1
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	3, 415	219	3, 415	219	1, 753, 398	1101.00
113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 154, 658				778, 497 33, 316, 392	
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 PEDI ATRI CS 192. 02 19202 BROOKVI LLE	3, 207 1, 869 0	0	1, 869	0	10, 526, 041 655, 122 1, 222, 324	192. 01
192. 03 19203 RADI OLOGY - OSGOOD 192. 04 19204 ENT 194. 00 07950 COMMUNI TY RELATI ONS 194. 01 07951 COMMUNI TY BENEFI TS	0 0 303 1, 206	ł	0		93, 079 232, 285 250, 369 475, 570	194. 00
194.02 07952 OTHER NON-REIMBURSABLE 194.03 07953 EMS 194.04 07954 BATESVILLE TOOL & DIE CLINIC	0 0	0 0	0 0 0	0 0 0	0 47, 928 71, 736	194. 02 194. 03 194. 04
194.05 07955 MMHCB RHC 200.00 Cross Foot Adjustments Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B,	2, 385, 473	241 832, 756	0 4, 422, 766	241 356, 130	112, 374 13, 049, 687	200. 00 201. 00
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	14. 794273				0. 277634	
Part II) Unit cost multiplier (Wkst. B, Part					0. 000608	205. 00
11)	İ		l			<u> </u>

Health Financial Systems MAI	RGARET MARY COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1		
				From 01/01/2018 To 12/31/2018	Date/Time Pre 2/13/2020 2:3		
		CAPITAL REL	_ATED COSTS				
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)		
	1. 00	1. 01	2. 00	2. 01	4. 00		
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1329 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 2/13/2020 2:38 pm 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 5.00 00500 ADMINISTRATIVE & GENERAL -15, 893, 000 81, 200, 916 5.00 7.00 00700 OPERATION OF PLANT 2, 554, 630 109, 093 7.00 00701 OPERATION OF PLANT -OFFSITE 287, 365 0 77, 764 7.01 7 01 \cap 00702 OPERATION OF PLANT - HOSPITAL & OFFS 7.02 0 695, 099 0 167, 648 7.02 8.00 00800 LAUNDRY & LINEN SERVICE 0 253, 678 1.797 0 1, 797 8.00 00900 HOUSEKEEPI NG 0 0 1, 726, 052 0 2,049 9.00 9.00 2.049 01000 DI ETARY 10.00 196, 053 695 0 695 10.00 11.00 01100 CAFETERI A 1, 303, 709 5, 375 0 5, 375 11.00 13.00 01300 NURSING ADMINISTRATION o 0 0 728, 811 61 61 13.00 o 01400 CENTRAL SERVICES & SUPPLY 757 14 00 26, 952 757 14 00 15.00 01500 PHARMACY 4, 605, 729 843 0 843 15.00 01600 MEDICAL RECORDS & LIBRARY 2, 328, 666 2, 915 0 2, 915 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 0 4, 136, 771 14 278 0 14 278 30.00 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 31.00 0 454, 534 1, 389 0 1, 389 31.00 04300 NURSERY 0 0 43.00 909.884 737 737 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 2, 492, 208 4.720 4.720 50 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 238, 345 1, 183 0 1, 183 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 11, 070, 068 0 54.00 19, 133 19, 133 54.00 0 06000 LABORATORY 0000000 60.00 4, 473, 710 3, 480 3, 480 60.00 06001 BLOOD LABORATORY 60.01 0 0 60.01 982, 626 65.00 06500 RESPIRATORY THERAPY 2, 661 0 2, 661 65.00 0 1, 727, 044 5, 572 66.00 06600 PHYSI CAL THERAPY 5, 572 66.00 06700 OCCUPATI ONAL THERAPY 529, 037 67 00 67.00 1, 169 1, 169 0 68.00 06800 SPEECH PATHOLOGY 306, 840 1,068 1,068 68.00 06900 ELECTROCARDI OLOGY 0 69.00 1,074,192 2,410 2,410 69.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 428, 834 71.00 0 0 07200 IMPL. DEV. CHARGED TO PATIENT 2,940 72 00 1, 129, 289 2.940 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 0 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 1, 569, 268 88.00 5.073 0 88.00 90.00 09000 CLI NI C 2, 358, 517 14.018 2.107 16, 125 90 00 90.01 09001 WOUND CLINC 0 457, 463 675 0 675 90.01 91.00 09100 EMERGENCY 3, 747, 654 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, 554, 926 3, 415 219 3, 634 101. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 367, 683 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) -15, 893, 000 104, 834 118. 00 118.00 59, 715, 637 102, 508 7, 399 NONREI MBURSABLE COST CENTERS 45, 783 192. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 16, 083, 733 3, 207 56, 394 192. 01 19201 PEDI ATRI CS 0 950, 377 1,869 1, 869 192. 01 13, 412 192. 02 192. 02 19202 BROOKVI LLE 0 0 1, 842, 807 13, 412 0 0 192.03 192. 03 19203 RADI OLOGY - OSGOOD 123, 782 0 318 192. 04 19204 ENT 308, 918 0 0 0 192.04 194.00 07950 COMMUNITY RELATIONS 0 0 0 303 194.00 941, 123 303 0 194. 01 07951 COMMUNITY BENEFITS 869, 856 ol 1, 206 194, 01 1, 206 194. 02 07952 OTHER NON-REI MBURSABLE 0 194.02 0 0 194. 03 07953 EMS 116, 452 0 0 0 194.03 194. 04 07954 BATESVILLE TOOL & DIE CLINIC 0 96, 791 0 0 0 194.04 194. 05 07955 MMHCB RHC 151, 440 0 241 241 194 05 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 15, 893, 000 3, 054, 632 343, 609 831, 147 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.195724 28.000257 4. 418613 4. 957691 203. 00 Cost to be allocated (per Wkst. B, 1,047,790 9, 293 204. 00 204.00 1, 162, 530 3, 708 Part II) 205.00 0.012904 0.047683 0. 055432 205. 00 Unit cost multiplier (Wkst. B, Part 10.656321 11)

Heal th Finar	ncial Systems MAF	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2018 To 12/31/2018		
	Cost Center Description	Reconciliatio	ADMI NI STRATI V	OPERATION OF	OPERATION OF	OPERATION OF	
		n	E & GENERAL	PLANT	PLANT	PLANT -	
			(ACCUM.	(SQUARE	-0FFSITE	HOSPITAL &	
			COST)	FEET)	(SQUARE	0FFS	
					FEET)	(SQUARE	
						FEET)	
		5A	5. 00	7. 00	7. 01	7. 02	
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

	ILLOCATION - STATISTICAL BASIS	NOAKET WAKE COM	Provi der Co	CN: 15-1329 P	eri od:	Worksheet B-1	
				F T	rom 01/01/2018 o 12/31/2018	Date/Time Pre 2/13/2020 2:3	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	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 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	370, 310 86, 722 310 2, 401 0 3, 727 0	116, 674 695 5, 375 61 757 843	14, 532 0 0 0	24, 586 605 0 712 1, 886	330, 217 0 14, 810 0	14. 00 15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	59, 244	14, 278	13, 755	4, 302	89, 484	30.00
31. 00	03100 INTENSIVE CARE UNIT	2, 439			4, 302	8, 886	
43.00	04300 NURSERY	17, 115		0	868	18, 057	1
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	29, 382	4, 720	Ι ο	2, 237	0	50. 00
50.00	05200 DELIVERY ROOM & LABOR ROOM	29, 382				3, 247	
54.00	05400 RADI OLOGY-DI AGNOSTI C	44, 875				41, 880	1
60.00	06000 LABORATORY	0			,	57, 824	1
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	4, 264	_	0	0 724	0 15, 065	
66. 00	06600 PHYSI CAL THERAPY	30, 873			0	15,005	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0			0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	1, 068		0	0	
71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATIENTS	3, 397			931 0	13, 094 0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	17, 980	,			0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	T 0	0	0	0	0	88. 00
90.00	09000 CLINIC	25, 934	_		0	0	1
	09001 WOUND CLINC	4, 516			0	0	
91.00	09100 EMERGENCY	23, 364	9, 168	0	3, 168	65, 896	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	0	3, 634	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS		ı				ļ
	11300 INTEREST_EXPENSE 11600 H0SPICE	0	0	_	0	0	113. 00 116. 00
118.00		_	_	14, 532	20, 809	328, 243	
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CLANS' PRI VATE OFFI CES	11, 344					192.00
	19201 PEDI ATRI CS 19202 BROOKVI LLE		1, 869 0	0			192. 01 192. 02
	19203 RADI OLOGY - OSGOOD	0	0	0			192. 03
	19204 ENT	0	0	0	-		192.04
	07950 COMMUNITY RELATIONS 07951 COMMUNITY BENEFITS	0	303 1, 206		299 646		194. 00 194. 01
	07952 OTHER NON-REIMBURSABLE	0	0	Ö	0		194. 02
	07953 EMS	0	0	0	95		194. 03
	07954 BATESVILLE TOOL & DIE CLINIC 07955 MMHCB RHC	0	0	0	0		194. 04 194. 05
200.00	1		0	0	U	0	200.00
201.00	, ,						201.00
202.00		362, 554	2, 216, 318	270, 837	1, 840, 479	919, 916	202. 00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 979055	18. 995817	18. 637283	74. 858822	2. 785792	203 00
204. 00	1	98, 456			309, 566		204. 00
205. 00	1 1 ,	0. 265875	1. 323483	2. 778764	12. 591149	0. 062604	205. 00
206. 00							206. 00

Health Financial Systems MAI	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co	CN: 15-1329	Peri od:	Worksheet B-1	
				From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
					2/13/2020 2: 3	8 pm
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	LINEN SERVICE	(SQUARE	(MEALS	(FTE' S)	ADMI NI STRATI O	
	(POUNDS OF	FEET)	SERVED)		N	
	LAUNDRY)				(HOURS OF	
					SERVICE)	
	8. 00	9. 00	10.00	11. 00	13.00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1329 Peri od: From 01/01/2018 To 12/31/2018 Worksheet B-1 Date/Time Prepared: 2/13/2020 2:38 pm CENTRAL SERVICES & Cost Center Description PHARMACY MEDI CAL (100% TO RECORDS &

		SERVICES & SUPPLY	(100% T0 DRUGS)	RECORDS & LI BRARY	
		(100% MED	DRUGS)	(TIME	
		SUPPLIES)	15.00	SPENT)	
GENERAL SERVI	CE COST CENTERS	14. 00	15. 00	16. 00	
1.00 00100 NEW CAP	REL COSTS-BLDG & FLXT				1.00
	REL COSTS-OFFSITE BLDG				1.01
	REL COSTS-MVBLE EQUIP REL COSTS-MVBLE EQUIP OFFSIT				2. 00 2. 01
	BENEFITS DEPARTMENT				4.00
I I	RATIVE & GENERAL				5.00
7. 00 00700 OPERATI 0					7.00
I I	N OF PLANT -OFFSITE				7. 01
	N OF PLANT - HOSPITAL & OFFS & LINEN SERVICE				7. 02 8. 00
9. 00 00900 HOUSEKEE					9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI					11.00
I	ADMINISTRATION SERVICES & SUPPLY	100			13. 00 14. 00
15. 00 01500 PHARMACY		0	100		15.00
	RECORDS & LIBRARY	Ö	0		16.00
	TINE SERVICE COST CENTERS				
30. 00 03000 ADULTS 8		0	0		30.00
31. 00 03100 NTENSI V 43. 00 04300 NURSERY	E CARE UNI I	0	0		31. 00 43. 00
	/ICE COST CENTERS			<u> </u>	45.00
50. 00 05000 OPERATI N		0	0	56	50.00
	ROOM & LABOR ROOM	0	0	_	52.00
54. 00 05400 RADI 0L00		0	0	102 0	54. 00 60. 00
60. 01 06000 LABORATO		0	0	0	60.00
65. 00 06500 RESPI RAT		Ö	0	Ö	65.00
66. 00 06600 PHYSI CAL		O	0	0	66. 00
67. 00 06700 OCCUPATI		0	0	0	67.00
68. 00 06800 SPEECH F		0	0	0	68. 00 69. 00
	SUPPLIES CHARGED TO PATIENTS	100	0	Ö	71.00
	V. CHARGED TO PATIENT	0	0	0	72.00
73. 00 07300 DRUGS CH		0	100	0	73.00
88. 00 08800 RURAL HE	RVICE COST CENTERS		0	0	88.00
90. 00 09000 CLINI C	ALIII CLINIC		0	28	90.00
90. 01 09001 WOUND CL	I NC	o	0	0	90. 01
91.00 09100 EMERGENO		0	0	62	91.00
	ION BEDS (NON-DISTINCT PART) SABLE COST CENTERS				92.00
101. 00 10100 HOME HEA		O	0	0	101.00
	SE COST CENTERS	, , , , , , , , , , , , , , , , , , ,		5	
113. 00 11300 I NTEREST	EXPENSE				113. 00
116. 00 11600 HOSPI CE	C (CIM OF LINES 1 through 117)	0	0		116.00
	S (SUM OF LINES 1 through 117) LE COST CENTERS	100	100	754	118.00
192. 00 19200 PHYSI CI A		0	0	6	192. 00
192. 01 19201 PEDI ATRI		O	0		192. 01
192. 02 19202 BROOKVI L		0	0		192.02
192. 03 19203 RADI 0L00 192. 04 19204 ENT	Y - USGUUD	0	0		192. 03 192. 04
194. 00 07950 COMMUNI T	Y RELATIONS	Ö	0	Ö	194.00
194. 01 07951 COMMUNI T		o	0	0	194. 01
194. 02 07952 OTHER NO	N-REI MBURSABLE	0	0	0	194. 02
194. 03 07953 EMS	LE TOOL & DIE CLINIC	0	0	0	194. 03 194. 04
194. 05 07955 MMHCB RF		0	0	0	194. 04
	ot Adjustments		· ·		200.00
	Cost Centers				201.00
	be allocated (per Wkst. B,	75, 205	5, 645, 534	3, 077, 072	202.00
203.00 Part I) Unit cos	t multiplier (Wkst. B, Part I)	752. 050000	56, 455. 340000	4, 048. 778947	203. 00
1	be allocated (per Wkst. B,	42, 413	115, 530		204.00
Part II)					
	t multiplier (Wkst. B, Part	397. 640000	1, 155. 300000	280. 082895	205.00
206.00 NAHE adj	ustment amount to be allocated				206. 00
(per Wks					[
	•	· '		· '	

Health Financial Systems MAR	RGARET MARY	COMMUN	NITY HOSPITA	L		In Lieu	of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provi der C	CN: 15-1329	Peri	od: n 01/01/2018	Worksheet B-1	
					To		Date/Time Pre 2/13/2020 2:3	pared: 8 pm
Cost Center Description	CENTRAL		PHARMACY	MEDI CAL				
	SERVICES 8	&	(100% T0	RECORDS &				
	SUPPLY		DRUGS)	LI BRARY				
	(100% MEI	D		(TIME				
	SUPPLI ES)			SPENT)				
	14. 00		15. 00	16.00				
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)								207. 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		Worksheet C
		From 01/01/2018	

					-rom 01/01/2018 Fo 12/31/2018		norod.
					10 12/31/2018	2/13/2020 2: 3	
			Title	XVIII	Hospi tal	Cost	о рііі
				,,,,,,	Costs	0001	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	,				
		col. 26)					
		1.00	2.00	3. 00	4.00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	8, 598, 303		8, 598, 303	3 0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	689, 249		689, 249	9 0	0	31.00
43.00	04300 NURSERY	1, 258, 297		1, 258, 29	7 0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	3, 648, 172		3, 648, 172	2 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	369, 551		369, 55°	1 0	0	1 02.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	14, 955, 049		14, 955, 049	9 0	0	54.00
60.00	06000 LABORATORY	5, 899, 315		5, 899, 31	5 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0		(0	0	00.0.
65.00	06500 RESPI RATORY THERAPY	1, 413, 539	0	1, 413, 539	9 0	0	00.00
66.00	06600 PHYSI CAL THERAPY	2, 384, 780	0	2, 384, 780	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	693, 316	0	693, 316		0	07.00
	06800 SPEECH PATHOLOGY	422, 383	0	422, 383		0	
	06900 ELECTROCARDI OLOGY	1, 543, 436		1, 543, 436	6 0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 175, 144		4, 175, 14	1 0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	1, 520, 666		1, 520, 666	6 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 645, 534		5, 645, 534	1 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	1, 898, 827		1, 898, 82		0	
	09000 CLI NI C	3, 706, 936		3, 706, 936		0	, , , , , ,
	09001 WOUND CLINC	586, 488		586, 488		0	, , , , , ,
91. 00	09100 EMERGENCY	5, 652, 097		5, 652, 09		0	,
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 367, 353		1, 367, 353	3	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	3, 238, 622		3, 238, 622	2	0	101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	1, 635, 371		1, 635, 37°			116. 00
200.00		71, 302, 428	0	,,			200. 00
201.00		1, 367, 353		1, 367, 353			201.00
202.00	Total (see instructions)	69, 935, 075	0	69, 935, 07	5 0	0	202. 00

Heal th F	inancial Systems MAF	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COMPUTAT	TION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2018 To 12/31/2018		
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS				.1	Г	
	3000 ADULTS & PEDIATRICS	5, 627, 786		5, 627, 78			30.00
	3100 INTENSIVE CARE UNIT	661, 178		661, 17			31.00
	4300 NURSERY	2, 363, 755		2, 363, 75	5		43.00
	NCILLARY SERVICE COST CENTERS	1 000 001	F (00 100	7.540.07	7 0 105577		
	5000 OPERATING ROOM	1, 832, 934	5, 680, 133				
	5200 DELIVERY ROOM & LABOR ROOM	184, 441	43, 374	227, 81			
	5400 RADI OLOGY-DI AGNOSTI C	1, 567, 379	64, 312, 011	65, 879, 39			
	6000 LABORATORY	3, 001, 513	28, 058, 683				
	6001 BLOOD LABORATORY	0	0		0.000000		
	6500 RESPI RATORY THERAPY	2, 559, 459	1, 157, 362	3, 716, 82			65.00
	6600 PHYSI CAL THERAPY	174, 517	4, 109, 842	4, 284, 35		l .	66.00
	6700 OCCUPATI ONAL THERAPY	102, 627	1, 236, 595			0.000000	
	6800 SPEECH PATHOLOGY	78, 885	684, 713			l	
	6900 ELECTROCARDI OLOGY	392, 035	4, 473, 360			0. 000000	69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 305, 979	10, 211, 095			0. 000000	
	7200 IMPL. DEV. CHARGED TO PATIENT	880, 404	848, 745				
	7300 DRUGS CHARGED TO PATIENTS	3, 802, 447	9, 330, 755	13, 133, 20	0. 429867	0.000000	73. 00
	UTPATIENT SERVICE COST CENTERS		4 400 075	4 400 07	-I	ı	00.00
	8800 RURAL HEALTH CLINIC 9000 CLINIC	0	1, 129, 275			0.000000	88. 00 90. 00
	9000 CLINIC 9001 WOUND CLINC	6, 842	5, 405, 684			0.000000	90.00
		0	1, 088, 326				
	9100 EMERGENCY 9200 OBSERVATION BEDS (NON-DISTINCT PART)	477, 244 39, 865	11, 584, 479 921, 255				
	THER REIMBURSABLE COST CENTERS	39, 805	921, 255	961, 12	1. 422666	0.000000	92.00
	0100 HOME HEALTH AGENCY	O	1, 778, 083	1, 778, 08	2		101.00
	PECIAL PURPOSE COST CENTERS	l d	1, 770, 003	1,776,00	13		101.00
	1300 I NTEREST EXPENSE						1 113. 00
	1600 HOSPI CE	0	2, 335, 386	2, 335, 38	6		116.00
200.00	Subtotal (see instructions)	28, 059, 290	154, 389, 156	182, 448, 44		l .	200.00
200.00	Less Observation Beds	20,037,290	134, 307, 130	102, 440, 44	.0		200.00
201.00	Total (see instructions)	28, 059, 290	154, 389, 156	182, 448, 44	6		201.00
202.00	Total (See Histiactions)	20,007,270	134, 307, 130	102, 440, 44	ا	I	1202.00

Health Financial Systems	MARGARET MARY COMMUI	NITY HOSPITAL	In Lieu	ı of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1329	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 2/13/2020 2:38 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Innatient			

INPATIENT ROUTINE SERVICE COST CENTERS 11.00			Title XVIII	Hospi tal	Cost
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 03100 INTENSI WE CARE UNIT 31.00 04300 NURSERY 43.00 04300 NURSERY 43.00 04300 NURSERY 43.00 04300 NURSERY 43.00 05000 DEELATI NG ROOM 0.000000 50.00 05000 DEELATI NG ROOM 0.000000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 05000 DEELATI NG ROOM 0.000000 52.00 05000 DEELATI NG ROOM 0.000000 54.00 06.0	Cost Center Description	PPS Inpatient			3001
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 31.00 43.00 04300 NURSERY 43.00		Ratio			
30.00		11. 00			
31. 00					
43.00					
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM 0.000000 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 55. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 60. 00 06000 LABORATORY 0.000000 06. 00 06000 LABORATORY 0.000000 06. 00 06500 RESPI RATORY THERAPY 0.000000 06500 RESPI RATORY THERAPY 0.000000 06500 RESPI RATORY THERAPY 0.000000 066. 00 06600 PHYSI CAL THERAPY 0.000000 067. 00 06700 0CCUPATI ONAL THERAPY 0.000000 06800 SPEECH PATHOLOGY 0.000000 06800 SPEECH PATHOLOGY 0.000000 069. 00 06900 ELECTROCARDI OLOGY 0.000000 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 072. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0.000000 0.00000 0.0000000 0.0000000 0.000000 0.00000000					43.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0.54.00 054.00 RADI OLOGY-DI AGNOSTI C 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000					
54. 00					
60. 00 06000 LABORATORY 0.000000 60. 01 60. 01 60. 01 60. 01 60. 01 60. 01 60. 01 60. 00 60. 01 60. 01 60. 00		1			
60. 01 06001 BLOOD LABORATORY 0.000000 65. 00 65. 00 65. 00 66. 00 65. 00 66. 00 6					
65. 00 06500 RESPIRATORY THERAPY 0.000000 66. 00					
66. 00					
67. 00					
68. 00					
69. 00					
71. 00	68.00 06800 SPEECH PATHOLOGY	0. 000000			
72. 00		0. 000000			
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		0. 000000			
SECTION SUBSTITUTE SERVICE COST CENTERS SECTION SERVICE COST CENTERS SERVICE CO	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
88. 00 08800 RURAL HEALTH CLINIC 0. 000000 90. 00 90. 00 90. 00 90. 00 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 00 90. 01 90. 00 90. 01 90. 00 90. 01 90. 00		0. 000000			73. 00
90. 00 990.0 CLINIC 0.000000 990.0 9					
90. 01 09001 WOUND CLINC 0. 000000 91. 00 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 000000 92. 00 OTHER REIMBURSABLE COST CENTERS 101. 00 Total Results of the state of t					88.00
91. 00 09100 EMERGENCY 0. 000000 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 0000000 92. 00 OTHER REIMBURSABLE COST CENTERS 101. 00 THOR PREIMBURSABLE COST CENTERS 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 114. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					
92. 00					
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	91. 00 09100 EMERGENCY	0. 000000			91.00
101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see i instructions) 200. 00 201. 00 Less Observation Beds 201. 00	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 116.00 11600	OTHER REIMBURSABLE COST CENTERS				
113. 00 11300 INTEREST EXPENSE					101. 00
116. 00 116.00 200. 00 Subtotal (see instructions) 201. 00 Less Observation Beds					
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					
201.00 Less Observation Beds 201.00					
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds				201. 00
	202.00 Total (see instructions)				202.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1329	Peri od:	Worksheet C
		From 01/01/2018	
		T- 10/01/0010	D-+- /T! D

					Fo 12/31/2018		
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
	03000 ADULTS & PEDIATRICS	8, 598, 303	l .	8, 598, 30		.,	1
31. 00	03100 INTENSIVE CARE UNIT	689, 249		689, 249		· ·	1
43.00	04300 NURSERY	1, 258, 297		1, 258, 29	7 0	1, 258, 297	43.00
F0 00	ANCILLARY SERVICE COST CENTERS	0 (10 170		0 (10 17		0 (40 470	
50.00	05000 OPERATING ROOM	3, 648, 172		3, 648, 17		3, 648, 172	
52.00	05200 DELIVERY ROOM & LABOR ROOM	369, 551		369, 55		,	
54.00	05400 RADI OLOGY-DI AGNOSTI C	14, 955, 049		14, 955, 04		14, 955, 049	
60.00	06000 LABORATORY	5, 899, 315		5, 899, 31	0	5, 899, 315	
60. 01	06001 BLOOD LABORATORY	0			0	0	
65.00	06500 RESPI RATORY THERAPY	1, 413, 539	ŀ	.,,		1, 413, 539	
66.00	06600 PHYSI CAL THERAPY	2, 384, 780	l e	2,001,70		2, 384, 780	
67.00	06700 OCCUPATI ONAL THERAPY	693, 316		693, 310		693, 316	
68.00	06800 SPEECH PATHOLOGY	422, 383		422, 383		422, 383	
69.00	06900 ELECTROCARDI OLOGY	1, 543, 436	l e	1, 543, 43		1, 543, 436	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 175, 144		4, 175, 14		4, 175, 144	
	07200 I MPL. DEV. CHARGED TO PATIENT	1, 520, 666		1, 520, 66		,	
/3.00	07300 DRUGS CHARGED TO PATIENTS	5, 645, 534		5, 645, 53	1 0	5, 645, 534	73.00
00.00	OUTPATIENT SERVICE COST CENTERS	1 000 007	l	4 000 00	7	4 000 007	00.00
88. 00	08800 RURAL HEALTH CLINIC	1, 898, 827		1, 898, 82		1, 898, 827	1
90.00	09000 CLINIC	3, 706, 936		3, 706, 93		3, 706, 936	
90. 01	09001 WOUND CLINC	586, 488		586, 488		586, 488	
	09100 EMERGENCY	5, 652, 097		5, 652, 09		5, 652, 097	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 367, 353		1, 367, 35	3	1, 367, 353	92.00
101 00	OTHER REIMBURSABLE COST CENTERS	2 220 (22		2 220 (2)		2 220 722	101 00
101.00	10100 HOME HEALTH AGENCY	3, 238, 622		3, 238, 62	<u> </u>	3, 238, 622	1101.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
	111600 HOSPI CE	1, 635, 371		1, 635, 37 ⁻	1	1, 635, 371	1
200.00		71, 302, 428	l .				
200.00	. ,	1, 367, 353		1, 367, 35		1, 367, 353	
201.00		69, 935, 075					
202.00	Total (See Histructions)	09, 935, 075	l 0	09, 935, 07	ار	09, 935, 075	1202.00

Heal th	Financial Systems MA	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
СОМРИТ	TATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2018 To 12/31/2018		
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. (Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	5, 627, 786		5, 627, 78			30.00
31.00	03100 INTENSIVE CARE UNIT	661, 178		661, 17			31.00
43.00	04300 NURSERY	2, 363, 755		2, 363, 75	5		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 832, 934	5, 680, 133			0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	184, 441	43, 374			0. 000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 567, 379	64, 312, 011			0. 000000	
60.00	06000 LABORATORY	3, 001, 513	28, 058, 683			0. 000000	
60. 01	06001 BLOOD LABORATORY	0	0		0. 000000	0. 000000	60. 01
65.00	06500 RESPI RATORY THERAPY	2, 559, 459	1, 157, 362			0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	174, 517	4, 109, 842			0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	102, 627	1, 236, 595			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	78, 885	684, 713			0. 000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	392, 035	4, 473, 360			0. 000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 305, 979	10, 211, 095			0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	880, 404	848, 745				
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 802, 447	9, 330, 755	13, 133, 20	2 0. 429867	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	1, 129, 275				
90.00	09000 CLI NI C	6, 842	5, 405, 684			0. 000000	
90. 01	09001 WOUND CLINC	0	1, 088, 326			0. 000000	90. 01
91.00	09100 EMERGENCY	477, 244	11, 584, 479			0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	39, 865	921, 255	961, 12	0 1. 422666	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	1, 778, 083	1, 778, 08	3		101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11600 H0SPI CE	0	2, 335, 386				116. 00
200.00	. ,	28, 059, 290	154, 389, 156	182, 448, 44	6		200. 00
201.00							201.00
202.00	Total (see instructions)	28, 059, 290	154, 389, 156	182, 448, 44	6		202. 00

Health Financial Systems	MARGARET MARY COMM	UNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1329	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 2/13/2020 2:3	pared: 8 pm
		Title XIX	Hospi tal	Cost	•
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00

		litle XIX	Hospi tai	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
55. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
57. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88.00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 WOUND CLINC	0. 000000			90. 01
91. 00 09100 EMERGENCY	0.000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 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

nancial Systems	MARGARET MARY COMMUN	ITY HOSPI	TAL	In Li€	eu of Form CMS-2552-10	

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CM					u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Co		Period: From 01/01/2018 To 12/31/2018		pared: 8 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	I npati ent	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					,	
50.00 05000 OPERATING ROOM	340, 835				19, 591	
52.00 05200 DELIVERY ROOM & LABOR ROOM	70, 163				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 251, 254				12, 211	54.00
60. 00 06000 LABORATORY	286, 162				10, 757	60.00
60. 01 06001 BL00D LABORATORY	0	1	0.0000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY	168, 602					
66. 00 06600 PHYSI CAL THERAPY	333, 518					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	70, 483	1, 339, 222			3, 301	67.00
68.00 06800 SPEECH PATHOLOGY	62, 030	763, 598	0. 08123	49, 066	3, 986	68.00
69. 00 06900 ELECTROCARDI OLOGY	160, 160		0. 03291	8 218, 549	7, 194	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	84, 010	14, 517, 074			7, 431	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	178, 873	1, 729, 149			45, 130	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	115, 530	13, 133, 202	0. 00879	7 1, 515, 965	13, 336	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	98, 714	1, 129, 275	0. 08741	4 0	0	88. 00
90. 00 09000 CLI NI C	839, 187	5, 412, 526	0. 15504	5 0	0	90.00
90. 01 09001 WOUND CLINC	43, 929	1, 088, 326	0. 04036	4 0	0	90. 01
91. 00 09100 EMERGENCY	614, 773	12, 061, 723	0. 05096	9 78, 523	4, 002	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	172, 381	961, 120	0. 17935	4 659	118	92.00
200.00 Total (lines 50 through 199)	4, 890, 604	169, 682, 258		7, 406, 987	199, 278	200. 00

THROUGH COSTS

				10 12/31/2016	2/13/2020 2: 3	
		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			1			
50. 00 05000 OPERATING ROOM	0	0		0	0	50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC		1 0	I	0 0	0	88. 00
90. 00 09000 CLI NI C	0	0		0	0	90.00
90. 01 09001 WOUND CLINC	0	0		0	0	90.00
91. 00 09100 EMERGENCY		0		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	91.00
200.00 Total (lines 50 through 199)				0	1	200.00
200.00 10tal (1111es 50 thi ough 199)	1	ı	I	o _l	l 0	200.00

| Peri od: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: THROUGH COSTS

			'	0 12/31/2010	2/13/2020 2: 3	8 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	T .	Г				
50. 00 05000 OPERATING ROOM	0	0	(7, 513, 067		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(227, 815		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(65, 879, 390		
60. 00 06000 LABORATORY	0	0	(31, 060, 196		
60. 01 06001 BLOOD LABORATORY	0	0	(0	0. 000000	
65. 00 06500 RESPIRATORY THERAPY	0	0	(3, 716, 821	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0	(4, 284, 359		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(1, 339, 222		
68.00 06800 SPEECH PATHOLOGY	0	0	(763, 598		
69. 00 06900 ELECTROCARDI OLOGY	0	0	(4, 865, 395		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(14, 517, 074		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(1, 729, 149	0. 000000	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	(13, 133, 202	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	(1, 129, 275		1
90. 00 09000 CLI NI C	0	0	(5, 412, 526		
90. 01 09001 WOUND CLINC	0	0	(1, 088, 326	0. 000000	90. 01
91. 00 09100 EMERGENCY	0	0	(12, 061, 723	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(961, 120		
200.00 Total (lines 50 through 199)	0	0	(169, 682, 258		200. 00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT / THROUGH COSTS	NCI LLARY SERVI CE OTHER PASS Provi der CCN: 15-1329	Peri od: Worksheet D From 01/01/2018 Part IV To 12/31/2018 Date/Time Prepared:

THROUGH COSTS					o 12/31/2018		pared: 8 pm
			Title	: XVIII	Hospi tal	Cost	<u></u>
Cost Center De	escription	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE C							
50. 00 05000 OPERATI NG ROOF		0. 000000	431, 833	[C	0	0	50.00
52. 00 05200 DELI VERY ROOM		0. 000000	0	(0	0	52.00
54. 00 05400 RADI OLOGY-DI A	GNOSTIC	0. 000000	642, 932	(0	0	54.00
60. 00 06000 LABORATORY		0. 000000	1, 167, 601	(0	0	60.00
60. 01 06001 BL00D LABORAT		0. 000000	0	(0	0	60. 01
65. 00 06500 RESPI RATORY TI		0. 000000	1, 416, 244	(0	0	65.00
66. 00 06600 PHYSI CAL THERA		0. 000000	102, 475		0	0	66.00
67. 00 06700 0CCUPATI ONAL		0. 000000	62, 724	(0	0	67.00
68.00 06800 SPEECH PATHOLO		0. 000000	49, 066	[C	0	0	68. 00
69. 00 06900 ELECTROCARDI OI	_OGY	0. 000000	218, 549	[C	0	0	69.00
71.00 07100 MEDICAL SUPPL	ES CHARGED TO PATIENTS	0. 000000	1, 284, 152	[C	0	0	71.00
72.00 07200 I MPL. DEV. CH	ARGED TO PATLENT	0. 000000	436, 264	[C	0	0	72.00
73. 00 07300 DRUGS CHARGED	TO PATIENTS	0. 000000	1, 515, 965	C	0	0	73.00
OUTPATIENT SERVICE	COST CENTERS						
88.00 08800 RURAL HEALTH (CLI NI C	0.000000	0	(0	0	88. 00
90. 00 09000 CLI NI C		0. 000000	0	(0	0	90.00
90. 01 09001 WOUND CLINC		0. 000000	0	(0	0	90. 01
91.00 09100 EMERGENCY		0. 000000	78, 523	0	0	0	91.00
92.00 09200 OBSERVATION BI	EDS (NON-DISTINCT PART)	0. 000000	659	0	0	0	92.00
200.00 Total (lines!	50 through 199)		7, 406, 987	0	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 01/01/2018 To 12/31/2018 Part V Date/Time Prepared: 2/13/2020 2:38 pm 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 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 485577 50.00 1, 152, 830 05200 DELIVERY ROOM & LABOR ROOM 52.00 1.622154 0 0 52.00 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 22, 292, 939 0. 227006 3, 495 0 54.00 60.00 06000 LABORATORY 0.189932 8, 198, 049 0 0 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 0 60.01 288, 864 06500 RESPIRATORY THERAPY 0. 380309 65.00 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 556625 956, 792 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 517701 161, 729 0 67.00 o 68.00 06800 SPEECH PATHOLOGY 0.553148 0 68.00 15, 649 0 06900 ELECTROCARDI OLOGY 1, 612, 307 0 69.00 69.00 0.317227 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 287602 0 2, 722, 525 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.879430 0 0 0 72.00 311, 334 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 0. 429867 2, 889, 011 609 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 90.00 09000 CLI NI C 0.684881 0 1, 557, 082 31 0 90.00 09001 WOUND CLINC 0.538890 90. 01 90 01 0 470, 875 18 0 91.00 09100 EMERGENCY 0.468598 0 2, 709, 892 1, 618 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 422666 463, 755 0 92.00 0 200.00 200.00 Subtotal (see instructions) 0 45, 803, 633 5.771 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 45, 803, 633 5,771 0 202.00

Peri od: | Worksheet D From 01/01/2018 | Part V

				To 12/31/2	018 Date/Time 2/13/2020	Prepared: 2:38 pm
		Title	XVIII	Hospi tal		ost
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	559, 788	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 060, 631	793				54.00
60. 00 06000 LABORATORY	1, 557, 072	0				60.00
60. 01 06001 BL00D LABORATORY	0	0				60. 01
65. 00 06500 RESPI RATORY THERAPY	109, 858	0				65.00
66. 00 06600 PHYSI CAL THERAPY	532, 574	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	83, 727	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	8, 656	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	511, 467	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	783, 004	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	273, 796					72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	1, 241, 890	262				73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88. 00
90. 00 09000 CLI NI C	1, 066, 416	21				90.00
90. 01 09001 WOUND CLINC	253, 750	10				90. 01
91. 00 09100 EMERGENCY	1, 269, 850	758				91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	659, 768	0				92.00
200.00 Subtotal (see instructions)	13, 972, 247	1, 844				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	13, 972, 247	1, 844				202.00

Health Financial Systems	MARGARET MARY COMMUNI	TY HOSPI TAL	In Lieu	of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	F	Provider CCN: 15-1329	Peri od:	Worksheet D-1	
			From 01/01/2018		
			To 12/31/2018	Date/Time Pre	pared:
				2/13/2020 2: 3	8 pm
		Title XVIII	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

PART I - ALL PROVIDER COMPONENTS 1.00
PART - ALL PROVIDER COMPONENTS InPATIENT DAYS
INPATIENT DAYS 1.00
1.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 5,213 2.0
Private room days (excluding swing-bed and observation bed days). If you have only private room days do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 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) 9.00 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) 10.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 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 (see instructions) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (see instructions) 15.00 Total nursery days (title V or XIX only) 16.00 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 (see instructions) 16.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting perio
do not complete this line. 4, 384 4.00 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 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) 9.00 Solid 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) 10.01 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 10.00 Total swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 10.00 Total swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 10.00 1
4.384 4.05 5.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.01 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.01 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 7.02 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) 7.03 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) 7.01 Swing-bed SNF type inpatient days applicable to titles Vor XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.03 Swing-bed SNF type inpatient days applicable to titles Vor XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.04 Swing-bed SNF type inpatient days applicable to titles Vor XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.01 Total nursery days (title Vor XIX only) 7.02 Total nursery days (title Vor XIX only) 7.03 Norsery days (title Vor XIX only) 7.04 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (period period (period period (p
Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period of (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 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) 10.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (see instructions) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total nursery days (title V or XIX only) 22.00 Medicare rate for swing-bed
reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar 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 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12.00 Swing-bed NF type inpatient days applicable to titles VVIII only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 7.01 7.02 7.03 8.04 8.05 8.06 8.06 8.07 7.08 8.08 8.08 8.09 8.09 8.09 8.09 8.09 8.09 8.09 8.00 8.09 8.00 8.0
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 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) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 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) 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) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (l
reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if cal endar 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) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) SWING BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicab
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) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 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) 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) 14.00 Modically necessary private room days applicable to the Program (excluding private room days) 0 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to the Program (excluding private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to the Program (excluding private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed Swing-bed SNF services applicable to services through December 31 of the cost reporting period 14.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 15.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 15.00 Medicare rate for swing-bed NF services applicable to services after De
reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 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) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 13.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 13.00 Swing-bed days) 14.00 Swing-bed
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16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 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 reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)
SWING BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 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 reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 8,598,303 21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)
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20.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)
21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 8,598,303 21.0
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)
5 x line 17)
x line 18)
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.0
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 25.0
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)
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 8,598,303 27.0
PRI VATE ROOM DI FFERENTI AL ADJUSTMENT
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.0
29. 00 Pri vate room charges (excluding swing-bed charges) 0 29. (20. 00 Cari private gaze abanas (evaluding swing-bed charges)
30.00 Semi-private room charges (excluding swing-bed charges) 0 30.0 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.0
32. 00 Average private room per diem charge (line 29 ÷ line 3)
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 33.
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 34.0
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)
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8,598,303 37.0 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) 1,649.40 38.00
39.00 Program general inpatient routine service cost (line 9 x line 38) 2,690,171 39.0
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 41.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,690,171 41.0

PART IT - HUSPITAL AND SUBPROVIDERS UNLY		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00 Adjusted general inpatient routine service cost per diem (see instructions)	1, 649. 40	38. C
39.00 Program general inpatient routine service cost (line 9 x line 38)	2, 690, 171	39. C
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.0
41.00 Total Program general inpatient routine service cost (line 39 + line 40)	2, 690, 171	41. C

COMPUT	Financial Systems MAR ATION OF INPATIENT OPERATING COST	GARET MARY COM	Provider C	CN: 15-1329	Peri od:	u of Form CMS-2 Worksheet D-1		
					From 01/01/2018 To 12/31/2018			
			Title	· XVIII	Hospi tal	2/13/2020 2: 3: Cost	о рііі	
	Cost Center Description	Total Inpati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1. 00	2. 00	3.00	4.00	5. 00		
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.00	
43. 00	INTENSIVE CARE UNIT	689, 249	217	3, 176. 2	176	559, 022	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 center bescriptron					1. 00		
48. 00	Program inpatient ancillary service cost (Wk					2, 744, 381	48.00	
49. 00	5 1 ,	41 through 48)	(see instructi	ons)		5, 993, 574	49.00	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	corvi coc (fro	m Wks+ D su	m of Dorte L and		50.00	
30.00	[Flass through costs appricable to Program Trip	atrent routine	services (110	III WKSt. D, Sui	II OI PALLS I AIIO	١	30.00	
51.00	Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	0	51.00	
	and IV)		•					
52.00	Total Program excludable cost (sum of lines		مام ممم مام	voleien eneet	hatiat and	0		
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	J 1	erated, non-pn	ysician anesti	netist, and	ا	53.00	
	TARGET AMOUNT AND LIMIT COMPUTATION	02)						
	Program di scharges						54.00	
55.00	Target amount per discharge						55.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and to	arget amount (line 56 minus	line 53)	0	1	
58. 00	Bonus payment (see instructions)	ing cost and to	arget amount (i i ile 50 illi ilus	111le 55)	0	1	
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the			
	market basket							
60.00	Lesser of lines 53/54 or 55 from prior year				***		60.00	
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.0	
	amount (line 56), otherwise enter zero (see		ts (Tries 54 X	00), 01 1% 0	i the target			
	Relief payment (see instructions)							
63. 00	Allowable Inpatient cost plus incentive payment (see instructions)							
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost report	ing period (See	0	64.00	
04.00	instructions)(title XVIII only)	ts through beek	Simber 31 Of th	c cost report	ing perrod (see	,	04.00	
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the	cost reportin	g period (See	0	65.00	
// 00	instructions)(title XVIII only)	+- (1:	(4 -1 1:	/E) /±: ±1 = \/\/!				
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (iine	64 prus rine	os)(title xvi	ii oniy). For	0	66.00	
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31	of the cost r	eporting period	0	67.00	
	(line 12 x line 19)							
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost rep	orting period	0	68.00	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 + lin	e 68)		0	69.00	
	PART III - SKILLED NURSING FACILITY, OTHER N					_		
70.00	Skilled nursing facility/other nursing facil)		70.00	
71.00	Adjusted general inpatient routine service c	,	ine 70 ÷ line	2)			71.00	
72. 00 73. 00	Program routine service cost (line 9 x line 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	Worksheet B,	Part II, column		75.00	
74 00	26, line 45)	no 2)					74 00	
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76.00	
78. 00	Inpatient routine service cost (line 74 minu	,					78.0	
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p		*.			79.0	
80.00	9		cost limitatio	n (line 78 mi	nus line 79)		80.00	
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	•	•				85.00	
86. 00	Total Program inpatient operating costs (sum		nrough 85)				86.0	
	PART IV - COMPUTATION OF OBSERVATION BED PASS							
87. 00	Total observation bed days (see instructions)			ı	8291	1 87 N	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	: line 2)			829 1, 649. 40	1	

Health Financial Systems MAI	RGARET MARY COM	MMUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Period: From 01/01/2018	Worksheet D-1	
				To 12/31/2018		pared: 8 pm
			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, 083, 980	8, 598, 303	0. 12606	9 1, 367, 353	172, 381	90.00
91.00 Nursing School cost	0	8, 598, 303	0.00000	0 1, 367, 353	0	91.00
92.00 Allied health cost	0	8, 598, 303	0.00000	0 1, 367, 353	0	92.00
93.00 All other Medical Education	0	8, 598, 303	0. 00000	0 1, 367, 353	0	93.00

Health Financial Systems	MARGARET MARY COMMUNITY F	HOSPI TAL	In Lieu	ı of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST	Prov		From 01/01/2018	Worksheet D-1	
			To 12/31/2018	Date/Time Prep 2/13/2020 2:38	oared: 3 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NDATI ENT. DAVE					

		Title XIX	Hospi tal	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)		5, 213	1.00
2.00	Inpatient days (including private room days, excluding swing-b			5, 213	2.00
3. 00	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d days)		4, 384	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room		or 31 of the cost	4, 364	1
0.00	reporting period	aaye, t eag beedbe	0. 0. 1 0001	Ü	0.00
6.00	Total swing-bed SNF type inpatient days (including private room	m 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 reporting period	days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 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	51	9. 00
10.00	newborn days)	v (i polydina privoto p	soom dove)	0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct)		oolii days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, en				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e 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 privat	e room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar year			O	13.00
14.00	Medically necessary private room days applicable to the Program			0	14.00
15. 00	Total nursery days (title V or XIX only)			1, 049	
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service:	s through December 31 o	of the cost		17. 00
17.00	reporting period	3 through beechber 31 c	in the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost		18. 00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0. 00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			8, 598, 303	1
22. 00	Swing-bed cost applicable to SNF type services through December	⁻ 31 of the cost report	ing period (line	0	22.00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December:	31 of the cost reportin	na period (line A	0	23. 00
20.00	x line 18)	or the cost reporting	ig perrod (Trile o	· ·	20.00
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.00
05.00	7 x line 19)			0	05.00
25. 00	Swing-bed cost applicable to NF type services after December 3×1 ine 20)	i of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (ine 21 minus line 26)		8, 598, 303	27. 00
00.5	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	iarges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	1
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	ı
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34.00	Average per diem private room charge differential (line 32 min		tions)	0.00	1
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	e 31)		0.00	35. 00 36. 00
36. 00 37. 00	General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	8, 598, 303	
37.00	27 minus line 36)	.a privato room cost ur		5, 575, 505	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		<u>'</u>		
00.5	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST		1		
38.00	Adjusted general inpatient routine service cost per diem (see			1, 649. 40 84, 119	1
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	•		84, 119	ı
	Total Program general inpatient routine service cost (line 39			84, 119	
			'		•

7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 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	51	9. 00
	newborn days)		
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
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
10.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	G	10.00
	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only)	1, 049	15.00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
17.00	reporting period		17.00
18. 00			18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
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)	8, 598, 303	21. 00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	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 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
25 00	7 x line 19)	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	Ü	25. 00
	Total swing-bed cost (see instructions)	0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8, 598, 303	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	0	00.00
	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)	0	28. 00 29. 00
	Semi-private room charges (excluding swing-bed charges)	0	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
	Average per diem private room cost differential (line 34 x line 31)	0.00	
	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	8, 598, 303	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, 649. 40	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	84, 119	39.00
	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)	84, 119	41.00

COMPUT	Financial Systems MAR ATION OF INPATIENT OPERATING COST	GARET MARY COM	Provider C	CN: 15-1329	Peri od:	u of Form CMS-2 Worksheet D-1		
					From 01/01/2018 To 12/31/2018			
			Ti +I	e XIX	Hospi tal	2/13/2020 2: 3 Cost	8 pm	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
10.00	NUDGEDY (1'11 - W o WW o 11)	1.00	2.00	3.00	4. 00	5. 00	40.00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	1, 258, 297	1, 049	1, 199. 5	[2] 0	0	42.00	
43. 00		689, 249	217	3, 176. 2	26 4	12, 705	43.00	
44.00	i i						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.00	
171 00	Cost Center Description	l.					171.00	
49.00	Program inpatient ancillary service cost (Wk	ct D 2 col 3	2 Line 200)			1. 00	49.00	
48. 00 49. 00	, ,			ons)		116, 025 212, 849		
17.00	PASS THROUGH COST ADJUSTMENTS	Tr trii oagii 10) ((See Thistracti	3113)		212, 017	17.00	
50.00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	n Wkst. D, su	m of Parts I and	0	50.00	
51. 00		ationt ancillar	ry sorvices (fi	rom Wkst D	cum of Darts II	o	51.00	
31.00	and IV)	atrent ancirrai	y services (ii	OIII WKSt. D,	Sum Of Farts II	ا	31.00	
52.00	Total Program excludable cost (sum of lines	,				0		
53.00	Total Program inpatient operating cost exclu		elated, non-phy	ysician anest	hetist, and	0	53.00	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1	
54.00	Program di scharges					0	54.00	
55. 00							55.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and to	ract amount (lino E4 minus	Lino E2)	0	1	
58. 00	, , , , , , , , , , , , , , , , , , , ,	ing cost and ta	inger amount (THE 30 IIITIUS	11116 55)	0	1	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, i	updated and c	ompounded by the			
	market basket							
60.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0.00	60.00	
01.00	which operating costs (line 53) are less than					١	01.00	
	amount (line 56), otherwise enter zero (see	0	62.00					
	00 Relief payment (see instructions) 00 Allowable Inpatient cost plus incentive payment (see instructions)							
63.00	PROGRAM INPATIENT ROUTINE SWING BED COST	0	63.00					
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost report	ing period (See	0	64.00	
/F 00	instructions)(title XVIII only)	+£+ D	21 -6 +6-				/ - 00	
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 or the (Jost reportin	g period (see	0	65.00	
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	ll only). For	0	66.00	
/7.00	CAH (see instructions)		. D	-6 +1+			/7.00	
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs througr	n December 31 (or the cost r	eporting period	0	67.00	
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	December 31 of	the cost rep	orting period	o	68.00	
	(line 13 x line 20)		(11	(0)				
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00	
70.00	Skilled nursing facility/other nursing facil)		70.00	
71.00	Adjusted general inpatient routine service c	,	ine 70 ÷ line	2)			71.00	
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		. (lino 14 v li	ino 2E)			72.00	
74.00	Total Program general inpatient routine serv						74.00	
75. 00	Capital -related cost allocated to inpatient				Part II, column		75.00	
	26, line 45)	->					l	
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76.00	
78.00	,						78.00	
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p		*.			79.00	
80.00	,		cost limitation	າ (line 78 mi	nus line 79)		80.00	
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	structions)	•				84.0	
85.00	Utilization review - physician compensation	•	,				85.00	
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ıı ougri 85)				86.00	
	Total observation bed days (see instructions					829	87.00	
87. 00	Total observation bed days (see Instructions	,				02,	0,, 0,	
88. 00	,	diem (line 27 ÷				1, 649. 40 1, 367, 353	88. 0	

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 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 083, 980	8, 598, 303	0. 12606	9 1, 367, 353	172, 381	90.00
91.00 Nursing School cost	0	8, 598, 303	0.00000	0 1, 367, 353	0	91.00
92.00 Allied health cost	0	8, 598, 303	0.00000	0 1, 367, 353	0	92.00
93.00 All other Medical Education	0	8, 598, 303	0. 00000	0 1, 367, 353	0	93.00

Health Financial Systems MARGARET MARY CON INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-3	
INFAITENT ANCILLART SERVICE COST AFFORTIONWENT	Frovider C		From 01/01/2018)
			To 12/31/2018	Date/Time Pre	
				2/13/2020 2: 3	18 pm
<u> </u>	Ti tl e	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1 00	0.00	col . 2)	
INDATI ENT. DOUTINE CERVILOE COCT CENTERS		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			4 750 447		1 00 04
30. 00 03000 ADULTS & PEDI ATRI CS			1, 758, 417		30.00
31. 00 O3100 INTENSIVE CARE UNIT			341, 298		31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS		0.40557	7 424 022	200 (00	- ~
50. 00 05000 OPERATING ROOM		0. 48557	·	209, 688	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC		1. 62215 0. 22700		145.040	
				145, 949	
60. 00 06000 LAB0RAT0RY 60. 01 06001 BL00D LAB0RAT0RY		0. 18993		221, 765 0	60.00
65. 00 06500 RESPI RATORY THERAPY		0.00000		_	
66. 00 06600 PHYSI CAL THERAPY		0. 38030 0. 55662		538, 610 57, 040	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 51770	·	32, 472	
68.00 06800 SPEECH PATHOLOGY		0.51770	·	27, 141	
69. 00 06900 SPEECH PATHOLOGY		0. 33314	·	· ·	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 31722	·	369, 325	
72.00 07200 MPL. DEV. CHARGED TO PATIENT		0. 28760			
73. 00 07300 DRUGS CHARGED TO PATTENTS		0. 42986		651, 663	
OUTPATIENT SERVICE COST CENTERS		0.42700	1, 515, 705	031,003	73.00
B8. 00 08800 RURAL HEALTH CLINIC		0.00000		0	88.00
90. 00 09000 CLINI C		0. 68488		0	90.00
90. 01 09001 WOUND CLINC		0. 53889		0	90.0
21. 00 09100 EMERGENCY		0. 46859		36, 796	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 42266	·	938	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1. 12200	7, 406, 987	2, 744, 381	
Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		0, 100, 707		201.00
Net charges (Line 200 minus Line 201)	g (01)		7 406 987		202 00

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)
202.00 | Net charges (line 200 minus line 201)

7, 406, 987

202.00

Health Financial Systems MARGARET MARY COM				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1329	Peri od:	Worksheet D-3	3
			From 01/01/2018 To 12/31/2018		narod.
			10 12/31/2010	2/13/2020 2: 3	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	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			17, 643		30.00
31.00 03100 INTENSIVE CARE UNIT			3, 744		31.00
43. 00 04300 NURSERY			39, 901		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 48557	13, 248		
52.00 05200 DELIVERY ROOM & LABOR ROOM		1. 62215	43, 121	69, 949	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 22700			
60. 00 06000 LABORATORY		0. 18993		5, 707	
60. 01 06001 BL00D LABORATORY		0.00000		1	60. 01
65. 00 06500 RESPI RATORY THERAPY		0. 38030			
66. 00 06600 PHYSI CAL THERAPY		0. 55662		222	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 51770			67.00
68. 00 06800 SPEECH PATHOLOGY		0. 55314			
69. 00 06900 ELECTROCARDI OLOGY		0. 31722			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 28760	16, 848	4, 846	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 87943		2, 777	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 42986	57 24, 711	10, 622	73.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		1. 68145	57 0	0	88. 00
90. 00 09000 CLI NI C		0. 68488	81 66	45	90.00
90. 01 09001 WOUND CLINC		0. 53889		0	
91. 00 09100 EMERGENCY		0. 46859	9, 395	4, 402	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 42266		0	1 /2.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1	175. 074	116 025	200 00

201.00

202.00

175, 074

0 92.00 116,025 200.00

202.00

91.00 OPTION EMERGENCY
92.00 OP200 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 COMMUN	IITY HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1329	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 2/13/2020 2:38 pm

			10 12/31/2016	2/13/2020 2: 3	
		Title XVIII	Hospi tal	Cost	<u> </u>
				1. 00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			12 074 001	1 00
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	tions)		13, 974, 091 0	1. 00 2. 00
3. 00	OPPS payments	ti ons)		0	
4. 00				0	4.00
4. 01				Ö	4. 01
5. 00	, , ,			0.000	5.00
6. 00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			13, 974, 091	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12.00	Ancillary service charges	(0)		0	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15. 00	Customary charges Aggregate amount actually collected from patients liable for	nayment for services on	a chargo basis	0	15.00
16. 00	Amounts that would have been realized from patients liable fo			0	16.00
10.00	had such payment been made in accordance with 42 CFR §413.13(on a chargebasis	l	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	<u>.</u>		0. 000000	17. 00
18.00	Total customary charges (see instructions)			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)		, ,	I	
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)			I	
21. 00	Lesser of cost or charges (see instructions)			14, 113, 832	1
22. 00	Interns and residents (see instructions)			0	
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	2)		121 020	25 00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on line	•	ructions)	121, 029 7, 529, 027	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)]	•	'	6, 463, 776	
27.00	instructions)	prus the sum of fines 22	1 did 20] (300	0, 403, 770	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	29.00
30.00	Subtotal (sum of lines 27 through 29)			6, 463, 776	30.00
31.00	Primary payer payments			4, 646	31.00
32.00	Subtotal (line 30 minus line 31)			6, 459, 130	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			852, 522	
35.00	Adjusted reimbursable bad debts (see instructions)	rusti spa)		554, 139	
	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		384, 364 7, 013, 269	
38. 00	MSP-LCC reconciliation amount from PS&R			7,013,209	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		ı	39.50
39. 97	Demonstration payment adjustment amount before sequestration	3)		0	39. 97
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instruc	ctions)	Ō	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	(11111111111111111111111111111111111111		0	39. 99
40.00	Subtotal (see instructions)			7, 013, 269	40.00
40.01	Sequestration adjustment (see instructions)			140, 265	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	
41.00				6, 607, 787	
42.00	,			0	
43.00	Balance due provider/program (see instructions)			265, 217	
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR				00 00
90. 00 91. 00	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	
92.00	Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)				94.00
, 00	1.212. (22 0. 1.1100). 4.14 /0/		'	O	, , 00

Health Financial Systems MARGARET ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-1329

				0 12/31/2018	Date/lime Prep 2/13/2020 2:38	
		Title	XVIII	Hospi tal	Cost	<u> </u>
	<u> </u>	Inpatient Part A		Par	rt B	
		/- - /	A	/- - /	A	
		mm/dd/yyyy	Amount 2.00	mm/dd/yyyy 3.00	Amount	
1. 00	Total interim payments paid to provider	1.00	5, 351, 301		4. 00 6, 545, 640	1.00
2. 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		5, 331, 301		0, 545, 640	2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
2 01	Program to Provider ADJUSTMENTS TO PROVIDER	08/14/2018	144, 600	12/31/2019	62, 147	2 01
3. 01 3. 02 3. 03 3. 04 3. 05	ADJUSTMENTS TO PROVIDER	12/31/2019	199, 135 (5	0 0 0	3. 01 3. 02 3. 03 3. 04 3. 05
	Provider to Program					
3. 50 3. 51 3. 52 3. 53	ADJUSTMENTS TO PROGRAM		(0 0 0	3. 50 3. 51 3. 52 3. 53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		343, 735	1	0 62, 147	3. 54 3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5, 695, 036	5	6, 607, 787	4.00
F 00	TO BE COMPLETED BY CONTRACTOR	Γ	Γ	T		г ос
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provi der		_	.1	_	
5. 01 5. 02 5. 03	TENTATI VE TO PROVI DER				0 0	5. 01 5. 02 5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51			(0	5.5
5. 52			(0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(0	5. 9
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER)	1	265, 217	6.0
6. 02	SETTLEMENT TO PROGRAM		276, 965		0	6. 02
7. 00	Total Medicare program liability (see instructions)		5, 418, 071		6, 873, 004	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00
	1	ı		1	1 1	0

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-255					2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1329 Period:			Worksheet E-1	
			From 01/01/2018 To 12/31/2018	Date/Time Pr	enared:
			12, 01, 2010	2/13/2020 2:	
		Title XVIII	Hospi tal	Cost	
	TO DE COMPLETED BY CONTRACTOR FOR MONOTANDARD COOT REPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	AI			_
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		0.14		1.00
2. 00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2				3.00	
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12					4.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200					5.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20					6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I				7. 00	
	line 168	-			
8. 00	8.00 Calculation of the HIT incentive payment (see instructions)				8. 00
9.00					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 Instructio	ns)		32.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1329	From 01/01/2018	Worksheet E-3 Part V Date/Time Pre 2/13/2020 2:3	pared:
	Title XVIII	Hospi tal	Cost	
			1.00	
PART V - CALCULATION OF REIMBURSEMENT	SETTLEMENT FOR MEDICARE PART A SERVICES - CO	ST REIMBURSEMENT		
1.00 Inpatient services			5, 993, 574	1.00
2.00 Nursing and Allied Health Managed Care	navment (see instructions)		0	2.00

		LOST	
	AND ALL AND ALL THE AND AS DELUNINGSHIPLY OF THE RESULT FOR HIS LAND AND A STOLEN AND A SOUTH AND A SOUTH AS A	1. 00	
4 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT	5 000 574	
1.00	Inpatient services	5, 993, 574	
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)	5, 993, 574	
5.00	Pri mary payer payments	0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)	6, 053, 510	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		1
	Reasonable charges	_	
7. 00	Routine service charges	0	7. 00
8. 00	Ancillary service charges	0	8. 00
9. 00	Organ acquisition charges, net of revenue	0	
10.00	Total reasonable charges	0	10.00
	Customary charges		1
11. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
12. 00	Amounts that would have been realized from patients liable for payment for services on a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)		1
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0. 000000	
14. 00	Total customary charges (see instructions)	0	14.00
15. 00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see	0	15.00
47.00	instructions)		144.00
16. 00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see	0	16. 00
17. 00	instructions) Cost of physicians' services in a teaching hospital (see instructions)	0	17. 00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	- 0	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	6, 053, 510	
20. 00	Deducti bl es (excl ude professi onal component)	554, 736	
21. 00	Excess reasonable cost (from line 16)	0	
22. 00	Subtotal (line 19 minus line 20 and 21)	5, 498, 774	
23. 00	Coi nsurance		23. 00
24. 00	Subtotal (line 22 minus line 23)	5, 494, 754	
25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	52, 139	
26. 00	Adjusted reimbursable bad debts (see instructions)	33, 890	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22, 149	
	j ,		
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	5, 528, 644	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	
29. 99	Demonstration payment adjustment amount before sequestration	0	
30. 00	Subtotal (see instructions)	5, 528, 644	
30. 01	Sequestration adjustment (see instructions)	110, 573	
30. 02	Demonstration payment adjustment amount after sequestration	0	
31. 00	Interim payments	5, 695, 036	
32. 00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-276, 965	
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	34.00
	§115. 2		

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

		-	To 12/31/2018	Date/Time Pre 2/13/2020 2:3	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	CES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		212, 849		1.00
2.00	Medi cal 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)		212, 849	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)		212, 849	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routine service charges		61, 289		8. 00
9. 00	Ancillary service charges		175, 074	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		236, 363	0	12.00
12 00	CUSTOMARY CHARGES				12.00
13. 00	Amount actually collected from patients liable for payment for se	ervices on a charge	0	0	13.00
14. 00	basis Amounts that would have been realized from patients liable for pa	nument for social sec or	0	0	14.00
14.00	a charge basis had such payment been made in accordance with 42 (٥	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	CIR 9413. 13(e)	0. 000000	0. 000000	15.00
16. 00	Total customary charges (see instructions)		236, 363	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete only i	if line 16 exceeds	23, 514	0	
17.00	line 4) (see instructions)	TT TTTC TO CACCCAS	20,011	O	17.00
18.00		if line 4 exceeds line	o	0	18. 00
	16) (see instructions)				
19.00			0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruct	tions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		212, 849	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	mpleted for PPS provid	ers.		
22.00	Other than outlier payments		0	0	22. 00
23.00	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		0	0	
			0		24. 00
			0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00			212, 849	0	29. 00
00.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				00.00
30.00	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		212, 849	0	
32.00	Deducti bl es		0	0	
	Coinsurance		0	0	33. 00 34. 00
	Allowable bad debts (see instructions)	0	Ü	35.00	
35. 00 36. 00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33	212, 849	0	1	
		212, 049	0		
	Subtotal (line 36 ± line 37)	212, 849	0		
39. 00	Direct graduate medical education payments (from Wkst. E-4)	212,047	U	39.00	
40. 00		212, 849	0		
41. 00	Interim payments	195, 739	0		
42. 00	Balance due provider/program (line 40 minus line 41)		17, 110	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2.	0	0	
	chapter 1, §115.2			Ü	

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

oni y)				1270172010	2/13/2020 2: 3	8 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
1 00	CURRENT ASSETS Cash on hand in banks	1 404 100		0	0	1 00
1. 00 2. 00	Temporary investments	1, 496, 199	0	0	0	1.00 2.00
3. 00	Notes recei vabl e		Ö	0	Ö	3.00
4.00	Accounts receivable	54, 951, 228	0	0	0	
5.00	Other recei vable	0	0	0	0	
6. 00	Allowances for uncollectible notes and accounts receivable		1	0	0	
7.00	Inventory	1, 355, 219	1	0	0	7.00
8. 00 9. 00	Prepaid expenses Other current assets	1, 839, 815 311, 178	1	0	0	8. 00 9. 00
10.00	Due from other funds	311, 170		0	0	10.00
11.00	Total current assets (sum of lines 1-10)	28, 437, 711	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2, 419, 583	1	0	0	
13.00	Land improvements	272, 044	1	0	0	
14. 00 15. 00	Accumulated depreciation Buildings	-177, 675 79, 896, 265	1	0	0	14.00 15.00
16. 00	Accumulated depreciation	-42, 949, 570	1	0	0	16.00
17. 00	Leasehold improvements	0	Ö	0	Ö	17.00
18.00	Accumul ated depreciation	0	0	0	0	18.00
19.00	Fi xed equipment	5, 245, 768	0	0	0	19.00
20.00	Accumulated depreciation	-5, 119, 044		0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22. 00	Accumulated depreciation Major movable equipment	E7 227 422	0	0	0	22.00
23. 00 24. 00	Accumulated depreciation	57, 327, 432 -33, 052, 191		0	0	23. 00 24. 00
25. 00	Mi nor equi pment depreci abl e	-33,032,191		0	0	25.00
26. 00	Accumulated depreciation		Ö	0	Ö	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	Mi nor equi pment-nondepreci abl e	0	0	0	0	
30. 00	Total fixed assets (sum of lines 12-29)	63, 862, 612	0	0	0	30.00
31. 00	OTHER ASSETS Investments	0	ol	0	0	31. 00
32.00	Deposits on Leases		Ö	0	Ö	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	71, 470, 580	1	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	71, 470, 580	1	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	163, 770, 903	0	0	0	36.00
37. 00	CURRENT LIABILITIES Accounts payable	7, 712, 903	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	7,712,703		0	0	38.00
39. 00	Payrol I taxes payable	9, 260, 156	_	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	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	3, 051, 850 20, 024, 909		0	0	
43.00	LONG TERM LIABILITIES	20,024,909	0	0	0	45.00
46. 00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0	0	0	0	
48. 00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	23, 823, 994	1	0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	23, 823, 994	1	0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	43, 848, 903	0	0	0	51.00
52. 00	General fund balance	119, 922, 000				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	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59. 00	Total fund balances (sum of lines 52 thru 58)	119, 922, 000	o	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	163, 770, 903	1	0	0	60.00
	59)					
			,			

In Lieu of Form CMS-2552-10 Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-1329 Peri od: Worksheet G-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 2/13/2020 2:38 pm General Fund Special Purpose Fund Endowment Fund 1. 00 2.00 3.00 4.00 5.00 1.00 Fund balances at beginning of period 127, 963, 057 0 1.00 Net income (loss) (from Wkst. G-3, line 29) -8, 041, 208 2.00 2.00 119, 921, 849 3.00 Total (sum of line 1 and line 2) ol 3.00 4.00 MI SC 151 4.00 0 5.00 0 0 5.00 0 6.00 0 0 0 0 6.00 0 7.00 0 7.00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 151 0 10.00 119, 922, 000 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 000000 13.00 0 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 119, 922, 000 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 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 0 0 3.00 Total (sum of line 1 and line 2) 3.00 4.00 MI SC 4.00 5.00 5.00 6.00 0 6.00 7.00 0 7.00

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12. 00 13. 00

14.00

15.00

16.00

17.00

18.00

Total additions (sum of line 4-9)

Deductions (debit adjustments) (specify)

Total deductions (sum of lines 12-17)

Fund balance at end of period per balance

Subtotal (line 3 plus line 10)

sheet (line 11 minus line 18)

Health Financial Systems MARGA STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1329

			To 12/31/2018	Date/Time Pre 2/13/2020 2:3	
	Cost Center Description	Inpatient	Outpati ent	Total	O pili
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	7, 991, 54	0	7, 991, 540	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVIDER - IRF				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, 991, 54	10	7, 991, 540	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	661, 17	'8	661, 178	11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	661, 17	'8	661, 178	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	8, 652, 71		8, 652, 718	17. 00
18. 00	Ancillary services	18, 882, 61		149, 029, 286	18. 00
19. 00	Outpati ent servi ces	522, 68		19, 523, 695	19. 00
20.00	RURAL HEALTH CLINIC		0 1, 129, 275	1, 129, 275	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY		1, 778, 083	1, 778, 083	22. 00
23. 00	AMBULANCE SERVICES				23.00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGI CAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE		0 2, 335, 386	2, 335, 386	26. 00
27. 00	NON-PROVI DER BASED	20		8, 788, 513	27. 00
27. 01	PROFESSI ONAL FEES	2, 165, 21		25, 124, 051	27. 01
27. 02	DI ETARY		0 8, 692	8, 692	27. 02
28. 00	Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.	30, 223, 43	186, 146, 260	216, 369, 699	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		107 221 (01		20.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		107, 331, 601		29.00
30.00	ADD (SPECIFY)		0		30.00
31. 00 32. 00			0		31. 00 32. 00
32.00			0		32.00
			0		
34.00			0		34.00
35. 00 36. 00	Total additions (sum of Lines 20 25)		0		35. 00 36. 00
37. 00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)		0		37.00
38.00	DEDUCT (SELOTE)		0		38.00
39.00			0		39.00
40.00			0		40.00
40.00			0		40.00
41.00	Total deductions (sum of lines 37-41)				41.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	yr	107, 331, 601		43.00
43.00	to Wkst. G-3, line 4)	1	107, 331, 001		75.00
	100 1100 17	1	1		ı

	Financial Systems MARGARET MARY COMMU			u of Form CMS-2	
STATEM	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1329	Peri od:	Worksheet G-3	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	nared·
			10 12/01/2010	2/13/2020 2: 3	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			216, 369, 699	1.00
2.00	Less contractual allowances and discounts on patients' accounts		115, 769, 341	2.00	
3.00	Net patient revenues (line 1 minus line 2)			100, 600, 358	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		107, 331, 601	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-6, 731, 243	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 I NCOME			1, 397, 789	24.00
24. 01	CONTRI BUTI ONS			461, 900	24. 01
24. 02	GAIN ON DISPOSAL			17, 099	24. 02
24. 03	INVESTMENT RETURN			3, 670, 726	24. 03
24. 04	UNREALI ZED GAIN, DERI VATI VE			399, 170	
24. 05	TEMPORARILY RESTRICTED ASSETS			12, 504	24. 05
24.06	UNREALIZED GAIN, INVESTMENTS			-7, 135, 078	
24 07	DONATION OF LAND			_13/ 075	

24.07

25.00 26. 00 27. 00

0 28.00

-134, 075

-1, 309, 965

-8, 041, 208

0

-8, 041, 208 29. 00

24.07 DONATION OF LAND
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

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-66, 658

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1, 920, 582

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1, 920, 582

18.00

19.00

20.00

21.00

22.00

23.00

23.50

24.00

18.00

19.00

20.00

21.00

22.00

23.00

23.50

Clinic

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

24.00 Total (sum of lines 1-23)

Health Promotion Activities

Home Delivered Meals Program

21.00	Thome berrivered mears rrogram		9	٥	9	9	0	21.00
	Homemaker Service	0	O	0	0	O	0	00
	All Others (specify)	0	0	0	0	0	0	23. 00
23.50	Tel emedi ci ne	0	0	0	0	0	0	23. 50
24.00	Total (sum of lines 1-23)	1, 920, 582	0	0	0	O	1, 920, 582	24.00
		Admi ni strati v	Total (col s.		<u> </u>			
		e & General	4A + 5)					
		5. 00	6. 00					
	GENERAL SERVICE COST CENTERS		<u> </u>			<u> </u>		
1.00	Capital Related - Bldg. &							1.00
	Fixtures							
2.00	Capital Related - Movable							2.00
2.00	Equi pment							2.00
3.00	Plant Operation & Maintenance							3.00
4. 00	Transportation							4.00
5. 00	Administrative and General	637, 240						5.00
5.00	HHA REIMBURSABLE SERVICES	037, 240						3.00
6. 00	Skilled Nursing Care	285, 849	861, 521					6. 00
7. 00	Physical Therapy	241, 118	726, 707					7.00
8. 00		84, 031	253, 261					8.00
	Occupational Therapy							
9.00	Speech Pathology	1, 813	5, 464					9.00
10.00	Medical Social Services	6, 794	20, 477					10.00
11. 00	Home Health Aide	17, 339	52, 259					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	0					15.00
16.00	Respi ratory Therapy	296	893					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	l o	0					22. 00
23.00	All Others (specify)	l ol	0					23. 00
	Tel emedi ci ne	0	0					23. 50
	Total (sum of lines 1-23)]	1, 920, 582					24. 00
50	1	1	., ,20,002					

Health Financial Systems	MAF	RGARET MARY COM	MUNITY HOSPITA	.L	In Lieu of Form CMS-2552-10			
COST ALLOCATION - HHA STATISTICAL BAS	SIS		Provi der Co		Peri od:	Worksheet H-1		
		HHA CCN:		From 01/01/2018 To 12/31/2018				
					Home Health	PPS	о рііі	
					Agency I			
	Capi tal Rel	ated Costs						
	BI dgs &	Movabl e			Reconciliatio			
	Fivturoc	Equipment	Operation 0	l b (MITEVCE)	n	a 0 Canaral	4	

						Agency I		
		Capi tal 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			(ACCUM. COST)	
			VALUE)	(SQUARE FEET)				
		1. 00	2. 00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		0			0		2.00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	C		0		3. 00
4.00	Transportation (see	0	0	C	0			4. 00
	instructions)							
5. 00	Administrative and General	0	0	C	0	-637, 240	1, 283, 342	5.00
	HHA REIMBURSABLE SERVICES				1			
6.00	Skilled Nursing Care	0	0	C	0	0	575, 672	6.00
7. 00	Physi cal Therapy	0	0	C	0	0	485, 589	
8.00	Occupational Therapy	0	0	C	0	0	169, 230	
9. 00	Speech Pathology	0	0	C	0	0	3, 651	9. 00
10.00	Medical Social Services	0	0	C	0	0	13, 683	
11. 00	Home Health Aide	0	0	C	0	0	34, 920	
12.00	Supplies (see instructions)	0	0	C	0	0	0	12.00
13.00	Drugs	0	0	C		0	0	13.00
14.00	DME	0	0	C	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	0	C	0	0		15. 00
16.00	Respiratory Therapy	0	0	C	0	0	597	16.00
17. 00	Private Duty Nursing	0	0	C	0	0	0	
18.00	Clinic	0	0	C	0	0	0	18. 00
19.00	Health Promotion Activities	0	0	C	0	0	0	19.00
20.00	Day Care Program	0	0	C	0	0	0	20.00
21. 00	Home Delivered Meals Program	0	0	C	0	0	0	21.00
22.00	Homemaker Service	0	0	C	0	0	0	22.00
23.00	All Others (specify)	0	0	C	0	0	0	23.00
23. 50	Tel emedi ci ne	0	0	C	0	0	0	23. 50
24.00	Total (sum of lines 1-23)	0	0	C	0	-637, 240		
25.00	Cost To Be Allocated (per	0	0	C	0		637, 240	25. 00
	Worksheet H-1, Part I)							
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0. 000000		0. 496547	26.00

In Lieu of Form CMS-2552-10 Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Provider CCN: 15-1329 Peri od: Worksheet H-2 From 01/01/2018 Part I HHA CCN: 15-7143 12/31/2018 Date/Time Prepared: To 2/13/2020 2:38 pm Home Health Agency I CAPITAL RELATED COSTS NEW MVBLE NEW BLDG & NEW OFFSITE NEW MVBLE **EMPLOYEE** Cost Center Description HHA Trial Bal ance (1) FI XT BLDG EQUI P EQUIP OFFSIT **BENEFITS** DEPARTMENT 1. 00 1. 01 2. 01 0 2.00 4. 00 1.00 Administrative and General 50, 522 2, 345 1,003 486, 803 1.00 93, 671 2.00 Skilled Nursing Care 861, 521 2.00 3.00 Physical Therapy 726, 707 0 o 3.00 0 0 Occupational Therapy 253, 261 0 0 o 4.00 4.00 0 Speech Pathology 0 5.00 5, 464 0 5.00 0 6.00 Medical Social Services 20, 477 00000000000 0 0 6.00 7.00 Home Health Aide 52, 259 0 0 0 7.00 Supplies (see instructions) 0 0 8.00 8 00 Ω 0 0 0 9.00 Drugs 9.00 10.00 DMF 0 10.00 0 0 11.00 Home Dialysis Aide Services 0 0 11.00 Respiratory Therapy 893 0 12.00 12.00 13.00 Private Duty Nursing 0 0 13.00 14.00 Clinic 0 0 14.00 Health Promotion Activities 0 15.00 0 0 15.00 0 16.00 16.00 Day Care Program Ω 17.00 Home Delivered Meals Program 0 0 0 0 0 17.00 Homemaker Service 0 0 o 18.00 0 18.00 All Others (specify) 0 0 0 o 19 00 0 19 00 19.50 Tel emedi ci ne 0 0 0 0 19.50 Total (sum of lines 1-19) (2) 1, 920, 582 50, 522 2, 345 93, 671 1,003 486, 803 20.00 20.00

	20, Title I divided by the 3dill							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	Subtotal	ADMI NI STRATI V	OPERATION OF	OPERATION OF	OPERATION OF	LAUNDRY &	
			E & GENERAL	PLANT	PLANT	PLANT -	LINEN SERVICE	
					-0FFSITE	HOSPITAL &		
						0FFS		
		4A	5. 00	7. 00	7. 01	7. 02	8. 00	
1.00	Administrative and General	634, 344	124, 156	95, 621	968	18, 016	0	1.00
2.00	Skilled Nursing Care	861, 521	168, 621	0	0	0	0	2.00
3.00	Physi cal Therapy	726, 707	142, 234	0	0	0	0	3.00
4.00	Occupational Therapy	253, 261	49, 569	0	0	0	0	4.00
5.00	Speech Pathology	5, 464	1, 069	0	0	0	0	5.00
6.00	Medical Social Services	20, 477	4, 008	0	0	0	0	6.00
7.00	Home Health Aide	52, 259	10, 228	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respi ratory Therapy	893	175	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18. 00	Homemaker Service	0	0	0	0	0	0	18.00
19. 00	All Others (specify)	0	0	0	0	0	0	19.00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20.00	Total (sum of lines 1-19) (2)	2, 554, 926	500, 060	95, 621	968	18, 016	0	20.00
21. 00	Unit Cost Multiplier: column	0. 000000				,		21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	1		1	1	1	n		

21.00

21.00

Unit Cost Multiplier: column

26, line 1 divided by the sum

⁽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.

ALLOCATION OF GENERAL SERVI	LLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS			Provider C		Period: From 01/01/2018 To 12/31/2018		pared:
						Home Health Agency I	PPS	
Cost Center Des	cription	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI C	CENTRAL	PHARMACY	
		9. 00	10. 00	11. 00	13.00	14. 00	15. 00	
1.00 Administrative and Ge 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Servic 7.00 Home Health Aide 8.00 Supplies (see instruc 9.00 DME 11.00 DME 11.00 Home Dialysis Aide Se 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Acti 16.00 Day Care Program 17.00 Home Delivered Meals 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1 21.00 Unit Cost Multiplier: 26, line 1 divided by of column 26, line 1, ro 6 decimal places.	ces ctions) ervices vities Program 1-19) (2) column y the sum ominus counded to	69, 031 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0				0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
Cost Center Des	cription	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	
1.00 Administrative and Ge 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Service 7.00 Home Health Aide 8.00 Supplies (see instruce 9.00 DME 11.00 Home Dialysis Aide Sc 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Acti 16.00 Day Care Program 17.00 Home Delivered Meals 18.00 Home Delivered Meals 18.00 Home Delivered Meals 19.00 Home Delivered Meals 10.00 Unit Cost Multiplier: 26, line 1 divided by of column 26, line 1, re 6 decimal places.	ces ctions) ervices vities Program 1-19) (2) column y the sum ominus	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	942, 136 1, 030, 142 868, 941 302, 830 6, 533 24, 485 62, 487 0 0 1, 068 0 0 0 0 0 3, 238, 622		1, 030, 14, 868, 94 302, 83 6, 53 24, 48 62, 48 1, 066	2 422, 618 356, 484 0 124, 236 3 2, 680 5 10, 045 7 25, 635 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 225, 425 427, 066 9, 213 34, 530 88, 122 0 0 0 1, 506 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 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

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

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 15-1329 Period: Worksheet H-2
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 2/13/2020 2:38 pm BASIS HHA CCN: 15-7143

					Home Health Agency I	PPS	
		CAPITAL REL	ATED COSTS		Agency i		
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SOUARE FEET)	NEW MVBLE EQUIP (SOUARE 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, 753, 398 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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	634, 344 861, 521 726, 707 253, 261 5, 464 20, 477 52, 259 0 0 0 893 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 BASIS HHA CCN: 15-7143

						Home Health	PPS	
						Agency I		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MEALS	(FTE'S)	ADMI NI STRATI O	SERVICES &	(100% T0	RECORDS &	
		SERVED)		N	SUPPLY	DRUGS)	LI BRARY	
				(HOURS OF	(100% MED		(TIME	
				SERVI CE)	SUPPLI ES)		SPENT)	
		10. 00	11. 00	13. 00	14. 00	15. 00	16. 00	
1.00	Administrative and General	0	0	0	(0	0	1.00
2.00	Skilled Nursing Care	0	0	0	(0	0	2.00
3.00	Physi cal Therapy	0	0	0	(0	0	3.00
4.00	Occupational Therapy	0	0	0	(0	0	4.00
5.00	Speech Pathology	0	0	0	(0	0	5. 00
6.00	Medical Social Services	0	0	0	C	0	0	6.00
7.00	Home Health Aide	0	0	0	C	0	0	7. 00
8.00	Supplies (see instructions)	0	0	0	C	0	0	8.00
9.00	Drugs	0	0	0	C	0	0	9. 00
10.00	DME	0	0	0	C	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	C	0	0	11.00
12.00	Respiratory Therapy	0	0	0	C	0	0	12.00
13.00	Private Duty Nursing	0	0	0	C	0	0	13.00
14.00	Clinic	0	0	0	C	0	0	14.00
15.00	Health Promotion Activities	0	0	0	C	0	0	15.00
16.00	Day Care Program	0	0	0	C	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	C	0	0	17.00
18.00	Homemaker Service	o	0	0	C	o	0	18.00
19.00	All Others (specify)	o	0	0	l	ol	0	19.00
19. 50	Tel emedi ci ne	o	0	0	l	ol	0	19. 50
20.00	Total (sum of lines 1-19)	0	0	0		o	0	20.00
21.00	Total cost to be allocated	0	0	0		o	0	21.00
22. 00	Unit cost multiplier	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	22.00

Heal th	Financial Systems	MAF	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	552-10
	IONMENT OF PATIENT SERVICE COS			Provi der C	CN: 15-1329	Peri od:	Worksheet H-3	
				HHA CCN:		From 01/01/2018 To 12/31/2018	Part I Date/Time Prep 2/13/2020 2:38	pared:
				Title	XVIII	Home Health	PPS	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Agency I Total Visits	Average Cost	
	·	H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
		0	Part I) 1.00	Part II)	3.00	4. 00	col . 4) 5.00	
	PART I - COMPUTATION OF LESSER			2.00				
	COST LIMITATION	OF AUGINEDATE	TROUNAM COST, A		TE I NOOKAW ET	WITATION COST, C	N BENEFI CIANT	
1 00	Cost Per Visit Computation	2.00	1 450 7(0		1 450 74	O E 242	271 05	1 00
1. 00 2. 00	Skilled Nursing Care Physical Therapy	2. 00 3. 00		0	1, 452, 76 1, 225, 42		271. 95 417. 66	1. 00 2. 00
3. 00	Occupational Therapy	4.00		0			364. 70	3. 00
4. 00	Speech Pathology	5. 00		0			151. 03	4. 00
5.00	Medical Social Services	6.00			34, 53		3, 453. 00	5.00
6.00	Home Health Aide	7.00	88, 122		88, 12	2 1, 042	84. 57	6.00
7. 00	Total (sum of lines 1-6)		3, 237, 116	0	3, 237, 11			7.00
					Program Visit	S		
					Pa	ırt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
					to	Deducti bl es		
					Deductibles			
		0	1.00	2.00	Coi nsurance		F 00	
	Limitation Cost Computation	0	1. 00	2. 00	3.00	4. 00	5. 00	
8. 00	Skilled Nursing Care		99915	0	2, 39	5		8. 00
8. 01	Skilled Nursing Care		17140	0				8. 01
9.00	Physi cal Therapy		99915	0	1, 44	0		9.00
9. 01	Physi cal Therapy		17140	0				9. 01
10.00	Occupational Therapy	•	99915	0	62			10.00
10.01	Occupational Therapy	•	17140	0		1		10.01
11. 00 11. 01	Speech Pathology Speech Pathology	+	99915 17140	0		2 0		11. 00 11. 01
12. 00	Medical Social Services		99915	0	•	4		12.00
12. 01	Medical Social Services		17140	0		o l		12. 01
13. 00	Home Health Aide		99915	0				13.00
13.01	Home Health Aide		17140	0	18	7		13.01
14. 00	Total (sum of lines 8-13)			0				14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA Costs (cols.	Total Charges		
		H-2 Part I, col. 28, line	Costs (from Wkst. H-2,	Ancillary Costs (from	1 + 2)	(from HHA Records)	÷ col. 4)	
		20, 11116	Part I)	Part II)	1 + 2)	Records)		
		0	1. 00	2.00	3.00	4. 00	5. 00	
15 00	Supplies and Drugs Cost Comput Cost of Medical Supplies						0.000000	
		1 8 00	0	0		ol ol	() ()()()()()()()	15 00
16.00	Cost of Drugs	8. 00 9. 00		0		0 0	0. 000000	15. 00 16. 00
16.00		9. 00			Cost of			
16.00		9. 00	Program Visits	0		0 0		
16.00	Cost of Drugs	9. 00	O Program Visits	0	Cost of			
16.00		9.00	Program Visits Part Not Subject	0 t B	Cost of Services	0 0 Part B	0.000000 Subject to Deductibles &	
16.00	Cost of Drugs	9.00	Program Visits Part Not Subject to Deductibles &	t B Subject to	Cost of Services	O O Part B Not Subject to Deductibles &	0.000000 Subject to	
16.00	Cost of Drugs	9.00 Part A	Program Visits Part Not Subject to Deductibles & Coinsurance	t B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	0.000000 Subject to Deductibles & Coinsurance	
16.00	Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER	9.00 Part A 6.00	Program Visits Part Not Subject to Deductibles & Coinsurance 7.00	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A 9.00	Part B Not Subject to Deductibles & Coinsurance 10.00	O. 000000 Subject to Deductibles & Coinsurance	
16. 00	Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION	9.00 Part A 6.00	Program Visits Part Not Subject to Deductibles & Coinsurance 7.00	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A 9.00	Part B Not Subject to Deductibles & Coinsurance 10.00	O. 000000 Subject to Deductibles & Coinsurance	
	Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER	9.00 Part A 6.00	Program Visits Part Not Subject to Deductibles & Coinsurance 7.00	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A 9.00 HE PROGRAM LII	Part B Not Subject to Deductibles & Coinsurance 10.00	O. 000000 Subject to Deductibles & Coinsurance	
	Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation	9.00 Part A 6.00	Program Visits Part Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A 9.00 HE PROGRAM LI	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, 0	O. 000000 Subject to Deductibles & Coinsurance	16.00
1. 00 2. 00	Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	9.00 Part A 6.00 OF AGGREGATE	Program Visits Part Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 2,653 1,571 653	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A 9.00 HE PROGRAM LI	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, 0	O. 000000 Subject to Deductibles & Coinsurance	1. 00
1. 00 2. 00 3. 00 4. 00	Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	9.00 Part A 6.00 OF AGGREGATE	Program Visits Part Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 2,653 1,571 653 42	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A 9.00 HE PROGRAM LII	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, CO 0 721, 483 0 656, 144 0 238, 149 0 6, 343	O. 000000 Subject to Deductibles & Coinsurance	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	9.00 Part A 6.00 OF AGGREGATE	Program Visits Part Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 2,653 1,571 653 42 4	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A 9.00 HE PROGRAM LII	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, CO 0 721, 483 0 656, 144 0 238, 149 0 6, 343 0 6, 343 0 13, 812	O. 000000 Subject to Deductibles & Coinsurance	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00	Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	9.00 Part A 6.00 OF AGGREGATE	Program Visits Part Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 2,653 1,571 653 42 4 639	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A 9.00 HE PROGRAM LII	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, CO 0 721, 483 0 656, 144 0 238, 149 0 6, 343	O. 000000 Subject to Deductibles & Coinsurance 11.00 IR BENEFICIARY	1. 00 2. 00 3. 00 4. 00

	Financial Systems TONMENT OF PATIENT SERVICE COS		GARET MARY CON	Provider Co	CN: 15-1329 15-7143	Peri od: From 01/01/2018 To 12/31/2018	2/13/2020 2: 3	pared:
	Cost Contar Decement on			Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 00 12. 01 13. 00 13. 01 14. 00	Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)							8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 11. 01 12. 00 12. 01 13. 00 13. 01 14. 00
		Progr	ram Covered Cha	arges	Cost of Services			
					Sel vi ces			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
15. 00	Supplies and Drugs Cost Comput Cost of Medical Supplies	ations 0	0	0	ı	0 0	0	15.00
	Cost of Drugs		0	l .		0	0	1
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE I	PROGRAM COST, A	AGGREGATE OF TI	HE PROGRAM L	IMITATION COST, O	R BENEFICIARY	
1. 00	Cost Per Visit Computation Skilled Nursing Care	721, 483						1.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	656, 144 238, 149 6, 343 13, 812 54, 040 1, 689, 971						2.00 3.00 4.00 5.00 6.00 7.00
	Limitation Cost Computation							
8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services							8.00 8.01 9.00 9.01 10.00 10.01 11.00 11.01 12.00

Не	ealth Financial Systems MARGARET MARY CO				MUNITY HOSPITA	JNITY HOSPITAL In Lieu			2552-10
Al	PPORT	IONMENT OF PATIENT SERVICE COST	S		Provi der C	CN: 15-1329	Peri od:	Worksheet H-3	
					HHA CCN:	15-7143	From 01/01/2018 To 12/31/2018		pared: 8 pm
					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 Indicated		
					records)	x col. 2)			
			0	1. 00	2. 00	3.00	4. 00		
		PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED I	BY SHARED HOSP	ITAL DEPARTME	NTS		
1.	00	Physi cal Therapy	66. 00	0. 556625	0		0 col. 2, line 2	. 00	1.00
2.	00	Occupational Therapy	67.00	0. 517701	0		Ocol. 2, line 3	. 00	2.00
3.	00	Speech Pathology	68.00	0. 553148	0		0 col. 2, line 4	. 00	3.00
4.	00	Cost of Medical Supplies	71.00	0. 287602	0		0 col. 2, line 1	5. 00	4.00
5.	00	Cost of Drugs	73. 00	0. 429867	0	o[0 col. 2, line 1	6. 00	5. 00

ALCUL	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der CO	CN: 15-1329	Peri od		Worksheet H-4	2552
		HHA CCN:	15-7143		1/01/2018 2/31/2018	Date/Time Pre	
		Title	XVIII		Heal th	2/13/2020 2: 3 PPS	в рп
				Age	ency I Par	† B	
			Part A	Not	Subj ect	Subject to	
					to	Deductibles &	
					ctibles &	Coi nsurance	
			1.00		nsurance 2.00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	OMARY CHARGE			2.00	3.00	
	Reasonable Cost of Part A & Part B Services						İ
00	Reasonable cost of services (see instructions)			0	0	0	1
00	Total charges			0	0	0	2
00	Customary Charges				ما	0	١,
00	Amount actually collected from patients liable for payment fo on a charge basis (from your records)	r services		0	0	0	3
00	Amount that would have been realized from patients liable for	pavment		0	0	0	4
	for services on a charge basis had such payment been made in	accordance					
	with 42 CFR §413.13(b)						
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	_	0.000000	0. 000000	
00	Total customary charges (see instructions) Excess of total customary charges over total reasonable cost	(complete		0	0	0	6
00	only if line 6 exceeds line 1)	(Compilete		O .	ď	0	ĺ '
00	Excess of reasonable cost over customary charges (complete on	lyifline		0	0	0	8
00	1 exceeds line 6) Primary payer amounts			0	0	0	9
00	Titiliar y payer amounts			-	art A	Part B	
					rvi ces	Servi ces	
					1. 00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				ما	0	1,
. 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				0	0 652, 517	
. 00	Total PPS Reimbursement - Full Episodes without outliers				0	177, 541	
. 00	Total PPS Reimbursement - LUPA Episodes				ő	14, 676	
. 00	Total PPS Reimbursement - PEP Episodes				o	3, 100	
6. 00	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0	57, 824	
. 00	Total PPS Outlier Reimbursement - PEP Episodes				0	3, 112	
. 00	Total Other Payments				0	0	17
. 00	DME Payments Oxygen Payments				0	0	18
. 00	Prosthetic and Orthotic Payments				0	0	20
. 00	Part B deductibles billed to Medicare patients (exclude coins	urance)			Ĭ	0	
. 00	Subtotal (sum of lines 10 thru 20 minus line 21)	,			О	908, 770	
. 00	Excess reasonable cost (from line 8)				o	0	23
. 00	Subtotal (line 22 minus line 23)				0	908, 770	
. 00					_	0	25
. 00					0	908, 770	
. 00	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i	netructione)					27
. 00	Total costs - current cost reporting period (line 26 plus lin		,		0	908, 770	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	.5 27)			ő	0	
. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)			o	0	
). 99	Demonstration payment adjustment amount before sequestration				o	0	30
. 00	Subtotal (see instructions)				0	908, 770	
. 01	Sequestration adjustment (see instructions)				0	18, 175	ı
. 02	Demonstration payment adjustment amount after sequestration				0	000 505	31
	Interim payments (see instructions)				0	890, 595	
	Tentative settlement (for contractor use only)				O O	0	
3.00	Ralance due provider/program (line 31 minus lines 31 01 22	and 33)					
. 00	Balance due provider/program (line 31 minus lines 31.01, 32, Protested amounts (nonallowable cost report items) in accorda		S Pub. 15-2		0	0	

Provi der CCN: 15-1329 Peri od: Worksheet H-5 15-1329 Period: Worksneet H-5 From 01/01/2018 Date/Time Prepared: TO PROGRAM BENEFICIARIES

		HHA CCN:	15-7143	10 12/31/2018	2/13/2020 2:3	
				Home Health	PPS	о рііі
				Agency I		
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		(D	890, 595	1. 00
2.00	Interim payments payable on individual bills, either			D	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			(D	0	3. 01
3. 02				D	0	3. 02
3. 03				0	0	3. 03
3.04					0	3. 04
3. 05	Provider to Program				0	3. 05
3. 50	Frovider to Frogram				0	3. 50
3. 51					ا	3. 51
3. 52					Ö	3. 52
3. 53				D	0	3. 53
3. 54				D	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			D	0	3. 99
4 00	3. 50-3. 98)				000 505	4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate,		·	D	890, 595	4. 00
	line 32)					
	TO BE COMPLETED BY CONTRACTOR			<u> </u>		
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 04	Program to Provider		1			F 04
5. 01 5. 02					0	5. 01 5. 02
5. 02						5. 02
5.05	Provider to Program		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	21	0	3.03
5. 50	Trovider to Trogram				0	5. 50
5. 51				o l	0	5. 51
5. 52				D	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			D	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER				o	6. 01
6. 02	SETTLEMENT TO PROGRAM					6. 02
7. 00	Total Medicare program liability (see instructions)				890, 595	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	

1. 00

2. 00

8.00 Name of Contractor

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106, 290

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COUNSELING - OTHER**

IMAGING SERVICES**

LABS & DLAGNOSTICS*3

OUTPATIENT SERVICES*

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*

PATIENT TRANSPORTATION**

HOSPICE AIDE & HOMEMAKER SERVICES**

DURABLE MEDICAL EQUIPMENT/OXYGEN**

MEDICAL SUPPLIES-NON-ROUTINE**

PALLIATIVE RADIATION THERAPY**

NONREI MBURSABLE COST CENTERS

OTHER PATIENT CARE SERVICES (SPECIFY) **

HOSPICE/PALLIATIVE MEDICINE FELLOWS*

DRUGS CHARGED TO PATIENTS**

PALLIATIVE CHEMOTHERAPY**

36.00

37 00

38.00

39.00

40.00

41 00

42.00

42.50

43 00

44.00

45.00

46.00

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.

Hospi ce CCN: 15-1551

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6. 00	7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1. 00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
					•
2.00	CAP REL COSTS-MVBLE EQUIP*	0			2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT*	0		l .	3.00
4.00	ADMINISTRATIVE & GENERAL*	0			4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	12, 363		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPI NG*	0	0		7. 00
8.00	DI ETARY*	0	0		8.00
9. 00	NURSI NG ADMI NI STRATI ON*	0			9.00
10.00	ROUTINE MEDICAL SUPPLIES*	Ö			10.00
11. 00	MEDI CAL RECORDS*	0		l .	11.00
				l .	
12.00	STAFF TRANSPORTATION*	0			12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0			13.00
14.00	PHARMACY*	0	,		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	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		l .	26.00
27. 00	NURSE PRACTITIONER**	0			27.00
		_	.,		
28. 00	REGI STERED NURSE**	0			28. 00
29. 00	LPN/LVN**	0			29. 00
30.00	PHYSI CAL THERAPY**	0		l .	30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	63, 931		33.00
34.00	SPI RI TUAL COUNSELI NG**	0	l .		34.00
35. 00	DI ETARY COUNSELI NG**	0			35.00
36. 00	COUNSELING - OTHER**	0	_		36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	Ö		l .	37.00
					•
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0		l .	38.00
39. 00	PATI ENT TRANSPORTATI ON**	0		l .	39.00
40.00	I MAGI NG SERVI CES**	0			40.00
41.00	LABS & DI AGNOSTI CS**	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0		l control of the cont	44.00
45. 00	PALLIATIVE CHEMOTHERAPY**	o o	l .	l control of the cont	45.00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	Ö		l control of the cont	46.00
40.00	NONREI MBURSABLE COST CENTERS		1 0		40.00
				T	1,000
60.00	BEREAVEMENT PROGRAM *	0			60.00
61. 00	VOLUNTEER PROGRAM *	0			61.00
62.00	FUNDRAI SI NG*	0	l .		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		l .	66.00
67. 00	ADVERTI SI NG*	0		l .	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG*	ı		l .	68.00
		0		l .	•
69.00	THRI FT STORE*	0		l .	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	l .		70.00
71. 00	` '	0			71.00
100.00	TOTAL	0	1, 151, 546		100.00
* T	6				

^{*} 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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617, 495

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39.00

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617, 495 100. 00

100.00 TOTAL *	•	•	1	603, 095
* Transfer the amou	int in column 7 to Wkst	0-5 col	umn 1	line 51

PATIENT TRANSPORTATION

MEDICAL SUPPLIES-NON-ROUTINE

PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

DRUGS CHARGED TO PATIENTS

PALLIATIVE CHEMOTHERAPY

IMAGING SERVICES

LABS & DIAGNOSTICS

OUTPATIENT SERVICES

39.00

40.00

41.00

42.00

42.50

43.00

44.00

		ADJUSTMENTS	TOTAL (col. 5	
		715000111151110	± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED			25. 00
26.00	PHYSICIAN SERVICES	0	14, 400	26.00
27.00	NURSE PRACTITIONER	0	1, 166	27.00
28.00	REGI STERED NURSE	0	383, 654	28. 00
29.00	LPN/LVN	0	16, 836	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	63, 874	33.00
34.00	SPI RI TUAL COUNSELI NG	0	31, 370	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	106, 195	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
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
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	617, 495	100.00

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

0

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214

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44.00

45.00

46.00

214 100. 00

PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

PALLIATIVE CHEMOTHERAPY

		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	0	26. 00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	136	28. 00
29. 00	LPN/LVN	0	6	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	o	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	o	32.00
33.00	MEDICAL SOCIAL SERVICES	0	23	33.00
34.00	SPIRITUAL COUNSELING	0	11	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	38	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	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	214	100.00

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

44.00

^{100. 00} TOTAL * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

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44.00

45.00

46.00

323 100. 00

PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

PALLIATIVE CHEMOTHERAPY

		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		Ö	26.00
27. 00	NURSE PRACTITIONER		1	27.00
28. 00	REGI STERED NURSE		205	28. 00
29. 00	LPN/LVN	0	9	29. 00
30.00	PHYSI CAL THERAPY	0	Ó	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	34	33.00
34.00	SPIRITUAL COUNSELING	0	17	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	57	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	o	38.00
39.00	PATI ENT TRANSPORTATION	0	o	39.00
40.00	I MAGING SERVICES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	o	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	o	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	323	100.00

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

44.00

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

Health Financial Systems	MARGARET MARY COMMUN	ITY HOSPITA	L	In Lieu of Form CMS-2552-10			
COST ALLOCATION - DETERMINATION OF HOSPITAL-BA	SED HOSPICE NET	Provi der Co		Peri od:	Worksheet 0-5		
EXPENSES FOR ALLOCATION				From 01/01/2018			
		Hospi ce CCI	N: 15-1551	To 12/31/2018			
					2/13/2020 2: 3	8 pm	
				Hospi ce I			
Descriptions			HOSPI CE	GENERAL	TOTAL		
			DI RECT	SERVI CE	EXPENSES (sum		
				EXPENSES FROM			
			instructions)	WKST B PART I	2)		
				(see			

	Descriptions	HOSPI CE	GENERAL	TOTAL	
		DI RECT	SERVI CE	EXPENSES (sum	
			EXPENSES FROM	of cols. 1 +	
		instructions)	WKST B PART I	2)	
			(see		
			instructions)		
	OFFICE ALL OFFICE AGENT OFFITEDS	1. 00	2. 00	3. 00	
4 00	GENERAL SERVI CE COST CENTERS	1	_		4 00
1.00	CAP REL COSTS-BLDG & FLXT		0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0	0	2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	0	216, 137	216, 137	3.00
4. 00	ADMINISTRATIVE & GENERAL	308, 247	·		4.00
5. 00	PLANT OPERATION & MAINTENANCE	12, 363		12, 363	5.00
6. 00	LAUNDRY & LINEN SERVICE	0	0	0	6. 00
7. 00	HOUSEKEEPI NG	0	0	0	7. 00
8. 00	DI ETARY	0	0	0	8. 00
9. 00	NURSI NG ADMI NI STRATI ON	0	0	0	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
	MEDI CAL RECORDS	0	0	0	11. 00
	STAFF TRANSPORTATION	70, 533		70, 533	12.00
	VOLUNTEER SERVICE COORDINATION	0		0	13.00
	PHARMACY	142, 371	0	142, 371	14.00
	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15. 00
	OTHER GENERAL SERVICE	0	_		16.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES		0	0	17.00
	LEVEL OF CARE				
	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
	HOSPICE ROUTINE HOME CARE	617, 495		617, 495	51.00
	HOSPICE INPATIENT RESPITE CARE	214		214	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	323		323	53.00
	NONREI MBURSABLE COST CENTERS	1		_	
	BEREAVEMENT PROGRAM	0		0	60.00
	VOLUNTEER PROGRAM	0		0	61.00
	FUNDRAI SI NG	0		0	62.00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0		0	64.00
	OTHER PHYSICIAN SERVICES	0		0	65.00
	RESI DENTI AL CARE	0		0	66.00
	ADVERTI SI NG	0		0	67.00
	TELEHEALTH/TELEMONI TORI NG	0		0	68.00
	THRI FT STORE	0		0	69. 00
	NURSING FACILITY ROOM & BOARD	0		0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
	NEGATI VE COST CENTER	0		0	99.00
100.00	TOTAL	1, 151, 546	483, 825	1, 635, 371	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS				CN: 15-1329 N: 15-1551	Period: From 01/01/2018 To 12/31/2018		pared:
					Hospi ce I		
	Descriptions	TOTAL	CAP REL BLDG			SUBTOTAL	
		EXPENSES	& FIX	EQUI P	BENEFITS		
					DEPARTMENT		
		0	1. 00	2. 00	3. 00	3A	
	GENERAL SERVICE COST CENTERS					T	
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	216, 137	0)	0 216, 13		3.00
4.00	ADMINISTRATIVE & GENERAL	575, 935	0)	0	575, 935	4. 00
5.00	PLANT OPERATION & MAINTENANCE	12, 363	0)	0	12, 363	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0)	0	0	6.00
7.00	HOUSEKEEPI NG	0	0		0	0	7. 00
8.00	DI ETARY	0	0		0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON	0	0		0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0	ol o	10.00
11.00	MEDI CAL RECORDS	0	0	ol .	0	ol o	11.00
12. 00	STAFF TRANSPORTATION	70, 533	0	ol .	0	70, 533	
13. 00	VOLUNTEER SERVICE COORDINATION	0	0		0	0	1
14. 00	PHARMACY	142, 371	0			142, 371	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	142, 371	0		0	0 142, 371	
16. 00	OTHER GENERAL SERVICES	0	0				1
	PATI ENT/RESI DENTI AL CARE SERVI CES	U	0	()	0		
17.00	LEVEL OF CARE			'1	U		17.00
EO 00	HOSPI CE CONTINUOUS HOME CARE	0					FO 00
50.00		-			215 041	-	
51.00	HOSPICE ROUTINE HOME CARE	617, 495			215, 94!		1
52.00	HOSPICE INPATIENT RESPITE CARE	214	0		0 7		52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	323	0)	0 11!	5 438	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0)	-	0	
61.00	VOLUNTEER PROGRAM	0	0	9	0	0	61.00
62. 00	FUNDRAI SI NG	0	0)	0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0)	0	0	
64. 00	PALLIATIVE CARE PROGRAM	0	0)	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0)	0	0	65.00
66.00	RESI DENTI AL CARE	0	0)	0	0	66.00
67.00	ADVERTI SI NG	0	0)	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0	0	68.00
69.00	THRI FT STORE	0	0		0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	71.00
99.00	NEGATI VE COST CENTER	0	0		0		99.00
100.00		1, 635, 371	0		0 216, 13	1, 635, 371	100.00
	1			1	1	1	

	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI		Provider CCN: 15-1329		Worksheet 0-6 Part I Date/Time Pre 2/13/2020 2:3	epared:	
					Hospi ce I		
	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	'	E & GENERAL	OPERATION &	LINEN SERVICE	E		
			MAI NTENANCE				
		4. 00	5. 00	6.00	7. 00	8. 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	575, 935					4.00
5.00	PLANT OPERATION & MAINTENANCE	6, 721	19, 084				5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0		0		6. 00
7.00	HOUSEKEEPI NG	0	0		0		7. 00
8.00	DI ETARY	0	0		0	l c	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0		0		9. 00
10.00	ROUTINE MEDICAL SUPPLIES	O	0		0		10.00
11. 00	MEDI CAL RECORDS	o	0		0		11.00
12. 00	STAFF TRANSPORTATION	38, 343	0		0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14. 00	PHARMACY	77, 396	0		0		14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15. 00
16. 00	OTHER GENERAL SERVICE	0	0		0		16.00
17. 00		0	0		0		17. 00
	LEVEL OF CARE		-	1	_		
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51. 00	HOSPICE ROUTINE HOME CARE	453, 079					51.00
52.00		158	7, 634		0 0	l c	•
53. 00		238	11, 450		0 0	ĺ	
	NONREI MBURSABLE COST CENTERS		,	1		<u>-</u>	
60.00		0	0)	0		60.00
61.00	VOLUNTEER PROGRAM	ol	0	ol .	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	0	0		0		64.00
65. 00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66. 00	RESI DENTI AL CARE	0	0		0	l c	
67. 00		0	0		0	_	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0		0		68.00
	THRIFT STORE	0	0	ol .	0		69.00
70. 00	NURSING FACILITY ROOM & BOARD		· ·				70.00
71. 00		0	Ω		0	l c	•
99. 00		l o	0		0 0	ĺ	•
	TOTAL	575, 935	19, 084		0 0		100.00
	T .		, 50 1	1	1	'	1

Heal th	Financial Systems MA	RGARET MARY COMM	<u>IUNITY HOSPITA</u>	\L	In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provi der Co	CN: 15-1329	Peri od:	Worksheet 0-6)
			Hospi ce CCI	N: 15-1551	From 01/01/2018 To 12/31/2018	Part Date/Time Prepared:	
			nospi ce cci	N. 15-1551	10 12/31/2018	2/13/2020 2: 3	
					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		•	<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						4. 00
5. 00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6.00
							1
7.00	HOUSEKEEPI NG						7.00
8. 00	DI ETARY						8.00
9. 00	NURSING ADMINISTRATION	0					9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11. 00	MEDI CAL RECORDS	0			0		11.00
12.00	STAFF TRANSPORTATION	0			108, 876		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	O			0	0	15.00
16.00	OTHER GENERAL SERVICE	ol			0	0	16.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES						17.00
	LEVEL OF CARE	\\		·	-		1
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	0	0	1	0 108, 779		51.00
52. 00	HOSPICE INPATIENT RESPITE CARE		0		0 39	ł	
53. 00	HOSPICE GENERAL INPATIENT CARE		0	1	0 58		
55.00	NONREI MBURSABLE COST CENTERS	<u> </u>		1	0 30	0	33.00
60.00	BEREAVEMENT PROGRAM	O			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
	PALLIATIVE CARE PROGRAM	0			0	1	1
64.00		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
69. 00	THRI FT STORE	0		1	0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD					l	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATI VE COST CENTER	0	0)	0 0	0	99.00
100.00	TOTAL	0	0)	0 108, 876	0	100.00
				-	•		•

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS				CN: 15-1329 N: 15-1551	Peri od: From 01/01/2018 To 12/31/2018		epared:
		DUADAMA OV	DUN(01 01 44)	LOTUED OFNED	Hospi ce I	TOTAL	
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERA		TOTAL	
			ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
		14. 00	E SERVICES 15.00	16.00	CARE SERVICES 17.00	18. 00	
	GENERAL SERVICE COST CENTERS	14.00	15.00	10.00	17.00	16.00	
1. 00	CAP REL COSTS-BLDG & FIXT			1			1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMI NI STRATI VE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7.00
8. 00	DI ETARY						8.00
9. 00	NURSING ADMINISTRATION						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	219, 767					14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	217,707	C				15.00
16. 00	OTHER GENERAL SERVICE	0		Ί	0		16.00
17. 00	1	0					17. 00
17.00	LEVEL OF CARE			1	0		17.00
50.00		0	C		0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	219, 571		1	o	1, 614, 869	
52. 00	1	79		1	0 0	8, 201	1
53. 00	HOSPICE GENERAL INPATIENT CARE	117	Ċ	1	0 0	12, 301	1
00.00	NONREI MBURSABLE COST CENTERS			′1	<u> </u>	12,001	00.00
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	1
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	1
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	Ċ		0 0	0	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	1
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	C		0 0	0	71.00
99. 00		0	C		0 0	0	99. 00
100.00	TOTAL	219, 767	C		0 0	1, 635, 371	100.00

Health Financial Systems	NITY HOSPITAL	L	In Lieu of Form CMS-2552-10			
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STATISTICAL BASIS	SERVI CE COSTS	Provi der CC		Peri od: From 01/01/2018	Worksheet 0-6 Part II	
STATISTICAL BASIS		Hospi ce CCN	N: 15-1551	To 12/31/2018	Date/Time Pre 2/13/2020 2:3	
				Hospi ce I		
Cost Center Descriptions	CAP REL BLDG CA	AP REL MVBLE	EMPLOYEE	RECONCI LI ATI O	ADMI NI STRATI V	

			Hospi ce CCi	N: 15-1551 1	10 12/31/2018	2/13/2020 2:3	
					Hospi ce I	27 107 2020 210	<u>o p</u>
Cost Center Des	scriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE		ADMI NI STRATI V	
	·	& FIX	EQUI P	BENEFITS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
			VALUE)	(GROSS		COSTS)	
				SALARI ES)			
		1. 00	2. 00	3. 00	4A	4. 00	
GENERAL SERVICE COST			Г		T	Г	
1.00 CAP REL COSTS-BLDG &		0					1.00
2. 00 CAP REL COSTS-MVBLE		_	0				2.00
3. 00 EMPLOYEE BENEFITS DE		0	0	2.0, .,			3.00
4.00 ADMINISTRATIVE & GEN		0	0	(1, 059, 436	4.00
5.00 PLANT OPERATION & MA		0	0	(12, 363	5.00
6.00 LAUNDRY & LINEN SERV	I CE	0	0		٥ -	0	6.00
7. 00 HOUSEKEEPI NG		0	0	(٥ -	0	7. 00
8. 00 DI ETARY		0	0			0	8. 00
9. 00 NURSING ADMINISTRATI		0	0	(-	0	9. 00
10.00 ROUTINE MEDICAL SUPP	LIES	0	0		-	0	10.00
11.00 MEDICAL RECORDS		0	0	(-	0	11. 00
12.00 STAFF TRANSPORTATION		0	0	(70, 533	1
13.00 VOLUNTEER SERVICE CO	ORDI NATI ON	0	0	(-	0	13. 00
14.00 PHARMACY		0	0	(0	142, 371	14.00
15.00 PHYSICIAN ADMINISTRA		0	0	(0	15. 00
16.00 OTHER GENERAL SERVIC		0	0		-	0	16. 00
17. 00 PATI ENT/RESI DENTI AL	CARE SERVICES	0	0		0	0	17. 00
LEVEL OF CARE							
50.00 HOSPICE CONTINUOUS H				(l e	50.00
51.00 HOSPICE ROUTINE HOME				215, 983		833, 440	•
52.00 HOSPICE INPATIENT RE		0				291	52.00
53. 00 HOSPICE GENERAL INPA		0	0	115	5 0	438	53.00
NONREI MBURSABLE COST	CENTERS						
60.00 BEREAVEMENT PROGRAM		0	1	1		0	60.00
61.00 VOLUNTEER PROGRAM		0	0			0	61.00
62. 00 FUNDRAI SI NG		0	0			0	62.00
63.00 HOSPICE/PALLIATIVE M		0	0	(-	0	63.00
64.00 PALLIATIVE CARE PROG		0	0	١ .		0	64.00
65.00 OTHER PHYSICIAN SERV	I CES	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 T	ORI NG	0	0	(-	0	68. 00
69. 00 THRI FT STORE		0	0	(0	0	69. 00
70.00 NURSING FACILITY ROO					0		70.00
71.00 OTHER NONREIMBURSABL		0	0	(0	0	
99.00 NEGATI VE COST CENTER		1					99. 00
100 COLCOCT TO DE ALLOCATED	(per Wkst. 0-6, Part I)	1		1 214 12	7	575, 935	1100 00
101.00 UNIT COST MULTIPLIER		0. 000000	0. 000000			0. 543624	

Health Financial Systems	MAR	RGARET MARY COMMUN	II TY HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED	HOSPI CE GENERAL SE	ERVICE COSTS	Provider CCN: 15-1329	Peri od:	Worksheet 0-6
STATISTICAL BASIS				From 01/01/2018	Part II

STATIS	TICAL BASIS	Hospi ce CC		From 01/01/2018 o 12/31/2018			
					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	19, 195					5.00
6.00	LAUNDRY & LINEN SERVICE	0					6.00
7. 00	HOUSEKEEPI NG	0					7.00
8. 00	DIETARY	0			0		8.00
9. 00	NURSING ADMINISTRATION	0		1		0	
10.00	ROUTINE MEDICAL SUPPLIES	0				l o	1
11. 00	MEDI CAL RECORDS	0				0	11.00
12.00	STAFF TRANSPORTATION	0				0	12.00
13. 00	VOLUNTEER SERVICE COORDINATION					0	13.00
14. 00	PHARMACY					0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES					0	15.00
16. 00	OTHER GENERAL SERVICES	0				0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES					0	16.00 17.00
17.00	LEVEL OF CARE				<u>/ </u>		17.00
50. 00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51. 00	HOSPICE CONTINUOUS HOME CARE					0	51.00
		7 470		,		· -	
52.00	HOSPICE INPATIENT RESPITE CARE	7, 678					
53. 00	HOSPICE GENERAL INPATIENT CARE	11, 517		1) 0	0	53.00
(0.00	NONREI MBURSABLE COST CENTERS		1		\[\ \	0	(0.00
60.00	BEREAVEMENT PROGRAM	0					
61.00	VOLUNTEER PROGRAM	0				0	
62.00	FUNDRAL 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	1			0	65.00
66. 00	RESI DENTI AL CARE	0	C	1	0		66. 00
67. 00	ADVERTI SI NG	0)	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0)	0	68. 00
69. 00	THRI FT STORE	0)	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	C	ol c	0	0	1
	NEGATI VE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I		C		0		100.00
101. 00	UNIT COST MULTIPLIER	0. 994217	0. 000000	0.000000	0. 000000	0.000000	101. 00

Heal th	Financial Systems MAR	RGARET MARY COM	IMUNITY HOSPITA	AI	In lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE STICAL BASIS	ERVICE COSTS Provider CCN: 1		CN: 15-1329	Peri od:		pared:
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDI CAL RECORDS (PATI ENT DAYS)	STAFF TRANSPORTATION N (MI LEAGE)	VOLUNTEER SERVI CE COORDI NATI ON (HOURS OF SERVI CE)	PHARMACY (CHARGES)	
		10. 00	11. 00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
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	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES	0	C	109, 55	3 0 0 0 0 0 0 0	221, 134 0 0	15. 00
50. 00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE	0		1	ol o	0	50.00
51. 00 52. 00 53. 00	HOSPICE CONTINOUS HOME CARE HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	0 0	0 0	109, 45	6 0	220, 937 79 118	51.00 52.00
60.00	BEREAVEMENT PROGRAM				0 0	0	60.00
61. 00 62. 00	VOLUNTEER PROGRAM FUNDRAI SI NG				0 0	0	

0.000000

0.000000

63.00

64.00

67.00

68.00

0 69.00

70.00

71.00

99.00

0 65.00

0 66.00

0

219, 767 100. 00 0. 993818 101. 00

0 0 0

0

0.000000

108, 876 0. 993820

63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS

PALLIATIVE CARE PROGRAM

OTHER PHYSICIAN SERVICES

TELEHEALTH/TELEMONI TORI NG

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD

71.00 OTHER NONREIMBURSABLE (SPECIFY)

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

66.00 RESIDENTIAL CARE

ADVERTI SI NG

99.00 NEGATIVE COST CENTER

64.00

65.00

Heal th Financial	Systems		MARGARET	MARY COMMUN	NITY HOSPITA	AL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION	- HOSPI TAL-BASE	D HOSPICE GEN	NERAL SERVICE	COSTS	Provider C	CCN: 15-1329	Peri od:	Worksheet 0-6
STATISTICAL BASI	S						From 01/01/2018	Part II

Hospi ce CCN: 15-1551 To 12/31/2018 Date/Time Prepared: 2/13/2020 2:38 pm Hospi ce I Cost Center Descriptions PHYSI CI AN OTHER GENERAL PATI ENT/ ADMI NI STRATI V SERVI CE RESI DENTI AL E SERVICES (SPECIFY 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 11.00 MEDICAL RECORDS 11.00 STAFF TRANSPORTATION 12.00 12.00 13.00 VOLUNTEER SERVICE COORDINATION 13.00 14.00 **PHARMACY** 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 0 15.00 OTHER GENERAL SERVICE 16.00 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 62 00 FUNDRAI SI NG 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 64.00 PALLIATIVE CARE PROGRAM 64.00 OTHER PHYSICIAN SERVICES 65.00 65.00 66.00 RESIDENTIAL CARE 0 0 66.00 0 67.00 ADVERTI SI NG 67.00 68.00 TELEHEALTH/TELEMONI TORI NG 68.00 69.00 THRIFT STORE 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 71.00 99. 00 NEGATI VE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 100.00 101.00 UNIT COST MULTIPLIER 0.000000 0.000000 0.000000 101.00

Health Financial Systems	MARGARET MARY	COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF HOSPITAL-BASED HO	OSPICE SHARED SERVICE COSTS E	Provider CCN: 15-1329	Period: Worksheet 0-7
LEVEL OF CARE		Hospi ce CCN: 15-1551	From 01/01/2018 To 12/31/2018 Date/Time Prepared

LEVEL OF CARE	/EL OF CARE					pared: 8 pm
				Hospi ce I		
			Charges by	LOC (from Provi	der Records)	
Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	НСНС	HRHC	HI RC	
	0	1. 00	2. 00	3. 00	4. 00	
ANCILLARY SERVICE COST CENTERS	ı					
1. 00 PHYSI CAL THERAPY	66.00		•	0	0	1.00
2. 00 OCCUPATI ONAL THERAPY	67.00			0	0	
3. 00 SPEECH PATHOLOGY	68. 00	0. 553148	•	0	0	3.00
4. 00 DRUGS CHARGED TO PATIENTS	73. 00	0. 429867		0	0	4.00
5. 00 DURABLE MEDICAL EQUIP-RENTED	96.00				_	5.00
6. 00 LABORATORY	60.00			0	0	6.00
6. 01 BLOOD LABORATORY	60. 01	0.000000		0	0	6. 01
7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0. 287602		U U	0	
8. 00 OTHER OUTPATIENT SERVICE COST CENTER 9. 00 RADIOLOGY-THERAPEUTIC	93. 00 55. 00					8. 00 9. 00
10. 00 OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00 Totals (sum of lines 1-11)	76.00					11.00
11.00 Total 3 (Suil of Titles 1-11)	Charges by		Shared Servi	ce Costs by LOC		11.00
	LOC (from Provider		onar ca ser vi	00313 29 200		
	Records)					
Cost Center Descriptions	HGI P	HCHC (col. 1	HRHC (col. 1	HIRC (col. 1	HGIP (col. 1	
		x col. 2)	x col. 3)	x col. 4)	x col. 5)	
	5. 00	6. 00	7. 00	8. 00	9. 00	
ANCILLARY SERVICE COST CENTERS	1		T	ما		
1. 00 PHYSI CAL THERAPY	0	0		0	0	1.00
2. 00 OCCUPATIONAL THERAPY	0	0		0	0	
3. 00 SPEECH PATHOLOGY 4. 00 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	3. 00 4. 00
4. 00 DRUGS CHARGED TO PATIENTS 5. 00 DURABLE MEDICAL EQUIP-RENTED	0	U		U U	U	5.00
6.00 LABORATORY	0	0		0	0	6.00
6. 01 BLOOD LABORATORY	0	0		0	0	
7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	7.00
8.00 OTHER OUTPATIENT SERVICE COST CENTER	0	U		o o	U	8.00
9. 00 RADI OLOGY-THERAPEUTI C						9.00
10. 00 OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00 Totals (sum of lines 1-11)		0		0	0	
	I .	·	1	-1		, 55

Health Financial Systems	MARGARET	MARY COM	MUNITY HOSPITAL		In Lieu	of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM	COST		Provi der CCN	: 15-1329	Peri od:	Worksheet 0-8

Hospice CCN: 15-1551 From 01/01/2018 To 12/31/2018 Date/Time Prepared: 2/13/2020 2:38 pm

					2/13/2020 2: 38	8 pm
				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,	col . 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				o	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	10)		o o		4.00
5.00	Program cost (line 3 times line 4)	•		o o		5.00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7,	col . 7,			1, 614, 869	6.00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				11, 255	7.00
8.00	Total average cost per diem (line 6 divided by line 7)				143. 48	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 11)	9, 44	1 211		9.00
10.00	Program cost (line 8 times line 9)		1, 354, 59	5 30, 274		10.00
	HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7,	col. 8,			8, 201	11.00
	line 11)					
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				4	12.00
13.00	Total average cost per diem (line 11 divided by line 12)				2, 050. 25	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 12)		0 0		14.00
15.00	Program cost (line 13 times line 14)			0 0		15.00
	HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7,	col. 9,			12, 301	16.00
	line 11)					
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				6	17.00
18.00	Total average cost per diem (line 16 divided by line 17)				2, 050. 17	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 13)		0		19.00
20.00	Program cost (line 18 times line 19)			0 0		20.00
	TOTAL HOSPICE CARE					
21.00					1, 635, 371	
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				11, 265	22.00
	Average cost per diem (line 21 divided by line 22)				145. 17	

Heal th	Financial Systems M.	ARGARET MARY COM	MUNITY HOSPITA	.L	In Lie	u of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1329	Peri od:	Worksheet M-1	
			Component	CCN, 1E 0E11	From 01/01/2018 To 12/31/2018	Doto /Timo Doo	narad.
			Component	CCN: 15-8511	10 12/31/2018	Date/Time Pre 2/13/2020 2:3	pareu: 8 nm
					RHC I	Cost	<u>o p</u>
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	2.22		4.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1. 00	2. 00	3.00	4. 00	5. 00	
1. 00		157, 293	0	157, 29	2	157 202	1.00
2.00	Physician Physician Assistant	120, 483		120, 4		157, 293 120, 483	2.00
3. 00	Nurse Practitioner	274, 684		274, 6		274, 684	3.00
4. 00	Vi si ti ng Nurse	274,004	0	2/4,00	0	274,004	4.00
5. 00	Other Nurse	104, 388	0	104, 38	0 0	104, 388	
6. 00	Clinical Psychologist	104, 300	0	104, 30	0	104, 300	6.00
7. 00	Clinical Social Worker	0	0			0	7.00
8. 00	Laboratory Technician	Ö	Ö		0 0	0	8.00
9. 00	Other Facility Health Care Staff Costs	256, 388	Ö	256, 38	38 0	256, 388	9.00
10.00	Subtotal (sum of lines 1 through 9)	913, 236		913, 2		913, 236	10.00
11.00	Physician Services Under Agreement	o	0		0 0	0	11.00
12.00	Physician Supervision Under Agreement	O	0		0 0	0	12.00
13.00	Other Costs Under Agreement	o	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	0		0 0	0	15.00
16. 00	Transportation (Health Care Staff)	0	0	1	0	0	16.00
17. 00	Depreciation-Medical Equipment	0	0	1	0 0	0	17. 00

913, 236

178, 147

178, 147

1, 091, 383

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44, 468

231, 001

275, 469

1, 188, 705

913, 236

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44, 468

52, 854

97, 322

97, 322

18.00

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20.00

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29.00

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31.00

32.00

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0 25.02

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44, 468

231, 001

275, 469

1, 188, 705

913, 236

0 0

0

0

0

0

Professional Liability Insurance

Subtotal (sum of lines 15 through 20)

lines 10, 14, and 21)
COSTS OTHER THAN RHC/FQHC SERVICES

Total Cost of Health Care Services (sum of

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Other Health Care Costs

Chronic Care Management

Nonallowable GME costs

Administrative Costs

All other nonreimbursable costs

Allowable GME Costs

Pharmacy

 ${\tt Optometry}$

Tel eheal th

through 27) FACILITY OVERHEAD

29.00 Facility Costs

and 31)

Dental

19.00

20.00

21.00

22.00

23.00

24.00

25.00

25.01

25.02

26.00

27.00

28.00

30.00

31.00

Health Financial Systems	MARGARET MARY COMMUNITY HOS	PI TAL	In Lieu	of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi d	er CCN: 15-1329	Peri od: From 01/01/2018	Worksheet M-1
	Compone	ent CCN: 15-8511		Date/Time Prepared:

						2/13/2020 2: 3	38 pm
					RHC I	Cost	
		Adjustments	Net Expenses				
		,	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00	1			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00	1			
1.00	Physi ci an	Ol	157, 293				1.00
2. 00	Physician Assistant	0	120, 483				2.00
3. 00	Nurse Practitioner		274, 684				3. 00
4. 00	1	0	274,004	1			4.00
	Visiting Nurse	o o	_	1			
5.00	Other Nurse	U	104, 388	1			5.00
6.00	Clinical Psychologist	O ₁	C	1			6.00
7.00	Clinical Social Worker	0	C	1			7.00
8. 00	Laboratory Techni ci an	0	C	1			8. 00
9. 00	Other Facility Health Care Staff Costs	0	256, 388				9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	913, 236)			10.00
11. 00	Physician Services Under Agreement	0	C	1			11.00
12.00	Physician Supervision Under Agreement	0	C)			12.00
13.00	Other Costs Under Agreement	0	C)			13.00
14.00	Subtotal (sum of lines 11 through 13)	0	C				14.00
15.00	Medical Supplies	o	C				15.00
16.00	Transportation (Health Care Staff)	ol	C				16.00
17.00	Depreciation-Medical Equipment	ol	C	ol .			17.00
18. 00	1 ' '	0	C				18.00
19.00	Other Health Care Costs	0	C				19.00
20. 00	Allowable GME Costs	-	_				20.00
21. 00	Subtotal (sum of lines 15 through 20)	٥	0				21.00
22. 00	Total Cost of Health Care Services (sum of	ol	913, 236				22.00
22.00	lines 10, 14, and 21)	ď	713, 230	1			22.00
	COSTS OTHER THAN RHC/FQHC SERVICES	l					
22 00	Pharmacy	O	C	VI.			23. 00
24. 00	Dental	0	C	1			24.00
25.00	1	ol ol		()			25. 00
	Optometry	ol ol		()			25. 00
25. 01	Tel eheal th	U	C	<u>'</u>			
25. 02	Chronic Care Management	O ₀	C	<u>'</u>			25. 02
26.00	All other nonreimbursable costs	٥	C	7			26. 00
27. 00	Nonallowable GME costs	_	_				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C)			28. 00
	through 27)						1
	FACILITY OVERHEAD	1					
	Facility Costs	0	44, 468	•			29. 00
30.00	Administrative Costs	0	231, 001	1			30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	275, 469	1			31.00
	30)						
32.00	, ,	0	1, 188, 705	i			32.00
	and 31)						

2.00 Physician Assistant	Heal th	Financial Systems MAI	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
Component CCN: 15-8511 To 12/31/2018 Date/Time Preparate (2/13/2020 2: 38 pm 2/31/2018 2	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C				
Number of FTE Personnel				0				
Number of FTE Total Visits Productivity Standard (1) Visits (col. Greater of col. 2 or col. 4				Component	CCN: 15-8511	10 12/31/2018		
Number of FTE Personnel Total Visits Productivity Standard (1) Visits (col. col. 2 or col. 4						RHC I		о рііі
No			Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
Note			Personnel				col. 2 or	
VISITS AND PRODUCTIVITY							col. 4	
Physician			1. 00	2.00	3.00	4. 00	5. 00	
1.00		VISITS AND PRODUCTIVITY						
2.00		Posi ti ons						
3.00 Nurse Practitioner 1.85 4,099 2,100 3,885 8,064 4.00	1.00	Physi ci an						1.00
4.00 Subtotal (sum of lines 1 through 3)								2. 00
5.00 Visiting Nurse								3. 00
6.00 Clinical Psychologist 0.00 0 0 0 0 0 7.00 7.00 7.00 7.00 7.00 0 0 7.00						8, 064	· ·	
7. 00 Clinical Social Worker 0. 00 0 0 0 7. 00 7. 00 7. 01 Medical Nutrition Therapist (FOHC only) 0. 00 0 0 0 7. 00 7. 00 0 0 0 0 0 0 0 0 0					1			
7. 01 Medical Nutrition Therapist (FQHC only)							_	
7. 02 Di abetes Self Management Training (FOHC 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				l .			_	
Section Services Services Under Agreements Services Se		' ' '		l .				1
8.00 Total FTEs and Visits (sum of lines 4 through 7) 9.00 Physician Services Under Agreements DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 17.00 Allowable GME overhead (see instructions) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 985, 591 19.00	7. 02		0.00	0			0	7.02
through 7) Physician Services Under Agreements 0 0 9.00	0.00		0.04	7 004			0.0/4	0.00
9.00 Physician Services Under Agreements 0 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES	8.00		3. 24	7, 281			8, 064	8.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 913, 236 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 011.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 913, 236 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 275, 469 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 710, 122 15.00 16.00 Total overhead (sum of lines 14 and 15) 985, 591 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 985, 591 18.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 985, 591 19.00	0 00						0	0.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES	9.00	Physician services under Agreements		0			U	9.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES							1 00	
10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 913,236 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) (sum of lines 10 and 11) 913,236 12.00 13.00 Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital -based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 275,469 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 710,122 15.00 16.00 Total overhead (sum of lines 14 and 15) 985,591 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 985,591 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 985,591 19.00		DETERMINATION OF ALLOWARIE COST APPLICABLE T	O HOSPITAL-BAS	ED RHC/FOHC SEL	RVICES		1.00	
11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 985,591 18.00 995,591 19.00							913 236	10.00
12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 12.00 13.00 13.00 15.00 17.00 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)								1
13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 985,591 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)							913, 236	
14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 275, 469 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 710, 122 15.00 17.00 Allowable GME overhead (see instructions) 8.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 275, 469 14.00 15.00 985, 591 16.00 985, 591 18.00 985, 591 19.00	13. 00							
15.00 Parent provider overhead allocated to facility (see instructions) 710, 122 15.00 16.00 Total overhead (sum of lines 14 and 15) 985, 591 16.00 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 90 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 985, 591 19.00	14. 00				i ne 31)			
16.00 Total overhead (sum of lines 14 and 15) 985,591 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 985,591 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 985,591 19.00	15.00				,		•	
18.00 Enter the amount from line 16985,59118.0019.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)985,59119.00	16.00		,	,			985, 591	16.00
19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 985,591 19.00	17.00	Allowable GME overhead (see instructions)					0	17. 00
	18.00						985, 591	18. 00
20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 1,898,827 20.00	19.00	Overhead applicable to hospital-based RHC/FC	DHC services (Ι	ine 13 x line	18)		985, 591	19. 00
	20.00	Total allowable cost of hospital-based RHC/F	FQHC services (sum of lines 1	0 and 19)		1, 898, 827	20.00

CALCUL SERVI C	ATION OF DELMBURGEMENT CETTLEMENT FOR LICEDITAL DACED DUC/FOLIC				<u> 2552-10</u>
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1329	Peri od: From 01/01/2018	Worksheet M-3	
SERVIC	ES	Component CCN: 15-8511	To 12/31/2018	Date/Time Pre 2/13/2020 2:3	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		1, 898, 827	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		105, 937	1
3. 00 4. 00	Total allowable cost excluding vaccine (line 1 minus line 2)			1, 792, 890 8, 064	
5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0,004	5.00
6. 00	Total adjusted visits (line 4 plus line 5)	7)		8, 064	1
7. 00	Adjusted cost per visit (line 3 divided by line 6)			222. 33	7. 00
			Cal cul ati on	of Limit (1)	
			Pri or to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1) 1.00	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or vour contractor)	82. 30	83. 45	8.00
9. 00	Rate for Program covered visits (see instructions)		222. 33	222. 33	1
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from	-	0	1, 429	1
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr	•	0	317, 710 0	1
13.00	Program covered cost from mental health services (line 9 x li		0	0	1
14. 00	Limit adjustment for mental health services (see instructions	*	0	0	1
15.00	Graduate Medical Education Pass Through Cost (see instruction	s)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	317, 710	1
16. 01	Total program charges (see instructions) (from contractor's re	•		203, 337	1
16. 02 16. 03	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times	•		6, 889 10, 764	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0			224, 843	1
	(Titles V and XIX see instructions.)	,		•	
16. 05	Total program cost (see instructions)		0	235, 607	1
17.00	Primary payer amounts	(from contractor		0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Trom contractor		25, 892	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		34, 111	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			235, 607	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		53, 920	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			289, 527	1
23. 00	Allowable bad debts (see instructions)			0	
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	1
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	1
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
	Demonstration payment adjustment amount before sequestration			0	
26. 00	Net reimbursable amount (see instructions)			289, 527	1
26. 01 26. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			5, 791 0	1
27. 00				283, 736	1
28. 00	1			0	1
29.00	,	02, 27, and 28)		0	
27.00		nce with CMS Pub. 15-II	1	0	30.00

Health Financial Systems	MARGARET MARY COMMUN	NITY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQH	C PNEUMOCOCCAL AND INFLUENZA	Provi der CCN: 15-1329	Peri od:	Worksheet M-4
VACCINE COST			From 01/01/2018	
		Component CCN: 15-8511	To 12/31/2018	Date/Time Prepared:
				2/13/2020 2:38 pm
		Ti +1 o VV/I I I	DHC I	Coct

				2/13/2020 2: 3	8 pm
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		913, 236	913, 236	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota	al health care staff time	0. 001511	0. 004581	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lir	ne 1 x line 2)	1, 380	4, 184	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fi	rom your records)	27, 787	17, 599	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	29, 167	21, 783	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksho	eet M-1, col. 7, line 22)	913, 236	913, 236	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		985, 591	985, 591	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 031938	0. 023853	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	31, 478	23, 509	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	60, 645	45, 292	10.00
	lines 5 and 9)				
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	92	279	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10	D/line 11)	659. 18	162. 34	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	52	121	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (the	neir) administration	34, 277	19, 643	14.00
	(line 12 x line 13)				
15.00	Total cost of pneumococcal and influenza vaccine and its (thei	r) administration (sum		105, 937	15.00
	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 i	ts (their)		53, 920	16.00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	MARGARET MARY COMMUN	NITY 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 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 2/13/2020 2:38 pm

		Component Con. 13-0311	10 12/31/2010	2/13/2020 2: 38	
			RHC I	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			203, 509	1. (
2. 00	Interim payments payable on individual bills, either submit			0	2. (
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				3. (
	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			12/31/2019	80, 227	3.
3. 02				0	3.
3. 03				o	3.
3. 04				l ol	3.
3. 05				ol	3.
	Provider to Program		<u> </u>		
. 50				0	3.
. 51				ol	3.
. 52				0	3.
. 53				0	3.
. 54				0	3.
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		80, 227	3.
1. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			283, 736	4.
. 00	27)	Ter to workshoot in o, Title		200, 700	
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des	k review Also show date o	f		5.
. 00	each payment. If none, write "NONE" or enter a zero. (1)	in review. 71130 Show date o	·		0.
	Program to Provider				
. 01				0	5.
. 02				0	5.
. 03				0	5.
	Provider to Program				
. 50				0	5.
. 51				l ol	5.
. 52				0	5.
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5.
	Determined net settlement amount (balance due) based on the				6.
. 00		opo. t. (.)			6.
	SETTLEMENT TO PROVIDER			[[[[]	
. 01	SETTLEMENT TO PROVIDER			0	
. 01	SETTLEMENT TO PROGRAM			O	6.
o. 01 o. 02			Contractor	0 283, 736	6.
o. 01 o. 02	SETTLEMENT TO PROGRAM		Contractor	0 283,736 NPR Date	6.
6. 00 6. 01 6. 02 7. 00	SETTLEMENT TO PROGRAM	0	Contractor Number	0 283, 736	6. 7.