STARKE MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0102 Worksheet S Peri od. From 01/01/2018 Parts I-III AND SETTLEMENT SUMMARY 12/31/2018 Date/Time Prepared: То 5/31/2019 4:09 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/31/2019 Time: 4:09 pm use only Manually submitted cost report 2 []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF 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 STARKE MEMORIAL HOSPITAL (15-0102) 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 aned) Officer or Administrator of Provider(s) VP, REVENUE MANAGEMENT Title

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-10, 910	33, 550	0	0	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
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-10, 910	33, 550	0	0	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.

Date

				i ovi aci c	CN: 15-0102	Peri od:		eet S-2
00 Street: 1						From 01/01/ To 12/31/		ime Prepare
00 Street: 1	1.00	2	00	3. 00				019 4:09 pm
	and Hospital Health Care Co		00	3. 00	5		1.00	
00 City: K	02 EAST CULVER RD	P0 Box:						1.
	NOX	State: I Component Na		ip Code: 46 CCN CI	534 Cou 3SA Provid	unty: ler Date	Payment Syst	2.
					mber Type		T, 0, or	
							V XVIII	
Hospi tal	and Hospital-Based Componer	1.00		2.00 3.	00 4.00	5.00	6.00 7.00	8.00
00 Hospi tal	and hospi tai -based componen	STARKE MEMORIAL		50102 99	915 1	07/11/1966	N P	P 3.
		HOSPI TAL						
	der – IPF der – IRF							4.
	der - (Other)							6.
0	ds - SNF							7.
00 Swing Be 00 Hospital	ds - NF -Based SNF							8.
	-Based NF							10.
	-Based OLTC							11.
	-Based HHA							12.
	ly Certified ASC -Based Hospice							13.
	-Based Health Clinic - RHC							15.
.00 Hospital	-Based Health Clinic - FQHC							16.
	-Based (CMHC) I							17.
10 Hospi tal 00 Renal Di	-Based (CORF) I alvsis							17.
00 Other								19.
						From:	To	
00 Cost Rep	orting Period (mm/dd/yyyy)					1.00	<u>2. (</u> 018 12/31/	
	Control (see instructions)					4		21.
					1.00	2.00	3. (00
I npati en	t PPS Information				1.00	2.00		
	s facility qualify and is it	2	0.5		Y	N		22.
	rtionate share hospital adju ? In column 1, enter "Y" fo							
	subject to 42 CFR Section §							
	?) In column 2, enter "Y" fo							
	hospital receive interim ur orting period? Enter in colu				Y	Y		22.
	ion of the cost reporting pe							
	column 2, "Y" for yes or "N							
	g period occurring on or aft a newly merged hospital that				N	N		22.
	to be determined at cost re				IN IN	N		22.
Enter in	column 1, "Y" for yes or "N	N" for no, for the	e portion o	of the				
	orting period prior to Octob							
or "N" f October	or no, for the portion of th 1.	ie cost reporting	period on	or arter				
03 Did this	hospital receive a geograph				N	N	N	I 22.
	a result of the OMB standar							
	by CMS in FY2015? Enter in c portion of the cost reportir							
	n 2, "Y" for yes or "N" for							
	g period occurring on or aft							
	s hospital contain at least in accordance with 42 CFR 41							
	N" for no.		001 0					
	thod is used to determine Me					3 N		23.
	n column 1, enter 1 if date of discharge. Is the method							
	g period different from the	method used in th	ne prior co	ost				
	g period? In column 2, ente	er "Y" for yes or			Out of			thor
			In-State Medicaid	In-State Medicaid				ther di cai d
			pai d days			Medi cai d	2	days
				unpai d	pai d days	eligible		
				days	2.00	unpai d	5.00 6	
			1 00					5 00
reportin	provider is an IPPS hospital	, enter the	1.00	2.00 3 1	3.00 0 0	4.00	154	<u>5.00</u> 0 24.
00 If this in-state	Medicaid paid days in colum	nn 1, in-state		-				
.00 If this in-state Medicaid	Medicaid paid days in colum eligible unpaid days in col	nn 1, in-state umn 2,		-				
00 f this in-state Medicaid out-of-s	Medicaid paid days in colum	nn 1, in-state umn 2, column 3,		-				
00 f this in-state Medicat out-of-s out-of-s 4, Medic	Medicaid paid days in colum eligible unpaid days in col tate Medicaid paid days in co	nn 1, in-state umn 2, column 3, d days in column ut unpaid days in		-				

SPI T	Financial Systems STARKE AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	N: 15-0102	Peri od:		Work	Form CM sheet S	
					From 01/ To 12/	01/2018 31/2018	Date	: I e/Time F /2019 4	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	aid	Other Medicai days	
		1.00	2.00	3.00	4.00	5.00	2	6.00	
5. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	(Urban/	Rural S	O	of Geo	25. ar
					1.	00		2.00	5.
. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	rural. age) status "2" for r cation in	at the end ural. If ap column 2.	l of the cos pplicable,	it	2			26. 27. 35.
	effect in the cost reporting period.								
						ni ng: 00	E	ndi ng: 2. 00	_
. 00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for numb					36.
. 00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	ls MDH statu	IS	1			37.
. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)								37.
00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.					/2018	12/	/31/2018	3 38
						/N 00		Y/N 2.00	_
	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 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction), (ii), or the mileage i)? Enter n adjustmen	(iii)? Ent requiremen in column 2 t? Enter "Y	er in colum nts in ""Y" for ye "" for yes o	n s	Y		Y	39. 40.
	"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r "Y" for y	ves or "N" f	or	V	XVI	11 XI	
						1.0	_		
00	Prospective Payment System (PPS)-Capital					N			45
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce		•			N			
. 00	pursuant to 42 CFR §412.348(f)? If yes, complete Wks1 Pt. III.								40.
	Is this a new hospital under 42 CFR §412.300(b) PPS on the facility electing full federal capital payment	•		2		N N	1	1	
. 00	Teaching Hospitals Is this a hospital involved in training residents in or "N" for no.	approved G	ME programs	? Enter "Y	‴ for yes	N			56
00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "\ "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or "N th of this (", complet	" for no in cost report e Worksheet	i column 1. ing period?	lf column ' Enter "Y				57
00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.		es as				58
	Are costs claimed on line 100 of Worksheet A? If yes	s, complete	Wkst. D-2,	Pt. I. NAHE 413.8 Y/N		heet A he #	Qual	s-Throug ificati	on
9.00							CLIFE	erion Co	bae
9.00				1.00		00	Crite	3.00	bae

IOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: fom 01/01/2018 p 12/31/2018	Worksheet S-2 Part I Date/Time Pre	pared:
		Y/N	IME	Direct GME	IME	5/31/2019 4:0 Direct GME	
	1	1.00	2.00	3.00	4.00	5.00	
1. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see	N			0.00	0. OC	61.0
1. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
1. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
51.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	_					61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
1. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61. 1
						1.00	
2. 00 2. 01	your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a	trai nec cti ons) a Teachi	d in this cost ng Health Cen	reporting peri ter (THC) into			62.0 62.0
3. 00	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se	er Setti	i ngs		eriod? Enter	N	63.0
	"Y" for yes or "N" for no in column 1. If yes, comple			67. (see instru Unweighted FTEs	ctions) Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der Si te 1.00	Hospi tal 2.00	2)) 3.00	
4.00	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair a-primar all nor d non-pr n columr	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	This base year 0.00	-		64.0

				om 01/01/2018	Worksheet S-2 Part I	
			To	12/31/2018	Date/Time Pre 5/31/2019 4:0	epared
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	1
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	позрі таї	4))	
	1.00	2.00	3.00	4.00	5.00	
0.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)						
			Unweighted	Unweighted	Ratio (col. 1/	/
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Current	/ear FTE Residents i	n Nonprovider Settir				
.00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	curring in all nonp nweighted non-prima I. Enter in column	rovider settings. ry care resident 3 the ratio of	0. 00	0.00	0. 000000) 66.
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	/
			FTEs Nonprovider Site	FTEs in Hospital	(col. 3 + col. 4))	
	1.00	2.00	Nonprovi der		4))	_
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	Nonprovi der Si te 3.00	Hospi tal 4.00	4))	_
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	1.00	2.00	Nonprovi der Si te 3.00	Hospi tal 4.00 0.00	4)) 5.00 0.000000	_
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)	25		Nonprovi der Si te 3. 00 0. 00	Hospi tal <u>4.00</u> 0.00 <u>1.0</u>	4)) 5.00 0.000000 0.000000 0.0000000	0 67.
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)	25 rchiatric Facility (IPF), or does it con	Nonprovi der Si te 3. 00 0. 00	Hospi tal <u>4.00</u> 0.00 0.00 1.0 rovi der? N	4)) 5.00 0.000000 0.000000 0.0000000	
<pre>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)</pre>	YS Ychiatric Facility (the facility have a fore November 15, 2 umn 2: Did this fac 2: 412.424 (d)(1)(iii ate which program y	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	Hospi tal 4.00 0.00 1.0 1.0 rovi der? N he most o. (see i ng o.	4)) 5.00 0.000000 0.000000 0.0000000	
<pre>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)</pre>	2S rchiatric Facility (the facility have a fore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y 2 PPS nabilitation Facility	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in ti yes or "N" for m s in a new teach yes or "N" for m s cost reporting	Hospi tal 4.00 0.00 1.0 1.0 rovi der? N he most o. (see i ng o.	4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.00000000	_

Heal th	Financial Systems STARKE MEMORIA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		Period:	Worksheet S-2	2
				From 01/01/2018 To 12/31/2018	Date/Time Pro	epared:
					5/31/2019 4:0	09 pm
					1.00	-
	Long Term Care Hospital PPS				1	
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes	and "N" for	no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part o	r all of the	cost reporting	g period? Enter	N	81.00
	"Y" for yes and "N" for no. TEFRA Providers					-
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)	TEFRA? Ente	r "Y" for yes	or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (exclude	d unit) under	42 CFR Sectio	on		86.00
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospita		under eastion		N	87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		under section		IN	07.00
				V	XI X	
				1.00	2.00	
	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospita	L services2 F	nter "V" for	N	Y	90.00
	yes or "N" for no in the applicable column.	I Services: L	inter i for	IN IN	1	70.00
91.00	Is this hospital reimbursed for title V and/or XIX through t			N	N	91.00
	full or in part? Enter "Y" for yes or "N" for no in the appl					
	Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica		Ion)? (see		N	92.00
	Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	N	93.00
	"Y" for yes or "N" for no in the applicable column.					
	Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94.00
	applicable column. If line 94 is "Y", enter the reduction percentage in the app	licable colum	n.	0.00	0.00	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes			N	N	96.00
	applicable column.					
	If line 96 is "Y", enter the reduction percentage in the app Does title V or XIX follow Medicare (title XVIII) for the in			0. 00 Y	0.00 Y	97.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f			T	T	90.00
	column 1 for title V, and in column 2 for title XIX.					
	Does title V or XIX follow Medicare (title XVIII) for the re			Y	Y	98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.	tle V, and in	column 2 for			
	Does title V or XIX follow Medicare (title XVIII) for the ca	lculation of	observati on	Y	Y	98.02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o	r "N" for no	in column 1			
	for title V, and in column 2 for title XIX.	ical accors b	ocpital (CAU)	N	N	98.03
	Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye				IN IN	70.03
	for title V, and in column 2 for title XIX.					
	Does title V or XIX follow Medicare (title XVIII) for a CAH			N	N	98.04
	outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.	column 1 for	title V, and			
	Does title V or XIX follow Medicare (title XVIII) and add ba	ck the RCE di	sallowance on	Y	Y	98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c			1		
	column 2 for title XIX.		- Wheet D		N N	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column			Y	Y	98.06
	column 2 for title XIX.		v, and m			
	Rural Providers				1	
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-	inclucivo mot	had of norman	N		105.00 106.00
100.00	for outpatient services? (see instructions)	inciusive met	nou or payment			100.00
	If this facility qualifies as a CAH, is it eligible for cost					107.00
	training programs? Enter "Y" for yes or "N" for no in column					
	yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	25 and the p	rogram is cos			
	Is this a rural hospital qualifying for an exception to the	CRNA fee sche	dul e? See 42	N		108.00
-	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	-	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	-
109.00	If this hospital qualifies as a CAH or a cost provider, are	1.00	2.00 N	N	4.00 N	109.00
	therapy services provided by outside supplier? Enter "Y"					
	for yes or "N" for no for each therapy.					
					1.00	-
	Did this hospital participate in the Rural Community Hospita				N N	110.00
	Demonstration) for the current cost reporting period? Enter "					
	complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	NOTICEL E-2, I	11165 200 111 01	iyii 210, do		

Health Financial Systems STARKE MEMORIAL	HOSPI TAL		١n	Lieu	ı of For	m CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-01		riod: om 01/01/2 12/31/2		Workshe Part I Date/Ti	me Pre	epared:
					5/31/20	19 4: (09 pm
			1.00		2.0	0	
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services.	t reporting period? I umn 1 is Y, enter the icipating in column 2	e 2.	N				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. I 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers) Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for	lf column 2 is "E", e for long term care) based on the defini	enter ir (include tion ir	n column es	N		0	115.00
117.00 Is this facility legally-required to carry malpractice insurar no.			l" for	N			117.00
118.00 s the malpractice insurance a claims-made or occurrence polic claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 if the po	blicy is	s	1			118.00
	Premi	ums	Losses		Insur	ance	
	1. (00	2.00		3.0	00	-
118.01 List amounts of malpractice premiums and paid losses:		38, 803	4,	564		(0118.01
		-	1.00		2.0	00	-
 118. 02 Are mal practice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein. 119. 00 DO NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments 	le listing cost cent Harmless provision in column 1, "Y" for yes lifies for the Outpa	n ACA s or tient	N		Y		118. 02 119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	table devices charged	d to	Υ				121.00
122.00 Does the cost report contain healthcare related taxes as defir Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included.			Ν				122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N" for no.	lf	N				125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date if continue to a solumn 2	er the certification	date					126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	r the certification o	date					127.00
128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.							128.00
129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.							129.00
130.00 If this is a Medicare certified pancreas transplant center, er date in column 1 and termination date, if applicable, in colum 21 0016 this is a Medicare certified intestingl transplant center.	mn 2.						130.00
131.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum 132.00 If this is a Medicare certified islet transplant center, enter	mn 2.						131.00 132.00
in column 1 and termination date, if applicable, in column 2. 133.00 f this is a Medicare certified other transplant center, enter							133.00
in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (OPO), enter the							134.00
and termination date, if applicable, in column 2. All Providers							-
140.00 Are there any related organization or home office costs as def chapter 10? Enter "Y" for yes or "N" for no in column 1. If ye are claimed, enter in column 2 the home office chain number.	es, and home office of		Y		4490	008	140. 00

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLEX		A Pr		N: 15-0102			u of Form CMS- Worksheet S- Part I Date/Time Pro 5/31/2019 4:0	2 epared:
1.00		2.00				3.00		_
If this facility is part of a chair home office and enter the home offi 41.00Name: CHS/COMMUNITY HEALTH SYSTEMS	ce contractor name	and contra		er.		d address imber: 0590		141.00
I NC 42.00 Street: 4000 MERIDIAN BOULEVARD	PO Box:	TN		7	-	270/	7	142.00
43.00 City: FRANKLIN	State:	TN		Zip Cod	le:	3706	/	143.00
							1.00	-
44.00 Are provider based physicians' cost	s included in Works	sheet A?					N	144.00
						1.00	2.00	-
45.00 If costs for renal services are cla inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" f 46.00 Has the cost allocation methodology	for yes or "N" for ude Medicare utiliz for no in column 2.	no in colur zation for 1	nn 1. lfc his cost	column 1 is reporting		N		145.00
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dc	column 1. (See CMS	Pub. 15-2,			f	1		
							1.00	-
47.00 Was there a change in the statistic	cal basis? Enter "Y	' for yes or	"N" for	no.			N	147.00
48.00 Was there a change in the order of	allocation? Enter '	'Y" for yes	or "N" fo	or no.			N	148.00
49.00 Was there a change to the simplifie	ed cost finding meth		Y" for ye art A	es or "N" fo Part B		itle V	N Title XIX	149.00
			1.00	2.00		3.00	4.00	
Does this facility contain a provic		for an exem	otion from	n the applic		f the lowe		
or charges? Enter "Y" for yes or "N 55.00Hospital	N" for no for each (component f	N Part A	and Part B. N	(See 4:	2 CFR §413 N	. 13) N	155. 0
56.00 Subprovi der – IPF			N	N		N	N	156.0
57.00 Subprovider - IRF			N	N		Ν	N	157.0
58. 00 SUBPROVI DER			N	N		N	N	158.0
59.00 SNF 60.00 HOME_HEALTH_AGENCY			N N	N N		N N	N N	159.0
61. 00 CMHC				N		N	N	161.0
61. 10 CORF				N		Ν	N	161. 1
							1.00	-
Multicampus								
65.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no.	npus hospital that h	nas one or r	ore campu	ises in diff	erent CE	BSAs?	N	165. 0
	Name		inty		ip Code	CBSA	FTE/Campus	
(/ 001 f line 1/F is yes for each	0	1.	00	2.00	3.00	4.00	5.00	01((0
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.0	0166.0
							1.00	_
Health Information Technology (HIT)					ent Act			
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 105 reasonable cost incurred for the HI	is "Y") and is a r	neaningful ເ	2), enter	- the	Y	167. 0 0168. 0
68.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)?	ot a meaningful user Enter "Y" for yes o	r, does this or "N" for m	io. (see i	nstructions	5)	•		168. 0
69.00 If this provider is a meaningful us transition factor. (see instruction		') and is no	taCAH (line 105 is		enter the	9.9 Endi ng	9169.0
					De	1. 00	2.00	
70.00 Enter in columns 1 and 2 the EHR be	eginning date and er	nding date 1	or the re	eporti ng	04,	/01/2018	06/30/2018	170. 0
period respectively (mm/dd/yyyy)								
period respectively (mm/dd/yyyy)						1.00	2.00	

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0102	Period: From 01/01/2018	Worksheet S- Part II	
				To 12/31/2018	Date/Time Pr 5/31/2019 4:	
				Y/N 1.00	Date 2.00	_
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente			
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					_
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.
. 00	reporting period? If yes, enter the date of the change in co					''
			Y/N	Date	V/I	
0.0		0.1.6	1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare Pr yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	fices, drug er or its the board	Y			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi	fied Dublic	Y	A		4.
. 00	Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled, lable in		~		
. 00	Are the cost report total expenses and total revenues differ		N			5.
	those on the filed financial statements? If yes, submit reco			Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ie provider i	s N		6.
. 00	Are costs claimed for Allied Health Programs? If "Y" see ins	structions		Ν		7.
. 00	Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.	and/or renewed	0	Ν		8.
. 00	Are costs claimed for Interns and Residents in an approved g		al education	N		9.
0. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		he current	Ν		10.
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	YZN	11.
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12. 13.
4.00	If line 12 is yes, were patient deductibles and/or co-paymer	nts waived? If	yes, see in:	structions.	N	14.
5. 00	Bed Complement Did total beds available change from the prior cost reportin	<u>9</u> 1	yes, see ins t A		Y t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	Y	04/16/2019	Y	04/16/2019	16.
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Ν		Ν		17.
8. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		18.
	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
9.00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.

	Financial Systems STARKE MEMORIA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0102	Peri od:	u of Form CM Worksheet S	
				From 01/01/2018 To 12/31/2018	Part II Date/Time P	
		Descri	ntion	Y/N	5/31/2019 4 Y/N	:09 pm
				1.00	3.00	
0. 00	If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20.
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
1.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEF	PT CHILDRENS H	OSPI TALS)			
	Capital Related Cost					
2.00	Have assets been relifed for Medicare purposes? If yes, see				N	22.
3. 00	Have changes occurred in the Medicare depreciation expense or reporting period? If yes, see instructions.	due to apprais	als made du	ring the cost	N	23.
4. 00	Were new leases and/or amendments to existing leases entered If yes, see instructions	d into during	this cost re	eporting period?	Ν	24.
5. 00	Have there been new capitalized leases entered into during t	the cost repor	ting period	?lfyes, see	Ν	25.
6. 00	instructions. Were assets subject to Sec.2314 of DEFRA acquired during the	e cost reporti	na neriod?	If yes see	N	26.
	instructions.	·	0.1	5		
7.00	Has the provider's capitalization policy changed during the copy. Interest Expense	cost reportin	g period? I	f yes, submit	N	27.
3. 00	Were new loans, mortgage agreements or letters of credit en	tered into dur	ing the cos	t reporting	N	28.
9.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or b		bt Service I	Reserve Fund)	Ν	29.
0. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur		debt? If yes	s, see	Ν	30.
I. 00	instructions. Has debt been recalled before scheduled maturity without iss	suance of new	debt? If yes	s, see	N	31.
	instructions. Purchased Services					_
2.00	Have changes or new agreements occurred in patient care serv arrangements with suppliers of services? If yes, see instruc		d through co	ontractual	Ν	32.
3. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appl no, see instructions.		g to competi	itive bidding? If	Ν	33.
	Provi der-Based Physi ci ans					
1.00	Are services furnished at the provider facility under an arm If yes, see instructions.	rangement with	provi der-ba	ased physi ci ans?	Y	34.
5. 00	If line 34 is yes, were there new agreements or amended exis physicians during the cost reporting period? If yes, see ins		ts with the	provi der-based	Ν	35.
	physicians during the cost reporting period: in yes, see the		-	Y/N	Date	
	Home Office Costs			1.00	2.00	
5.00	Were home office costs claimed on the cost report?			Y		36.
	If line 36 is yes, has a home office cost statement been pre	epared by the	home office			37.
3. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home offi	ice different	from that o	f N		38.
	the provider? If yes, enter in column 2 the fiscal year end	of the home o	ffi ce.			
9.00	If line 36 is yes, did the provider render services to other see instructions.		5			39.
0. 00	If line 36 is yes, did the provider render services to the H instructions.	home office?	lf yes, see	N		40.
		1.	00	2.	00	
1 00	Cost Report Preparer Contact Information	/1171.11/4		TCLCA		
1.00	held by the cost report preparer in columns 1, 2, and 3,	KUZI WA		TSI GA		41.
2 00		COMMUNITY HEAL	TH SYSTEMS			42.
2.00	preparer.					

Heal th	Financial Systems	STARKE MEMORIAL	L HOSPITAL			In Lieu	u of Form CMS-:	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-0102		i od:	Worksheet S-2	
					To	m 01/01/2018 12/31/2018	Part II Date/Time Pre 5/31/2019 4:0	
				3.00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the t	citle/position SI	R MANAGER -	REV MGT				41.00
	held by the cost report preparer in colum	ns 1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the co	ost report						42.00
	preparer.							
43.00	Enter the telephone number and email addr	ress of the cost						43.00
	report preparer in columns 1 and 2, respe	ecti vel y.						

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	STARKE MEMORIA	Provider CC	N: 15 0102	Peri od:		u of Form CMS-2 Worksheet S-3	
HUSPII	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-0102		1/01/2018	Part I	
						2/31/2018	Date/Time Pre 5/31/2019 4:0	
							I/P Days / O/P	
	Component	Worksheet A	No. of Beds	Bed Days	САН	Hours	<u>Visits / Trips</u> Title V	
	component	Line Number	No. of Deus	Avai I abl e	UAL	i nour s	intro v	
		1.00	2.00	3.00		4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	14	5, 1	10	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO I PF 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		14	5, 1	10	0.00	0	7.00
0.00	beds) (see instructions)	21.00	1	2	/ F	0.00	0	0.00
8.00 9.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	31.00	1	3	65	0.00	0	8.00 9.00
9.00 10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43.00					0	13.00
14.00	Total (see instructions)		15	5,4	75	0.00	0	14.00
15.00	CAH visits						0	15.00
16.00	SUBPROVIDER - IPF	40.00	0		0		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0		0		0	17.00
18.00	SUBPROVIDER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00 22.00	OTHER LONG TERM CARE HOME HEALTH AGENCY	101.00					0	21.00
22.00	AMBULATORY SURGICAL CENTER (D. P.)	115.00					0	22.00
24.00	HOSPICE	116.00	0		0			23.00
24.10	HOSPICE (non-distinct part)	30.00			0			24.10
25.00	CMHC - CMHC	99.00					0	25.00
25. 10	CMHC - CORF	99. 10					0	25.10
26.00	RURAL HEALTH CLINIC	88. 00					0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00					0	26. 25
27.00	Total (sum of lines 14-26)		15					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		0		0			31.00
32.00	Labor & delivery days (see instructions)		0		0			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00	LTCH non-covered days							33.00
	LTCH site neutral days and discharges							33.01

	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2018 To 12/31/2018		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	740	48	1, 22	7		1.00
. 00 . 00	HMO and other (see instructions) HMO IPF Subprovider	212 0	154 0				2.00
. 00	HMO IRF Subprovider	0	0				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	(D		5.00
. 00	Hospital Adults & Peds. Swing Bed NF		0	(D		6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	740	48	1, 22	7		7.00
. 00	INTENSIVE CARE UNIT	0	0	(C		8.00
. 00	CORONARY CARE UNIT						9.00
0.00	BURN INTENSIVE CARE UNIT						10.00
1.00	SURGICAL INTENSIVE CARE UNIT						11.00
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY	7.40	0			440.07	13.00
4.00	Total (see instructions)	740	48	1, 22		112.27	•
5.00	CAH visits	0	0			0.00	15.00
6.00 7.00	SUBPROVIDER - IPF	0	0		0.00	0.00 0.00	•
8.00	SUBPROVI DER – I RF SUBPROVI DER	0	0	,	0.00	0.00	18.00
9.00	SKILLED NURSING FACILITY						19.00
). 00). 00	NURSING FACILITY						20.00
1.00	OTHER LONG TERM CARE						21.00
2.00	HOME HEALTH AGENCY	0	0		0.00	0.00	
3.00	AMBULATORY SURGICAL CENTER (D. P.)	-			0.00		
4.00	HOSPI CE	0	0	(0.00	0.00	
4. 10	HOSPICE (non-distinct part)			(D		24.10
5.00	CMHC - CMHC	0	0	(0.00	0.00	25.00
5. 10	CMHC - CORF	0	0	(0.00	0.00	25.10
5.00	RURAL HEALTH CLINIC	0	0	(0.00	0.00	26.0
5. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0.00	0.00	26. 2
7.00	Total (sum of lines 14-26)				0.00	112.27	27.00
8.00	Observation Bed Days		0	34	ō		28.00
9.00	Ambulance Trips	0					29.00
0. 00	Employee discount days (see instruction)			(C		30.00
1.00	Employee discount days - IRF			(D		31.00
2.00	Labor & delivery days (see instructions)	0	0	(D		32.00
2. 01	Total ancillary labor & delivery room			(D		32.01
	outpatient days (see instructions)						
3.00	LTCH non-covered days	O			1		33.00

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	CN: 15-0102	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Pre 5/31/2019 4:0	pared:
		Full Time		Di s	charges		
	Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 12.00 20.00 21.00 22.00 23.00 24.00 25.10 26.00 27.00 28.00 29.00 20.00 25.10 26.00 27.00 28.00 29.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNI T CORONARY CARE UNI T SURGICAL INTENSI VE CARE UNI T SURGICAL INTENSI VE CARE UNI T OTHER SPECIAL CARE (SPECI FY) NURSERY Total (see instructions) CAH visits SUBPROVI DER - IPF SUBPROVI DER - I RF SUBPROVI DER - I RF SUBPROVI DER - I RF SUBPROVI DER - I RF SUBPROVI DER SACILI TY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CORF RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction)	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	12.00 0 0 0	2	45 77 65 0 65 77 0 0 0 0 0 0	486 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 14. 00 15. 00 14. 00 15. 00 20. 00 21. 00 21. 00 22. 00 23. 00 24. 00 25. 00 24. 00 25. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 20. 00
31. 00 32. 00 32. 01	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)						31. 0 32. 0 32. 0
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges				0		33. 0 33. 0

PLU	AL WAGE INDEX INFORMATION			Provider C	1	Period: From 01/01/2018 Fo 12/31/2018		pare
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
0	Total salaries (see	200.00	6, 463, 685	0	6, 463, 68	5 233, 531. 00	27.68	1
0	instructions) Non-physician anesthetist Part		0	0		0.00	0.00	2
0	A		0			0.00	0.00	
0	Non-physician anesthetist Part		0	0	(0.00	0.00	3
0	B Physician-Part A -		O	о		0.00	0.00	4
	Admi ni strati ve							
1	Physicians - Part A - Teaching Physician and Non		0	0		0.00		
0	Physician-Part B		0			0.00	0.00	
0	Non-physician-Part B for		0	0		0.00	0.00	6
	hospital-based RHC and FQHC services							
0	Interns & residents (in an	21.00	0	0	(0.00	0.00	7
1	approved program)		0				0.00	-
1	Contracted interns and residents (in an approved		U	0		0.00	0.00	7
	programs)							
0	Home office and/or related organization personnel		0	0		0.00	0.00	8
0	SNF	44.00	0	0	(0.00	0.00	Ģ
00	Excluded area salaries (see		0	0		0.00	0.00	10
	instructions) OTHER WAGES & RELATED COSTS							
00	Contract Labor: Direct Patient		154, 943	0	154, 943	3 2, 284.00	67.84	11
~~	Care							
00	Contract labor: Top level management and other		0	0		0.00	0.00	⊿
	management and administrative							
00	services Contract Labor: Physician-Part		500	0	500	4.00	125 00	1.
00	A - Administrative		500	0	500	4.00	125.00	
00	Home office and/or related		0	0	(0.00	0.00	14
	organization salaries and wage-related costs							
01	Home office salaries		598, 918	0	598, 918	18, 868. 00	31.74	14
02	Related organization salaries		0	0		0.00		
00	Home office: Physician Part A - Administrative		0	0		0.00	0.00	
00	Home office and Contract		0	0	(0.00	0.00	10
	Physicians Part A - Teaching WAGE-RELATED COSTS							
	Wage-related costs (core) (see		1, 342, 748	0	1, 342, 748	3		1 17
	instructions)							
00	Wage-related costs (other) (see instructions)		C	0	(18
00	Excluded areas		O	о		D		10
00	Non-physician anesthetist Part		0	0	(C		20
00	A Non-physician anesthetist Part		C	о		D		2
	В		C C					
00	Physician Part A - Administrative		0	0	(22
01	Physician Part A - Teaching		0	0	(D		22
	Physician Part B		0	0	(D		23
	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0				24
	approved program)		Ū.					
50	Home office wage-related		113, 878	0	113, 878	3		25
51	(core) Related organization		0	о		b		25
	wage-related (core)		-					
52	Home office: Physician Part A - Administrative -		0	0	(25
F. 6	wage-related (core)		-	_				
53	Home office & Contract Physicians Part A - Teaching -		0	0	(25
	wage-related (core)							
	OVERHEAD COSTS - DIRECT SALARIE			1				
00	Employee Benefits Department Administrative & General	4.00	27, 383	0 -45, 536			28. 29	26

Heal th	Financial Systems		STARKE MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2018 To 12/31/2018		pared:
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	$(col.2 \pm col.$		col. 5)	
				A-6)	3)	col. 4		
	1	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0		0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0		0.00	0.00	29.00
30.00	Operation of Plant	7.00	411, 824	0	411, 82	4 17, 581. 00	23. 42	30.00
31.00	Laundry & Linen Service	8.00	0	0	(0.00	0.00	31.00
32.00	Housekeepi ng	9.00	191, 698	0	191, 69	B 12, 420. 00	15. 43	32.00
33.00	Housekeeping under contract (see instructions)		63, 689	0	63, 68	9 1, 948. 63	32.68	33.00
34.00	Dietary	10.00	184, 301	-98, 919	85, 383	2 4, 992. 04	17. 10	34.00
35.00	Dietary under contract (see instructions)		0	0		0.00	0.00	35.00
36.00	Cafeteria	11.00	0	98, 919	98, 91	9 5, 874. 96	16. 84	36.00
37.00	Maintenance of Personnel	12.00	0	0	(0.00	0.00	37.00
38.00	Nursing Administration	13.00	97, 659	45, 536	143, 19	5 3, 022. 00	47.38	38.00
39.00	Central Services and Supply	14.00	57, 936	0	57, 93	6 3, 217. 00	18.01	39.00
40.00	Pharmacy	15.00	199, 478	0	199, 47	8 4, 852.00	41.11	40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	82, 321	0	82, 32			41.00
42.00	Soci al Servi ce	17.00	35, 654	0	35, 65	4 901.00	39.57	42.00
43.00	Other General Service	18.00	0	0		0.00	0.00	43.00

Heal th	Financial Systems	STARKE MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
HOSPI	FAL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2018	Worksheet S-3 Part III	
						To 12/31/2018		
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		6, 527, 374	0	6, 527, 37	4 235, 479. 63	27.72	1.00
	instructions)							
2.00	Excluded area salaries (see		0	0		0.00	0.00	2.00
	instructions)							
3.00	Subtotal salaries (line 1		6, 527, 374	0	6, 527, 37	4 235, 479. 63	27.72	3.00
	minus line 2)							
4.00	Subtotal other wages & related		754, 361	0	754, 36	1 21, 156. 00	35.66	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		1, 456, 626	0	1, 456, 62	6 0.00	22. 32	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		8, 738, 361	0	8, 738, 36	1 256, 635. 63	34.05	6.00
7.00	Total overhead cost (see		2, 160, 182	0	2, 160, 18	2 96, 457. 63	22.40	7.00
	instructions)							

Heal th	Financial Systems	STARKE MEMORIAL	HOSPI TAL			In Lie	u of Form CMS-:	2552-10
HOSPI T	AL WAGE RELATED COSTS		Provi der	CCN: 1	5-0102	Period: From 01/01/2018 To 12/31/2018		
							5/31/2019 4:0	
							Amount	
							Reported	
							1.00	
	PART IV - WAGE RELATED COSTS							-
	Part A - Core List							-
	RETIREMENT COST							1
1.00	401K Employer Contributions						86, 677	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribut						0	
3.00	Nonqualified Defined Benefit Plan Cost (see in						0	
4.00	Qualified Defined Benefit Plan Cost (see instr						0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Or	gani zati on)						
5.00	401K/TSA Plan Administration fees						0	
6.00	Legal /Accounting/Management Fees-Pension Plan	_					0	
7.00	Employee Managed Care Program Administration F	ees					0	7.00
	HEALTH AND INSURANCE COST							
8.00	Heal th Insurance (Purchased or Self Funded)						0	
8.01	Heal th Insurance (Self Funded without a Third						0	
8.02	Health Insurance (Self Funded with a Third Par	rty Administrato	r)				636, 377	
8.03	Heal th Insurance (Purchased)						0	
9.00	Prescription Drug Plan						0	
10.00	Dental, Hearing and Vision Plan						25, 151	1
11.00	Life Insurance (If employee is owner or benefi							11.00
12.00	Accident Insurance (If employee is owner or be							12.00
13.00	Disability Insurance (If employee is owner or		、					13.00
14.00	Long-Term Care Insurance (If employee is owner	or beneficiary)					14.00
15.00	'Workers' Compensation Insurance						52, 624	
16.00	Retirement Health Care Cost (Only current year	r, not the extra	ordinary a	iccruai	require	ed by FASB 106.	0	16.00
	Non cumulative portion) TAXES							
17 00	FICA-Employers Portion Only						383, 587	17 00
17.00	Medicare Taxes - Employers Portion Only						383, 587 89, 710	
18.00	Unemployment Insurance							19.00
	State or Federal Unemployment Taxes							
20.00	OTHER						43, 533	20.00
21 00	Executive Deferred Compensation (Other Than Re	ti romant Cost D	operted or	Linoc	1 throu	ich 1 abour (coo	0	21.00
21.00	instructions))	etriement cost k	epoi teu oi	i i i nes		igii 4 above. (See	0	21.00
22.00	Day Care Cost and Allowances						0	22.00
22.00	Tuition Reimbursement						0	1
	Total Wage Related cost (Sum of lines 1 -23)						1, 339, 354	
27.00	Part B - Other than Core Related Cost						1, 337, 334	27.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)						0	25.00
25.00	Tother moe Reented 00010 (or contr)						0	20.00

Health Financial Systems	STARKE MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0102	Peri od:	Worksheet S-3	
		From 01/01/2018		
		To 12/31/2018	Date/Time Pre 5/31/2019 4:0	
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identi	fication:			
1.00 Total facility's contract labor and benefit	cost	154, 943	1, 339, 354	1.00
2.00 Hospital		154, 943	1, 339, 354	2.00
3.00 Subprovider - IPF		0	0	3.00
4.00 Subprovider - IRF		0	0	4.00
5.00 Subprovider - (Other)		0	0	5.00
6.00 Swing Beds - SNF		0	0	6.00
7.00 Swing Beds - NF		0	0	7.00
8.00 Hospital-Based SNF				8.00
9.00 Hospital-Based NF				9.00
10.00 Hospital-Based OLTC				10.00
11.00 Hospital-Based HHA		0	0	11.00
12.00 Separately Certified ASC		0	0	12.00
13.00 Hospital-Based Hospice		0	0	13.00
14.00 Hospital-Based Health Clinic RHC		0	0	14.00
15.00 Hospital-Based Health Clinic FQHC		0	0	15.00
16.00 Hospital-Based-CMHC		0	0	16.00
16.10 Hospital-Based-CMHC 10		0	0	16.10
17.00 Renal Dialysis		0	0	
18.00 0ther		0	0	18.00

Heal th	Financial Systems STARKE MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-0102	Period: From 01/01/2018	Worksheet S-1	
				To 12/31/2018	Date/Time Pre 5/31/2019 4:0	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by lin	ne 202 colum	n 8)	0. 219061	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				2, 161, 843	•
3.00	Did you receive DSH or supplemental payments from Medicaid?	- + - 1		- : - 10	Y	3.00
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments			ai d ?	Y O	4.00
6.00	Medicaid charges		u		17, 904, 152	
7.00	Medicaid cost (line 1 times line 6)				3, 922, 101	
8.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	(line 7 minu	us sum of li	nes 2 and 5; if	1, 760, 258	
	Children's Health Insurance Program (CHIP) (see instructions 1	for each line	e)			
9.00	Net revenue from stand-alone CHIP				0	9.00
10.00	Stand-alone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP enter zero)	-			0	12.00
	Other state or local government indigent care program (see ins					1 4 9 9 9
	Net revenue from state or local indigent care program (Not in				0	•
14.00	Charges for patients covered under state or local indigent ca 10)	re program (i		TH THES 0 UI	0	14.00
15.00	State or local indigent care program cost (line 1 times line)	14)			0	15.00
	Difference between net revenue and costs for state or local in		program (li	ne 15 minus line	0	•
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, Ch	HP and state	e/local indig	gent care program	ns (see	
17.00	instructions for each line) Private grants, donations, or endowment income restricted to	fundi na chari	ity care		0	17.00
	Government grants, appropriations or transfers for support of				0	
	Total unreimbursed cost for Medicaid, CHIP and state and loc. 8, 12 and 16)			s (sum of lines	1, 760, 258	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20, 00	Charity care charges and uninsured discounts for the entire fa	acility	827, 8	93 0	827, 893	20.00
201.00	(see instructions)		02770	, , , , , , , , , , , , , , , , , , , ,	0277070	20.00
21.00	Cost of patients approved for charity care and uninsured disc instructions)	ounts (see	181, 3	59 0	181, 359	21.00
22.00	Payments received from patients for amounts previously written charity care	n off as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		181, 3	59 0	181, 359	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for pation	ent days bey	ond a length	of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indigent car If line 24 is yes, enter the charges for patient days beyond		care progra	n's length of	0	25.00
	stay limit					
	Total bad debt expense for the entire hospital complex (see in		ructions)		2, 745, 092	
	Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex				38, 479 59, 199	
	Non-Medicare bad debt expense (see instructions)		1 013/		2, 685, 893	
	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	xpense (see i	instructions)	609, 094	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				790, 453	•
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			2, 550, 711	31.00

CECLAS.	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CO		eriod: rom 01/01/2018	Worksheet A	
					0 12/31/2018	Date/Time Pre 5/31/2019 4:0	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		-2, 251, 055	-2, 251, 055	261, 245	-1, 989, 810	1.00
	00200 CAP REL COSTS-MVBLE EQUIP		3, 008, 733	3, 008, 733		3, 118, 535	
	00300 OTHER CAP REL COSTS	27, 202	0	0	0	0	
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	27, 383 808, 239	2, 431 2, 815, 200	29, 814 3, 623, 439		855, 732 2, 425, 349	
	00700 OPERATION OF PLANT	411, 824	872, 737	1, 284, 561		1, 800, 325	
	00800 LAUNDRY & LINEN SERVICE	0	52, 207	52, 207		52, 207	
	00900 HOUSEKEEPI NG 01000 DI ETARY	191, 698 184, 301	138, 537 112, 332	330, 235 296, 633		330, 235 131, 426	
	01100 CAFETERI A	0	0	0	165, 207	165, 207	
	01300 NURSI NG ADMI NI STRATI ON	97, 659	7,827	105, 486		151,001	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	57, 936 199, 478	58, 978 438, 976	116, 914 638, 454		98, 671 224, 194	
	01600 MEDICAL RECORDS & LIBRARY	82, 321	86, 114	168, 435		168, 350	
17.00	01700 SOCIAL SERVICE	35, 654	3, 041	38, 695	0	38, 695	17.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	808, 451	649, 640	1, 458, 091	-5, 249	1, 452, 842	30.00
	03100 I NTENSI VE CARE UNI T	0	0+9,040	0	0	1, 452, 842	
	04000 SUBPROVIDER - IPF	0	0	0	0	0	
	04100 SUBPROVI DER – I RF 04300 NURSERY	0	0		0	0	
	ANCI LLARY SERVI CE COST CENTERS	0	0		0	0	43.00
	05000 OPERATING ROOM	432, 006	240, 318	672, 324		649, 374	
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
	05300 ANESTHESI OLOGY	1, 811	281,069	282, 880	-1, 824	281,056	
54.00	05400 RADI OLOGY-DI AGNOSTI C	683, 838	448, 100	1, 131, 938	-270, 177	861, 761	54.00
	05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	91, 565	21, 469	113, 034	-10, 163	102, 871 0	1
	05600 RADI OLOGI - THERAPEUTI C	32, 708	57, 694	90, 402	-16, 548	73, 854	
	05700 CT SCAN	70, 660	124, 816	195, 476	-95, 723	99, 753	
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	56, 696	86, 221	142, 917	-80, 411	62, 506 0	1
	06000 LABORATORY	492, 164	500, 992	993, 156	-33, 608	959, 548	
52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
	06400 I NTRAVENOUS THERAPY	0 310, 084	0 25 704	0 345, 790	0	220,004	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	270, 999	35, 706 115, 615	345, 790		339, 004 386, 660	
57.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
	06800 SPEECH PATHOLOGY	0	0	104 419	0	0 00 003	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	86, 520 0	17, 898 0	104, 418 0	-4, 615 0	99, 803 0	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13, 162	13, 162	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	2,717	2, 717	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		408, 057 0	408, 057 0	
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
	03020 ACUPUNCTURE OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76.00
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
39.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
	09000 CLINIC	2, 745 1, 026, 945	423, 637	426, 382 2, 337, 274		426, 382	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 020, 945	1, 310, 329	2, 337, 274	-3, 494	2, 333, 780	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
	09900 CMHC	0	0	0	0	0	
	09910 CORF 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0	0	99.10 100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS						105 00
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0	0		0		105.00 106.00
	10700 LI VER ACQUI SI TI ON	0	0	0	0		107.00
	10800 LUNG ACQUI SI TI ON	0	0	0	0		108.00
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION		0		0		109.00 110.00
110 00							

Health Financial Systems	STARKE MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC		Period:	Worksheet A	
				rom 01/01/2018 To 12/31/2018		
Cost Center Description	Sal ari es	Other		Recl assi fi cati		
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	2.00	2.00	4.00	col. 4)	
113.0011300INTEREST EXPENSE	1.00	2.00	3.00	4.00	5.00	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0				113.00
	0	0				
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE	0	0				115.00 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 463, 685		16, 123, 24		16, 123, 247	
NONREI MBURSABLE COST CENTERS	0, 403, 005	9, 659, 562	10, 123, 24	0	10, 123, 247	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	190.00
191, 00 19100 RESEARCH	0	0				191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	-171, 433	-171, 433		-171, 433	
193. 00 19300 NONPALD WORKERS	0	171, 435	171,430			193.00
194. 00 07950 SPECIALTY CLINICS / MOB	0	0				194.00
200.00 TOTAL (SUM OF LINES 118 through 199)	6, 463, 685	9, 488, 129	15, 951, 814	i 0	15, 951, 814	

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	STARKE MEMORI	AL HOSPITAL Provider CCN: 15-010	In Lieu of Form CMS 2 Period: Worksheet A	8-2552-1
EULAS	STFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-010.	From 01/01/2018	
				To 12/31/2018 Date/Time Pi 5/31/2019 4	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8) 6.00	For Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		-
. 00	00100 CAP REL COSTS-BLDG & FIXT	2, 586, 438	596, 628		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-2, 352, 231			2.00
B. 00	00300 OTHER CAP REL COSTS		-		3.00
1.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1, 322, 853			4.00
7.00	00700 OPERATION OF PLANT	1, 022, 000			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	C	52, 207		8.00
9.00	00900 HOUSEKEEPI NG	C			9.00
0.00	01000 DI ETARY 01100 CAFETERI A	-69, 816			10.00
3.00	01300 NURSI NG ADMI NI STRATI ON	-41, 400			13.00
	01400 CENTRAL SERVICES & SUPPLY	C			14.00
	01500 PHARMACY	C			15.00
6.00	01600 MEDICAL RECORDS & LIBRARY	-1, 121			16.00
7.00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	C	38, 695		17.00
30. 00	03000 ADULTS & PEDI ATRI CS	C	1, 452, 842		30. 00
31.00	03100 I NTENSI VE CARE UNI T	C			31.00
	04000 SUBPROVIDER - IPF	C	0		40.00
	04100 SUBPROVIDER - IRF 04300 NURSERY		-		41.00
5.00	ANCI LLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	C			50.00
51.00	05100 RECOVERY ROOM	C	-		51.00
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY		0 281, 056		52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C	861, 761		54.00
64. 01	05401 ULTRASOUND	C	102, 871		54.0
5.00	05500 RADI OLOGY-THERAPEUTI C	C	0		55.00
56.00 57.00	05600 RADI OI SOTOPE	C	73, 854		56.00 57.00
57.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)		99, 753 62, 506		57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	C	0		59.00
0. 00	06000 LABORATORY	C	959, 548		60.00
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C			62.00
64.00 5.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY		339,004		64.00 65.00
6.00	06600 PHYSI CAL THERAPY	C	386, 660		66.00
7.00	06700 OCCUPATIONAL THERAPY	C	0		67.00
8.00 9.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		0 99, 803		68.00 69.00
70.00	07000 ELECTROCARDI OLOGI				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-13, 162	-		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	C	2, 717		72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	-9, 276			73.00
	07500 ASC (NON-DI STI NCT PART)				74.00
	03020 ACUPUNCTURE	C	1 1		76.00
	OUTPATIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER				88.00 89.00
9.00 90.00	09000 CLINIC	-423, 443	-		90.00
	09100 EMERGENCY	C			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
1 00	OTHER REIMBURSABLE COST CENTERS				
94.00 95.00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES				94.00 95.00
	09600 DURABLE MEDICAL EQUIP-RENTED		o		96.00
7.00	09700 DURABLE MEDI CAL EQUI P-SOLD	C	0		97.00
	09900 CMHC	C	0		99.00
	09910 CORF 10000 I &R SERVICES-NOT APPRVD PRGM				99. 10 100. 00
	10000 F&R SERVICES-NOT APPRVD PRGM				100.00
	SPECIAL PURPOSE COST CENTERS	. ~			
	10500 KI DNEY ACQUI SI TI ON	C	8		105.00
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION				106.00 107.00
	10800 LUNG ACQUISITION		o		107.00
	10900 PANCREAS ACQUI SI TI ON	C	Ō		109.00
10 00	11000 INTESTINAL ACQUISITION	C	0		110. 00
11.00	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE				111.00 113.00

Health Financial Systems	STARKE MEMORIA	L HOSPITAL	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN: 15-0102	Peri od:	Worksheet A
			From 01/01/2018 To 12/31/2018	Date/Time Prepared: 5/31/2019 4:09 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8) F	or Allocation		
	6.00	7.00		
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
116. 00 11600 HOSPI CE	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	998, 842	17, 122, 089		118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191. 00 19100 RESEARCH	0	0		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	171, 433	0		192.00
193.00 19300 NONPALD WORKERS	0	0		193.00
194.00 07950 SPECIALTY CLINICS / MOB	0	0		194.00
200.00 TOTAL (SUM OF LINES 118 through 199)	1, 170, 275	17, 122, 089		200.00

	Financial Systems		STARKE MEMORI	AL HOSPITAL Provider CC	N· 15_0102	Period:	u of Form CMS-2552-1 Worksheet A-6
LAJ					N. 13-0102	From 01/01/2018 To 12/31/2018	Date/Time Prepared:
		Increases					5/31/2019 4:09 pm
	Cost Center	Li ne #	Salary	Other			
	2.00	3.00	4.00	5.00			
	A - EMPLOYEE BENEFITS						
0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	<u> </u>			1.0
	TOTALS		0	825, 918			
_	B - RENTAL & LEASE EXPENSES						
0	CAP REL COSTS-BLDG & FIXT	1.00	0	110, 432			1.0
0	CAP REL COSTS-MVBLE EQUIP	2.00	0	107, 359			2.0
0		0.00 0.00	0	0			3. 0
0		0.00	0	0			5.0
0		0.00	0	0			6.0
0		0.00	0	0			7.0
0		0.00	0	0			8.0
0		0.00	0	0			9.0
00		0.00	0	0			10.0
	TOTALS		0	217, 791			
	C - OTHER CAPITAL COSTS	I					
0	CAP REL COSTS-BLDG & FIXT	1.00	0	43, 414			1. (
0	CAP REL COSTS-BLDG & FIXT	1.00	0	107, 399			2.0
0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2, 443			3.0
	TOTALS		ī	153, 256			
	D - REPAIRS/MAINTENANCE COST						
	OPERATION OF PLANT	7.00	0	524, 697			1.0
0	PHYSI CAL THERAPY	66.00	0	46			2.0
0		0.00	0	0			3.0
0		0.00	0	0			4.0
0		0.00	0	0			5. C
0		0.00	0	0			6.0
0		0.00	0	0			7.0
0		0.00	0	0			8.0
0		0.00	0	0			9.0
00		0.00	0	0			10.0
00 00		0.00 0.00	0	0			11.0
00		0.00	0	0			12.0
00		0.00	0	0			14. 0
00		0.00	0	0			15.0
00	TOTALS			524, 743			10.0
	E - NURSING SALARIES			0217710			
0	NURSING ADMINISTRATION	13.00	45, 536	0			1.0
	TOTALS		45, 536	<u>0</u>			
	F - MEDICAL SUPPLIES						
0	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	13, 162			1. C
	PATIENTS	70.00	~	0 747			
	IMPL. DEV. CHARGED TO	72.00	0	2, 717			2.0
	PATI ENTS	+	— — — _d	15, 879			
	G - COST OF DRUGS		U	15, 679			
0	DRUGS CHARGED TO PATIENTS	73.00	o	408, 057			1.0
0	TOTALS		<u>0</u>	408,057			1.0
	H - DIETARY COSTS		0	100, 007			
0	CAFETERI A	11.00	98, 919	66, 288			1.0
0	TOTALS			<u>66, 288</u>			1.0
	Grand Total: Increases		144, 455	2, 211, 932			500.0

CLAS	SIFICATIONS			Provider (Period:	Worksheet A	4-6
						From 01/01/2018 To 12/31/2018	Date/Time F	
		Decreases					5/31/2019 4	+: 09 pm
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref.			
	6. 00	7.00	8.00	9.00	10.00			
	A - EMPLOYEE BENEFITS							
00	ADMI NI STRATI VE & GENERAL	5.00	0	<u>825, 9</u> 18		2		1.00
	TOTALS		0	825, 918				
	B - RENTAL & LEASE EXPENSES					-1		_
00	ADMI NI STRATI VE & GENERAL	5.00	0	159, 754		9		1.00
00	OPERATION OF PLANT	7.00	0	8, 933		9		2.0
00	CENTRAL SERVICES & SUPPLY	14.00	0	2, 364		p		3.0
00	PHARMACY	15.00	0	4, 926		p		4.0
00	ADULTS & PEDIATRICS	30.00	0	4, 814		p		5.00
00	OPERATING ROOM	50.00	0	2, 496		C		6.00
00	RADI OLOGY-DI AGNOSTI C	54.00	0	176		D		7.0
00	LABORATORY	60.00	0	24, 398		C		8.00
00	RESPI RATORY THERAPY	65.00	0	6, 786		C		9.00
00	EMERGENCY	91.00	0	<u>3, 1</u> 44	(<u>)</u>		10.00
	TOTALS		0	217, 791				
	C - OTHER CAPITAL COSTS							
00	ADMI NI STRATI VE & GENERAL	5.00	0	153, 256	1:	2		1.00
00		0.00	0	0	1:	3		2.00
00		0.00	0	0	1:	2		3.00
	TOTALS		o	153, 256	,			
	D - REPAIRS/MAINTENANCE COST							
00	ADMI NI STRATI VE & GENERAL	5.00	0	13, 626) (D		1.00
00	NURSING ADMINISTRATION	13.00	0	21	(b		2.00
0	PHARMACY	15.00	0	1, 277	(b		3.00
00	MEDICAL RECORDS & LIBRARY	16.00	0	85		b		4.00
00	ADULTS & PEDIATRICS	30.00	0	435				5.00
00	OPERATING ROOM	50.00	0	20, 454				6.00
00	ANESTHESI OLOGY	53.00	0	1, 824				7.00
00	RADI OLOGY-DI AGNOSTI C	54.00	0	270, 001				8.00
00	ULTRASOUND	54.01	0	10, 163				9.0
00	RADI OI SOTOPE	56.00	0	16, 548				10.00
00	CT SCAN	57.00	0	95, 723				11.00
00	MAGNETIC RESONANCE I MAGING	58.00	0	80, 411				12.00
00	(MRI)	58.00	0	00, 411				12.00
. 00	LABORATORY	60.00	0	9, 210		0		13.00
00	ELECTROCARDI OLOGY	69.00	0	4, 615				14.0
00		91.00	0	4,013				15.00
00	EMERGENCY		0	524, 743		5		15.00
	TOTALS		U	524, 743				
0	E - NURSING SALARIES	F 00	45 524			2		1.00
00	ADMI NI STRATI VE & GENERAL		45, 536	0		2		1.00
			45, 536	0				
	F - MEDICAL SUPPLIES	11.00	a	45.070				
00	CENTRAL SERVICES & SUPPLY	14.00	0	15, 879		p		1.00
00		0.00	0	0		<u>2</u>		2.00
	TOTALS		0	15, 879				_
_	G - COST OF DRUGS					-1		_
0	PHARMACY	15.00	0	40 <u>8, 0</u> 57		2		1.00
	TOTALS		0	408, 057				
	H - DIETARY COSTS				1	1		
00	DI ETARY		98, 919	6 <u>6, 2</u> 88		2		1.00
	TOTALS		98, 919	66, 288				
1 00	Grand Total: Decreases		144, 455	2, 211, 932				500.00

Heal th	Financial Systems	STARKE MEMORIA	AL HOSPITAL			In Lie	u of Form CMS-2	2552-10
	ILLIATION OF CAPITAL COSTS CENTERS		Provi der CC	CN: 15-0102		ri od: om 01/01/2018 12/31/2018	Worksheet A-7 Part I	pared:
				Acqui si ti on	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES		_				
1.00	Land	0	142, 789		0	142, 789	0	1.00
2.00	Land Improvements	0	52, 134		0	52, 134	0	2.00
3.00	Buildings and Fixtures	23	1, 760, 163		0	1, 760, 163	0	3.00
4.00	Building Improvements	613, 323	3, 625, 266		0	3, 625, 266	0	4.00
5.00	Fixed Equipment	94, 446	1,003,326		0	1, 003, 326	0	5.00
6.00	Movable Equipment	3, 593, 188	6,007,447		0	6,007,447	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	4, 300, 980	12, 591, 125		0	12, 591, 125	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	4, 300, 980	12, 591, 125		0	12, 591, 125	0	10.00
	· · · ·	Ending Balance	Fully					
		Ŭ	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	142, 789	0					1.00
2.00	Land Improvements	52, 134	0					2.00
3.00	Buildings and Fixtures	1, 760, 186	0					3.00
4.00	Building Improvements	4, 238, 589	0					4.00
5.00	Fixed Equipment	1, 097, 772	0					5.00
6.00	Movable Equipment	9, 600, 635	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	16, 892, 105	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	16, 892, 105	0					10.00

Heal th	Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0102	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
			SI	JMMARY OF CAP		5/31/2019 4:0	9 pm
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	-2, 251, 055			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 008, 733	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	757, 678	0)	0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description		Total (1) (sum	1			
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)		-			
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	-2, 251, 055				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3, 008, 733				2.00
3.00	Total (sum of lines 1-2)	0	757, 678				3.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2018 To 12/31/2018		
	COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		I				
1.00 CAP REL COSTS-BLDG & FIXT	7, 291, 470		7, 291, 47			1.00
2.00 CAP REL COSTS-MVBLE EQUIP	9, 600, 635		// 000/ 00			2.00
3.00 Total (sum of lines 1-2)	16, 892, 105		<u>16, 892, 10</u>			3.00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other	Total (sum of	f Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				1		
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 563, 577		1.00
2.00 CAP REL COSTS-MVBLE EQUI P	0	0		0 763, 861		2.00
3.00 Total (sum of lines 1-2)	0	0	I JMMARY OF CAPI	0 1, 327, 438	0	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)) Capi tal -Rel ate		
				d Costs (see	through 14)	
		10.00	10.00	instructions)	45.00	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		-74, 348	107, 39	9 0	596, 628	1.00
2.00 CAP REL COSTS-BEDG & FIXT	0			0 0		2.00
3.00 Total (sum of lines 1-2)	0					2.00
5.00 110tar (Sum 01 11165 1-2)	0	-71,903	1 107, 39	1 0	1, 302, 932	5.00

	Financial Systems MENTS TO EXPENSES		STARKE MEMORIA	Provider CCN: 15-0102 P	eriod: rom 01/01/2018	u of Form CMS-2 Worksheet A-8	
				Т	0 12/31/2018	Date/Time Pre 5/31/2019 4:0	
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # \ 4.00	Nkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	1.00		CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	А	-13, 061,	ADMI NI STRATI VE & GENERAL	5.00	0	7.00
8.00	21) Television and radio service	A	-410	CAP REL COSTS-MVBLE EQUIP	2.00	9	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	0			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1, 546, 584			0	12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -69_816	CAFETERI A	0.00 11.00	0	
15.00	Rental of quarters to employee and others		0		0.00	0	
16.00	Sale of medical and surgical supplies to other than	В		MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	16.00
17.00	patients Sale of drugs to other than	В	-9, 276	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	patients Sale of medical records and	В	-1, 121	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
20.00	books, etc.) Vending machines		0		0.00	0	
21.00	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
22.00	overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL	А	2, 692, 992	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL	А	-2, 415, 183	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00	0	29.00 30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0,	ADULTS & PEDIATRICS	30.00		30.99
31.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
33.00	Depreciation and Interest TRAINING REVENUE	В	-41, 400	NURSING ADMINISTRATION	13.00	0	33.00

Health Financial Systems		STARKE MEMORI	AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 01/01/2018 To 12/31/2018	Date/Time Prep 5/31/2019 4:09	
			Expense Classification or	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description Bas	sis/(odo (2))	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4, 00	5.00	
33.01 RENTAL INCOME	B		CAP REL COSTS-BLDG & FIXT	1.00		33.01
33. 02 MI SCELLANEOUS NON-PATI ENT	В		ADMI NI STRATI VE & GENERAL	5.00		33. 02
REVENUE	5	.,		0.00	Ű	00.02
33. 03 GRANT I NCOME	В	-11, 989	ADMI NI STRATI VE & GENERAL	5.00	о	33.03
33.04 OTHER MI SCELLANEOUS REVENUE	В	-23, 465	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05 TELEPHONE DEPRECIATION EXPENSE	A	-904	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06 TELEVI SI ON EXPENSE	A	-9,069	ADMI NI STRATI VE & GENERAL	5.00	0	33.06
33.07 MARKETING EXPENSE	A	2, 306	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 MARKETING DEPARTMENT	A	-67, 829	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33. 09 CHARI TBABLE CONTRI BUTI ONS	A	-13, 600	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33. 10 LEGAL	A		ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 ALLOCATED RENT EXPENSE	A		PHYSICIANS' PRIVATE OFFICES			33. 11
33.12 PHYSICIAN GUARANTEE	A	-423, 443		90.00		33.12
33.13 SALE OF SUPPLIES	В		ADMINISTRATIVE & GENERAL	5.00	0	33.13
50.00 TOTAL (sum of lines 1 thru 49)		1, 170, 275				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	STARKE MEMOR	RIAL HOSPITAL	In Lie	eu of Form CMS-	2552-10	
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Period:	Worksheet A-8	-1	
OFFICE	COSTS			From 01/01/2018 To 12/31/2018		narod	
				10 12/31/2010	5/31/2019 4:0		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount		
				Allowable Cost			
					Wks. A, column		
	1.00	2.00	3, 00	4,00	5 5.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	0.00			0	0	1.00	
2.00	0.00			0	0	2.00	
3.00	0.00			0	0	3.00	
4.00			PASI Capital Costs - Bldg &	1,064	0	4.00	
4.01			PASI Capital Costs - Moveabl	185	0	4.01	
4.02			PASI Operating Costs	16, 758	55, 481	4.02	
4.03		ADMINISTRATIVE & GENERAL	Shared Service Center Alloca		127, 140	4.03	
4.04			New Capital - Building & Fix		0	4.04	
4.05		CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm		0	4.05	
4.06		ADMINISTRATIVE & GENERAL	Non-Capital Home Office Cost		0	4.06	
4.07		ADMINISTRATIVE & GENERAL	Malpractice Costs	43, 367	220, 404	4.07	
4.08		ADMINISTRATIVE & GENERAL	Interest Expense	0	-1, 838, 587	4.08	
4.09		ADMINISTRATIVE & GENERAL	Management Fees	0	706, 739	4.09	
4.10		ADMINISTRATIVE & GENERAL	401K Fees	0	5, 164	4.10	
4.11			Audit Fees	0	9, 441	4.11	
4.12			Corporate Overhead Allocatio	0	186, 253	4.12	
4.13		ADMINISTRATIVE & GENERAL	HIIM Allocation	0	47, 107	4.13	
5.00	TOTALS (sum of lines 1-4).			1, 065, 726	-480, 858	5.00	
	Transfer column 6, line 5 to						
	Worksheet A-8, column 2,						
	line 12.						

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and	'or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of				
		Ownershi p		Ownershi p				
1.00	2.00	3.00	4.00	5.00				
 B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII

6.00 B	0. 00 COMMULNETY HEAL	100. 00	6.00
7.00 B	0. 00 PASI	100. 00	7.00
8.00	0.00	0.00	8.00
9.00	0.00	0.00	9.00
10.00	0.00	0.00	10.00
100.00 G. Other (financial or			100.00
non-financial) specify:			

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

 C. Provider has financial interest in corporation, partnership, or other organization.
 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems		STARKE MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANI	ZATIONS AND HOME	Provider CCN: 15-01	From 01/01/2018	Worksheet A-8-1 Date/Time Prepared:
				10 12/31/2010	

					5/31/2019	1:09 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
			MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED C	RGANIZATIONS OR CLAIMED	
	HOME OFFICE COS	STS:				
1.00	0	0				1.00
2.00	0	0				2.00
3.00	0	0				3.00
4.00	1, 064	9				4.00
4.01	185	9				4.01
4.02	-38, 723	0				4.02
4.03	153, 884	0				4.03
4.04	10, 144	9				4.04
4.05	64, 081	9				4.05
4.06	649, 103	0				4.06
4.07	-177, 037	0				4.07
4.08	1, 838, 587	0				4.08
4.09	-706, 739	0				4.09
4.10	-5, 164	0				4.10
4.11	-9, 441	0				4.11
4.12	-186, 253	0				4.12
4.13	-47, 107	0				4.13
5.00	1, 546, 584					5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amounts decrease cost. For related organization or home office cost which

has not been posted to Worksheet A,	columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.	
Rel ated Organi zati on(s)		
and/or Home Office		
Type of Business		
6.00	1	
B INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

Ternibur	Sement under title AVIII.	
6.00	HOSP COMPANY	6.00
7.00	COLLECTI ONS	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00
(1) Use	the following symbols to inc	dicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Financial Syste	ms	STARKE MEMOR	RIAL F	IOSPI TAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSICI	AN ADJUSTMENT			Provider C	CN: 15-0102	Period: From 01/01/2018 To 12/31/2018	B Date/Time Pre	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Drot	fessi onal	Provi der	RCE Amount	5/31/2019 4:0 Physi ci an/Prov)9 pm
	WKSt. A LINE #	I denti fi er	Remuneration		mponent	Component		ider Component	
								Hours	
	1.00	2.00	3.00		4.00	5.00	6.00	7.00	
1.00	0.00		0		0		0 0		
2.00	0.00		0		0		0 0	-	2.00
3.00	0.00		0		0		0 0		3.00
4.00	0.00		0		0			Ű	4.00
5.00	0.00		0		0			, s	5.00
6.00 7.00	0. 00 0. 00		0		0			0	6.00 7.00
8.00	0.00		0		0			0	8.00
9.00	0.00				0				9.00
10.00	0.00		0		0			0	10.00
200.00	0.00		0		0			0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Pe	ercent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit		usted RCE	Memberships &	Component	of Mal practi ce	
					Limit	Conti nui ng	Share of col.	Insurance	
						Educati on	12		
1.00	1.00	2.00	8.00		9.00	12.00	13.00	14.00	1.00
1.00	0.00		0		0		0 0		
2.00	0. 00 0. 00		0		0				2.00
3.00 4.00	0.00				0			-	3.00 4.00
4.00 5.00	0.00				0			, s	5.00
6.00	0.00		0		0			, s	6.00
7.00	0.00		0		0			0	7.00
8.00	0,00		0		0			0	
9.00	0.00		0		0		0 0	0	9.00
10.00	0.00		0		0		o o	0	10.00
200.00			0		0		o o	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der		usted RCE	RCE	Adjustment		
		Identifier	Component		Limit	Di sal I owance			
			Share of col.						
	1.00	2.00	14 15.00		16.00	17.00	18.00		
1.00	0.00	2:00	15.00		0		0 0		1.00
2.00	0.00		0		0				2.00
3.00	0.00		0		0				3.00
4.00	0,00		0		0		ol o		4.00
5.00	0.00		0		0		0 0		5.00
6.00	0.00		0		0		0 0		6.00
7.00	0.00		0		0		o o		7.00
8.00	0.00		0		0		o o		8.00
9.00	0.00		0		0		0 0		9.00
10.00	0.00		0		0		0 0		10.00
200.00			0	1	0		0 IC		200. 00

Disk ALLOCATION - CRETERAL SERVICE COSTS Prod - CRETERAL SERVICE CORT 5-0012 Print - CRETERAL SERVI	Heal th	Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
Total 12.012.02101 Distribution Programmedia Solid Control (Line Rel. Distribution Programmedia (Line With IF Data) Total 20.0110 (Line With IF Data) Distribution Programmedia Solid Control (Line With								
Cast Center Description Met Expense (frim Natr. A color) Color A The Cast All cost in (frim Natr. A color) Color A true (frim Natr. A color) Color A color A color A color Color A col							Date/Time Pre	
Loss Contor Description Ref. Exercise Interaction (row Wst.1) Ref. Exercise Interaction (row Wst.1) WHE EXUIT Interaction (row Wst.1) EVENTS Interaction (row Wst.1) Subtotal 1.00 Disloy CAP FIL COTST BLOB & FLVT (row Wst.1) 76, 628				CAPITAL RELATED COSTS			5/31/2019 4:0	9 pm
Incompany Incompany <t< td=""><td></td><td></td><td></td><td colspan="2"></td><td></td><td></td><td></td></t<>								
All Docation (rrom with) All Docation (rrom with) Department (rrom wi		Cost Center Description		BLDG & FIXT	MVBLE EQUIP		Subtotal	
Image: constraint of constraint is not constr								
0 0 1.00 2.00 4.00 4.40 1.00 00000 PA REL COST SLUD # PATTO 76, 304 76, 304 76, 304 2.00 1.00 00000 PA REL COST SLUD # PATTO 76, 304 76, 404 38, 959 71, 75, 75 71, 75, 75, 75, 75, 75, 75, 75, 75, 75, 75						DEFARTMENT		
DEREAL SERVICE DOST CONTENT 100 000000000000000000000000000000000000								
1.000 COTOR CAP HEL COSTS HUBE & LIVIT 996, 62H 996, 62H 9 6 1 0 0.000 CONORD EMPLOYCE ENERTY IS DEPARTNENT 865, 732 1, 199 1, 1529 858, 452 2, 04 2, 04 0.000 CONORD EMPLOYCE ENERTY IS DEPARTNENT 8, 65, 732 1, 199 1, 1529 858, 452 3, 944, 274 0 0.000 CONORD EMPLOYCE ENERTY IS DEPARTNENT 8, 532, 201 8, 00 0 0 0 0, 22, 207 8, 00 0.000 CONORD EMPLIANCE 52, 207 0 0 0 0, 11, 444 114, 444 114, 444 114, 444 114, 444 114, 444 114, 444 114, 444 114, 444 114, 444 114, 444 114, 444 114, 444 114, 444 114, 444 114, 445 116, 1144 114, 445 116, 1144 114, 444 114, 445 116, 1144 114, 445 116, 1144 114, 517 146, 516 50 50 7, 717 144, 517 146, 516 50 50 50 50 50 50<		CENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	4A	
4.00 Decoded Fuel DVFF INVEFT IS DEPARTINET 195, 732 1, 191 1, 529 BB8, 452 4.00 3, 44, 257 5.00 2000	1.00		596, 628	596, 628				1.00
5.00 DOBOOL ADMINISTRATIVE & CREERAL 3,746,202 40,289 51,747 10,401 3,944,279 5,0 6.00 DOBOOL LANNEY & LINEN SERVICE 52,202 14,00 11,80 10,80 10,80 10,80 10,80 10,80 10,80 10,80 10,80 10,80 10,80 10,80 10,80 10,80 11,80	2.00		766, 304		766, 304	ŀ		2.00
7.00 00700 0PERATION OF PLANT 1,800,320 137,947 177,176 5,0177 2,171,82 7,02 7,02 7,02 7,02 7,02 7,02 7,02 7,02 7,02 7,02 7,02 7,02 7,02 7,02 7,02 7,03 7,02 7,03 1,14,95 1,10 1,10,00 1,00 1,00								•
8.00 000000 LAIMORY & LINEN SERVICE 52.207 0								•
9.00 00000 HOUSEKEEPING 330.235 14,651 18,818 18,814 174,448 10.00 101000 DITARY STRATION 95,391 4,221 5,21 13,444 174,448 10.00 1100 DITARY STRATION 95,391 4,221 5,21 13,444 178,52 11.00 1100 DITARY MARK ALZINESTRATION 95,391 4,221 5,21 13,444 178,52 11.00 1100 DITARY MARK ALZINESTRATION 95,391 4,222 5,21 13,444 178,52 11.00 1100 DITARY MARK ALZINESTRATION 224,174 4,773 18,090 7,73 121,995 15,00 1100 DITARY MARK ALZINESTRATION 38,095 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								•
11.00 01100 CAPETERIA 95,391 4,221 5,421 13,494 118,527 11.00 12.00 01100 CAPETERIA 95,391 4,202 5,210 13,093 121,993 13,00 13.00 01100 CARIBALS, ERVICES & SUPPLY 98,671 9,712 12,793 12,293 12,093 11,0,013 11,0,013 12,093	9.00	00900 HOUSEKEEPI NG		14, 651	18, 818	3 26, 150		9.00
12.00 01200 UNESTING ADMINISTRATION 109, 601 1, 946 2.003 7, 933 121, 950 12.005 14.00 13.00 01000 PRARMACY 224, 194 6, 77, 294 27, 211 144, 50, 582 17, 294 27, 211 144, 50, 582 14, 00 10.00 01000 PRARMACY 107, 224 55, 862 7, 04 86, 495 15, 00 0								•
14.00 CNITAL SERVICES & SUPPLY 98.671 9.910 12.729 22.7211 144.9521 15.00 01500 MEDICAL RECORDS & LIBRARY 167.229 5.952 7.170 4.864 16.00 10.01 01700 SCLAL SIEVICE 38.694 0 0 0 0.8645 17.00 10.01 01700 SCLAL SIEVICE 38.694 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
15.00 DI-LOO PHARMACY 224,194 6,773 8,695 11,203 250,895 15.00 17.00 DI-TOO SOCIAL SERVICE 38,695 0 0 64.84 16.00 18.00 INSERVICE COST CENTERS 17.00 38,695 17.00 30.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>								•
17.00 00/1700 SOCIAL SERVICE 38,099 0 0 88,099 17.00 1000 03000 ADULTS & PEDIATRICS CITERS 1,452,842 55,468 71,243 110.282 1,669,853 0.00 30.00 40.00 0 0 0 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 50	15.00		224, 194	6, 773	8, 699	11, 229		
INPART ENT ROUTINE SERVICE COST CENTERS 1.452.482 55.408 71.243 110.282 1.699.833 30.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 50.00 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>•</td></th<>								•
30.00 40.00 90.00 0	17.00		38, 695	0	(0	38, 695	17.00
40. 00 04000 SUBPROVIDER - 1 PF 0 <td>30.00</td> <td></td> <td>1, 452, 842</td> <td>55, 468</td> <td>71, 243</td> <td>110, 282</td> <td>1, 689, 835</td> <td>30.00</td>	30.00		1, 452, 842	55, 468	71, 243	110, 282	1, 689, 835	30.00
11 00 01100 Superson DERATINE ORD 0<			0	0	(0 0	0	
43. 00 0 0 0<			0	0		, ,	-	•
NACILLARY SERVICE COST CENTERS Image: Cost Centers 0.00 05000 (DERATINE ROW 649, 374 60, 302 77, 452 56, 303 886, 655 50. 00 52. 00 51. 00 05100 (DECOUPER YROM 4.480, 774 60, 302 77, 452 56, 303 886, 655 54. 00 0 0 0 0 0 247 281, 305, 54. 00 53. 00 05300 (ANESTHES) OLCEY 77, 35, 54. 00 0			-	-				•
50. 00 GS000 (DFEATING ROOM 649, 374 60, 302 77, 452 58, 930 846, 058 50. 00 51. 00 GS000 (DECUVERY ROOM & LABOR ROOM 0 0 0 0 0 51. 00 52. 00 05200 (DELUVERY ROOM & LABOR ROOM 0 0 22. 00 22. 83. 35. 30. 35. 30. 53. 00 05400 (RADI LOGY) ARDI TOCY 281, 105. 50. 0 12. 490 115. 50. 55. 50. 54. 00 05500 (RADI LOGY) THERAPEUTI C 0 0 0 0 6.57. 00. 55. 00 05500 (RADI LOGY) THERAPEUTI C 0 0 0 4.395 7.7. 452 7.7. 49. 90. 65. 90. 50. 00 05600 (RADI AC CATHETERI ZATI ON 0 <td>43.00</td> <td></td> <td><u> </u></td> <td>0</td> <td></td> <td></td> <td>0</td> <td>43.00</td>	43.00		<u> </u>	0			0	43.00
52. 00 05200 [PELLVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 7 281.00 552.00 552.00 552.00 552.00 552.00 552.00 552.00 552.00 552.00 552.00 522.00	50.00	05000 OPERATI NG ROOM	649, 374	60, 302	77, 452	2 58, 930	846, 058	50.00
53. 00 05300 ANESTHESI OLGGY 281,056 0 24.7 281,303 53.00 54. 01 05401 QUEY-DARONSTI C. 861,761 25,602 32,884 93,283 1,13,530 54.00 55. 00 05500 RADI 01SOTOPE 73,854 0 0 4.662 78.316 56.00 05000 RADI 01SOTOPE 73,854 0 0 4.662 78.316 56.00 05000 CSCO CT SCAN 99,753 3.422 4.395 9.639 117.206 57.00 05000 CARDI ACCENTERENTIC RESONANCE (MRI) 62.506 9.025 0 0 0 59.00 06.000 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 62.00 06.000 CARDI AC CATHETERI ZATI ON 959,548 13.988 17.966 67.137 1.058.639 60.00 0 0 0 0 0 0 0 0 62.00 0 0 0 0 0 0 0 62.00 62.00 0 0 0 0 0 0 0 62.00 62.0			Ŭ	0	(0		•
54. 00 654.00 654.00 654.01 654.01 74.02 32,884 93,283 1,013,530 54.00 55. 00 65500 RADI LOCY-THERAPUTIC 0 0 12,490 115,361 54.01 56. 00 65500 RADI LOCY-THERAPUTIC 0 0 0 44.62 78.316 55.00 57. 00 65700 CT SCAN 99,753 3,422 4,395 9,639 117.209 57.00 58. 00 05900 CARDI AC CATHETERI ZATI ON 90 0<			-	0	-	-	-	•
55. 00 0550 (PADILOGY-THERAPUTIC 0 0 0 0 55. 00 0550 (PADILOGY-THERAPUTIC 0 0 4.462 77. 01 55. 00 0550 (CT 52.00 0 0 0 0 0 0 55. 00 0 0500 (CT 52.00 0 <th< td=""><td></td><td></td><td></td><td>0</td><td></td><td></td><td></td><td>•</td></th<>				0				•
56. 00 65.00 RDD 10SOTOPE 73, 854 0 0 4,462 78, 316 55. 00 57.00 05700 05700 05700 57.00 56.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 56.00 66.00 66.00 57.00 50.00 60.00 60.00 60.00 60.00 60.00 60.00 <t< td=""><td>54.01</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	54.01							
57. 00 057.00 CT SCAN 99, 753 3, 422 4, 395 9, 639 117, 209 57. 00 58. 00 05800 MARCH TOL RESONANCE IMAGING (MRI) 62, 506 9, 026 11, 593 7, 734 90, 859 58. 00 60. 00 06000 LABORATORY 959, 548 13, 988 17, 966 67, 137 1, 058, 639 60. 00 62. 00 06200 INDAL AC CATHETERI ZATI ON 959, 548 13, 988 17, 966 67, 137 1, 058, 639 60. 00 62. 00 64. 00 06400 INTRAVENOUS THERAPY 339, 004 6, 060 7, 784 42, 299 355, 147 65. 00 65. 00 06600 PESPI RATINENDAL THERAPY 380, 660 15, 300 19, 651 36, 967 458. 578 66. 00 70. 00 07000 CLECTROCANCEPHALOGGAPHY 0 <td></td> <td></td> <td>-</td> <td>0</td> <td></td> <td>, ,</td> <td></td> <td>•</td>			-	0		, ,		•
58. 00 0580.0 0580.0 0580.0 CASH ACCANTIC C RESONANCE IMAGING (MRI) 62. 50.6 9.0.25 11. 593 7.734 90.859 88. 00 00. 000 CARDIA C CATHETERIZATION 959,548 13. 988 17. 966 67. 137 1. 058,639 60. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 <t< td=""><td></td><td></td><td></td><td>0</td><td></td><td></td><td></td><td>•</td></t<>				0				•
59:00 0 59:00 0 59:00 0 0 0								•
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0	59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59.00
64. 00 06400 INTRAVENUUS THERAPY 0 0 0 0 0 0 65.00 65.00 06500 RESPI RATORY THERAPY 339,004 6.060 7.784 42.299 395,147 65.00 66.00 0				13, 988	17, 966	67, 137		•
65:00 0c500 RESPIRATORY THERAPY 339;004 60:00 7,784 42,299 395;147 65:00 66:00 06600 PHYSICAL THERAPY 306;660 15;300 19;651 36;967 458;578 66:00 67:00 0C00 CCUPATIONAL THERAPY 0 0 0 0 67:00 72:00 72:00 72:00 72:00 72:00 72:00 72:00 72:00 72:00 72:00 72:00 73:00 74:00 74:00			0	0			-	•
66.00 06600 PHYSICAL THERAPY 386,660 15,300 19,651 36,967 458,578 66,00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 99,803 3,137 4,029 11,802 118,771 69,00 0.00 0 0 0 0 0 0 70.00 0.00 0100 EECTROCARDI OLOGY 99,803 3,137 4,029 11,802 118,771 69,00 70.00 70.00 70.00 70.00 70.00 72.00 73.00 07300 PRUS CHARGED TO PATI ENTS 398,781 0 0 0 398,781 73.00 73.00 73.00 73.00 73.00 74.00 0 0 0 0 0 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00			339,004	6, 060	7, 784	42, 299	-	•
68.00 besche harthology 0 0 0 0 68.00 besche harthology 99,803 3,137 4,029 11,802 118,771 69.00 0.00 07000 ELECTROARDIOLOGY 99,803 3,137 4,029 11,802 118,771 69.00 0.00 07000 ELECTROARDIOLOGY 99,803 3,137 4,029 11,802 118,771 69.00 0.00 07000 ELECTROARDIOLOGY 99,803 3,137 4,029 118,771 69.00 0.00 07000 ELECTROARDIOLOGY 99,803 3,137 4,029 118,771 69.00 0.00 07000 ELECTROARDIOLOGY 938,781 0 0 0 0 0 74.00 0 0 0 0 0 74.00 0 0 0 0 0 0 0 0 0 74.00 74.00 75.00 75.00 75.00 75.00 76.00 76.00 76.00 76.00 88.00								•
69.00 06900 ELECTROCARDIOLOGY 99,803 3,137 4,029 11,802 118,771 69,00 70.00 07000 ELECTROCARDIOLOGY 0			0	0	(0		•
70.00 ICCOR ICCOR ICCOR O			0 90 803	0 2 127	4 020	0 11 802		•
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 2,717 0 0 0,710 0,710 0,710 0,710 0,710 0,710 0,710 0,717 72.00 0,710 0,710 0,717 72.00 0,710 0,710 0,710 0,717 72.00 0,710 0,710 0,710 0,717 72.00 0,717 72.00 0,710 0,710 0,717 72.00 0,710 0,710 0,717 72.00 0,710 0,710 0,710 0,717 72.00 0,717 72.00 0,710			0	0	4, 02	0		•
73.00 07300 DRUGS CHARGED TO PATIENTS 398,781 0 0 399,781 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 74.00 75.00 7500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 76.00 3020 ACUPUNCTURE 0 0 0 0 76.00 0017PATIENT SERVICE COST CENTERS 0 0 0 0 0 0 89.00 8800 R8800 R88.00 89.00 90.00 374 3,313 90.00 90.00 18.00 89.00 92.00 92.00 092.00 095.00 14.00,090 2,540,467 91.00 91.00 91.00 91.00 91.00 91.00 91.00 92.00 92.	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0 0	0	71.00
74 00 07400 RENAL DIALYSIS 0 0 0 0 74.00 75.00 075.00 ASC (NON-DI STI NCT PART) 0 0 0 0 0 75.00 00 03020 (ACUPUNCTURE 0 <td></td> <td></td> <td></td> <td>0</td> <td>(</td> <td>0</td> <td></td> <td></td>				0	(0		
75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 0 </td <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>				0				
76.00 03020 ACUPUNCTURE 0 0 0 0 0 76.00 OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 88.00 08800 RRAL HEALTH CLINIC 0 0 0 0 88.00 0 89.00 0 0 0 0 0 89.00 90.00 0 0 0 0 0 0 89.00 89.00 0 374 3,313 90.00 90.00 140.090 2,540,467 91.00 91.00 9200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 2,333,780 29,153 37,444 140,090 2,540,467 91.00 92.00 04.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 2,333,780 29,153 37,444 140,090 2,540,467 91.00 92.00 0500 MBULANCE SERVICES 0 0 0 0 92.00 95.00 95.00 95.00 95.00 95.00 99.00 97.00 97.00			-	0				
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 88.00 88.00 88.00 89.00 0000 CLINIC 0 <		03020 ACUPUNCTURE	0	0	(0 0	0	•
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0	00.00							00.00
90.00 09000 CLINIC 2,939 0 0 374 3,313 90.00 91.00 09100 EMERGENCY 2,333,780 29,153 37,444 140,090 2,540,467 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 0THER REIMBURSABLE COST CENTERS 0 0 0 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 95.00 95.00 0 0 0 0 95.00 95.00 96.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.10 0.00 0 0 0 99.00 99.10 99.10 100.00 188 SERVI CES-NOT APPRVD PRGM 0 0 0 0 101.00 101.00 101.00 101.00 101.00 <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td>•</td></t<>			0	0				•
91.00 09100 EMERGENCY 2, 333, 780 29, 153 37, 444 140, 090 2, 540, 467 91.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 94.00 94.00 94.00 94.00 94.00 94.00 94.00 94.00 95.00 0 0 0 0 94.00 94.00 99.00 94.00 96.00 0 0 0 94.00 94.00 95.00 96.00 0 0 0 95.00 99.00 99.00 99.00 99.00 97.00 90.00 97.00 90.00 97.00 97.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.10 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00			2,939	0	(374		
OTHER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 94.00 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 0 95.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 96.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97.00 97.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.10 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 101.00 101.00 IAWE FEALTH AGENCY 0 0 0 0 0 0 100.00 101.00				29, 153	37, 444			•
94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 94.00 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 0 95.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 96.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97.00 99.00 09900 CMHC 0 0 0 0 97.00 99.00 09900 CMHC 0 0 0 99.00 99.00 0 0 0 99.00 0 99.00 0 0 0 0 99.00 0 0 0 0 99.00 0	92.00						0	92.00
95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 99.00 09900 CMHC 0 0 0 0 99.00 99.10 09910 CORF 0 0 0 0 99.10 100.00 1& & SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101.00 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS TOS 0 0 0 0 0 105.00 1066.00 HEART ACQUISITION 0 0 0 0 0 106.00 106.00 106.00 106.00 106.00 0 0 0 106.00 106.00 106.00 106.00 106.00 106.00 0 0 0 0 0	04.00			0			0	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 96.00 97.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 0 97.00 97.00 99.00 0900 CMHC 0 0 0 0 0 0 97.00 99.00 99.00 99.00 0 0 0 0 0 0 99.00 99.00 99.00 0 0 0 0 0 99.00 99.00 99.00 0 0 0 0 0 99.00 99.00 99.10 0 0 0 0 0 99.10 0 99.10 0			0	0				
99.00 09900 CMHC 0 0 0 0 99.00 99.10 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00			0	0		0	-	•
99.10 09910 CORF 0 0 0 0 99.10 100.00 10000 1&& SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS TOS.00 10500 KIDNEY ACQUISITION 0 0 0 0 105.00 10500 105.00 105.00 105.00 105.00 0 0 0 0 0 0 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 0 0 0 105.00 105.00 106.00 0 0 0 105.00 106.00 106.00 0 106.00 0 107.00 107.00 0 0 0 0 0 0 107.00 108.00 10800 LINGR ACQUI SI	97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	(0 0	-	•
100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUISITION 0 0 0 0 105.00 106.00 HEART ACQUISITION 0 0 0 0 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 107.00 0 0 0 0 105.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 107.00 107.00 0 0 0 107.00 107.00 0 0 0 0 108.00 108.00 0 0 0 108.00 0 0 0 0 108.00 0 108.00 0 0 0 0 108.00			0	0		0	-	•
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105.00 106.00 10600 HEART ACQUI SI TI ON 0 0 0 0 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 0 107.00 108.00 LUNG ACQUI SI TI ON 0 0 0 0 107.00			0	0				
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105.00 106.00 10600 HEART ACQUI SI TI ON 0 0 0 0 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 0 107.00 108.00 10800 LUNG ACQUI SI TI ON 0 0 0 0 108.00			0	0		0		•
106.00 10600 HEART ACQUI SI TI ON 0 0 0 0 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 0 107.00 108.00 10800 LUNG ACQUI SI TI ON 0 0 0 0 108.00		SPECIAL PURPOSE COST CENTERS						1.05
107.00 10700 LIVER ACQUISITION 0 0 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 0 0 108.00			0	0		0		
108.00 10800 LUNG ACQUISITION 0 0 0 0 0 108.00			0	0				•
109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 109. 00	108.00	10800 LUNG ACQUISITION	0	0		o o	0	108.00
	109.00	10900 PANCREAS ACQUISITION	0	0	(0	0	109.00

Health Financial Systems	STARKE MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2018 To 12/31/2018		
		CAPI TAL REI	_ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION	0	0 0		0 0 0 0		110.00 111.00
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVIEW-SNF						113.00 114.00
115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.)	0	0		0 0		115.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 17, 122, 089	0 459, 454	590, 11	0 0 9 858, 452		116.00 118.00
NONREI MBURSABLE COST CENTERS				-		
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH	0	3, 551 0	4, 56			190.00 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	C	192.00
193. 00 19300 NONPALD WORKERS 194. 00 07950 SPECIALTY CLINICS / MOB	0	0 133, 623	171, 62	0 0 5 0	0 305, 248	193.00 194.00
200.00 Cross Foot Adjustments	0	100, 020	171,02		C	200. 00
201.00Negative Cost Centers202.00 TOTAL (sum lines 118 through 201)	17, 122, 089	0 596, 628	766, 30	0 0 4 858, 452		201. 00 202. 00

Heal th	Financial Systems	STARKE MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2018	Worksheet B Part I	
				T	o 12/31/2018	Date/Time Pre 5/31/2019 4:0	pared: 9 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT	3, 944, 279 649, 993	2, 821, 618				5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	15, 626	2, 821, 018	67, 833			8.00
9.00	00900 HOUSEKEEPI NG	116, 688	99, 090		610, 926		9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	53, 412 35, 477	104, 731		23, 501	360, 108 237, 534	•
13.00	01300 NURSI NG ADMI NI STRATI ON	36, 501	28, 546 13, 164		6, 406 2, 954	237, 334	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	44, 454	67, 024	0	15, 040	0	14.00
15.00 16.00	01500 PHARMACY	75, 096	45, 808		10, 279	0	15.00
17.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	55, 326 11, 582	37, 755 0		8, 472 0	0	16.00 17.00
	I NPATIENT ROUTINE SERVICE COST CENTERS		-	-			1
30. 00 31. 00	03000 ADULTS & PEDIATRICS	505, 788 0	375, 142 0		84, 181	93, 421 0	30.00
40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0	0	0	0	0	40.00
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
43.00		0	0	0	0	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	253, 235	407, 834	9, 030	91, 517	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	84, 197 303, 362	173, 154	0 839	0 38, 855	0	53.00 54.00
54.01	05401 ULTRASOUND	34, 529	0		0	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	23, 441 35, 082	0 23, 145		0 5, 194	0	56.00 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	27, 195	61, 045		13, 698	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00 62.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	316, 863 0	94, 605		21, 229 0	0	60.00 62.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	118, 272	40, 986		9, 197	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	137, 258	103, 477		23, 220	0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	35, 550	21, 216	0	4, 761	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	70.00
71.00 72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0 813	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	119, 360	0	0	0	0	73.00
74.00 75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	75.00 76.00
	OUTPATIENT SERVICE COST CENTERS		-	-			1
88. 00 89. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00 89.00
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	992	0	0	0	0	90.00
91.00	09100 EMERGENCY	760, 395	197, 167	30, 198	44, 243	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
94.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 99.00	09700 DURABLE MEDICAL EQUIP-SOLD 09900 CMHC	0	0	0	0	0	97.00 99.00
	09910 CORF	0	0	0	0	0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
105.00	10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	10600 HEART ACQUI SI TI ON	0	0	0	0	0	106. 00
	10700 LIVER ACQUISITION	0	0	0	0		107.00 108.00
	10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION	0	0	0	0		108.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	Ő	0	110.00
	11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113.00 114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2018	Worksheet B Part I	
				To 12/31/2018		pared:
					5/31/2019 4:0	
Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 850, 487	1, 893, 889	67,83	3 402, 747	330, 955	118.00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 428	24, 013		D 5, 388	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	29, 153	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 SPECIALTY CLINICS / MOB	91, 364	903, 716		202, 791	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	3, 944, 279	2, 821, 618	67, 83	610, 926	360, 108	202.00

Heal th	Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 01/01/2018	Worksheet B Part I	
				Ť		Date/Time Pre 5/31/2019 4:0	pared: 9 pm
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	426, 490					10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	420, 490					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	8, 792	0	283, 831			14.00
15.00		13, 216	1	376 992		202 001	15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	14, 691 2, 439		151	0	302, 081 0	16.00 17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	70, 278		18, 745		12, 666	30.00
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF			0	0	0	31.00 40.00
41.00	04100 SUBPROVI DER – I RF	0	-	0	Ō	0	41.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
50, 00	ANCI LLARY SERVICE COST CENTERS	37, 550	23, 144	85, 250	o	33, 117	50.00
51.00	05100 RECOVERY ROOM	0		03, 230	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	397 59, 104		5, 177 7, 611	0	6, 407 21, 653	53.00 54.00
54.00 54.01	05400 RADIOLOGI-DIAGNOSTIC	6, 410		719	0	12, 551	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	2,950		498	0	528	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	5, 672	1	8, 478 467	0	40, 944 10, 325	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	-	0	Ő	0	59.00
60.00	06000 LABORATORY	49,064		107, 071	0	56, 602	1
62.00 64.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06400 INTRAVENOUS THERAPY			0	0	494 0	62.00 64.00
65.00	06500 RESPIRATORY THERAPY	27, 737	-	2, 152	0	2, 800	65.00
66.00	06600 PHYSI CAL THERAPY	25, 752	1	1, 009		7, 895	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY			0	0	0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	7,090		1, 022	0	3, 799	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1	0		0	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 343			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0	1, 234 0	395, 670	1, 242 31, 067	72.00 73.00
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	
	07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	
76.00	03020 ACUPUNCTURE OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-	0	0	0	89.00
90. 00 91. 00	09000 CLINIC 09100 EMERGENCY	170 82, 642		0 41, 536	0	1 57, 779	90.00 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	02,042	02,207	41, 550	Ū	57,777	92.00
	OTHER REIMBURSABLE COST CENTERS	1					
94.00 95.00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0	0	-	0	94.00 95.00
95.00 96.00			0	0	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99.00		0	0	0	0	0	99.00
	09910 CORF 10000 I &R SERVICES-NOT APPRVD PRGM		0	0	0	0	99. 10 100. 00
	10100 HOME HEALTH AGENCY	0	Ő	0	Ő		101.00
105 5	SPECIAL PURPOSE COST CENTERS	-					105 66
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0	0	0	0		105.00 106.00
	10000 LIVER ACQUISITION		0	0	0		107.00
108.00	10800 LUNG ACQUISITION	0	0	0	0	0	108.00
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0	0	0	0		109. 00 110. 00
	11100 I SLET ACQUI SI TI ON		0	0	0		111.00
113.00	11300 INTEREST EXPENSE			-		-	113.00
114.00	11400 UTI LI ZATI ON REVI EW-SNF						114.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2018	Worksheet B Part I	
				To 12/31/2018	Date/Time Pre	
					5/31/2019 4:0	9 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0 0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0 0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	426, 490	182, 794	283, 83	1 395, 670	302, 081	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0 0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0 0		0 0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0 0		0 0	0	192.00
193. 00 19300 NONPALD WORKERS	0	0 0		0 0	0	193.00
194.00 07950 SPECIALTY CLINICS / MOB	0	0 0		0 0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0 0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	426, 490	182, 794	283, 83	1 395, 670	302, 081	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	STARKE MEMORIA			Period:	u of Form CMS-2552-10 Worksheet B
					From 01/01/2018 To 12/31/2018	Part I Date/Time Prepared: 5/31/2019 4:09 pm
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total t	<u> 573172019 4:04 piii</u>
		17.00	24.00	25.00	26.00	
1 00	GENERAL SERVICE COST CENTERS			1	1	
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL					5.00
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
	01100 CAFETERI A					11.00
	01300 NURSING ADMINISTRATION					13.00
	01400 CENTRAL SERVICES & SUPPLY					14.00
	01500 PHARMACY					15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	56, 746				16.00 17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	50,740				17.00
30, 00	03000 ADULTS & PEDIATRICS	56, 746	3,001,869		3, 001, 869	30.00
	03100 I NTENSI VE CARE UNI T	0	0,001,007			31.00
	04000 SUBPROVIDER - IPF	0	C			40.00
	04100 SUBPROVI DER – I RF	0	C		0 0	41.00
43.00	04300 NURSERY	0	C		0 0	43.00
	ANCI LLARY SERVI CE COST CENTERS			1		
	05000 OPERATI NG ROOM	0	1, 786, 735			50.00
	05100 RECOVERY ROOM	0	0		0 0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	277 401			52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	377, 481 1, 618, 108			53.00 54.00
	05400 RADIOLOGI - DI AGNOSTI C 05401 ULTRASOUND	0	1, 618, 108			54.00
	05500 RADI OLOGY-THERAPEUTI C	0	107, 370			55.00
	05600 RADI OI SOTOPE	0	105, 733		105, 733	56.00
57.00	05700 CT SCAN	0	235, 724			57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	207, 900			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	59.00
60.00	06000 LABORATORY	0	1, 704, 073	3 (1, 704, 073	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	494	(494	62.00
	06400 I NTRAVENOUS THERAPY	0				64.00
		0	596, 814		596, 814	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	757, 617		757, 617	66.00 67.00
	06800 SPEECH PATHOLOGY	0	(68.00
	06900 ELECTROCARDI OLOGY	0	192, 209			69.00
	07000 ELECTROENCEPHALOGRAPHY	0	()2,20		0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 554	4	3, 554	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	6, 006		6, 006	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	944, 878	3 (944, 878	73.00
	07400 RENAL DIALYSIS	0	C) (0 0	74.00
	07500 ASC (NON-DISTINCT PART)	0	C) (0 0	75.00
76.00	03020 ACUPUNCTURE OUTPATIENT SERVICE COST CENTERS	0		<u>и</u> (ן ע	76.00
88.00	08800 RURAL HEALTH CLINIC		ſ			88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	((89.00
	09000 CLINIC	0	4, 476		4,476	90.00
	09100 EMERGENCY	0	3, 836, 636		3, 836, 636	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		, ,			92.00
	OTHER REIMBURSABLE COST CENTERS					
	09400 HOME PROGRAM DI ALYSI S	0	C) (0 0	94.00
	09500 AMBULANCE SERVICES	0	C		이 이	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	(96.00
	09700 DURABLE MEDICAL EQUIP-SOLD 09900 CMHC		(97.00 99.00
	09910 CORF		C C			99.00
	10000 I &R SERVICES-NOT APPRVD PRGM	0	ſ			100.00
	10100 HOME HEALTH AGENCY	0	(101.00
	SPECIAL PURPOSE COST CENTERS	· · ·				
105.00	10500 KIDNEY ACQUISITION	0	C) (0 0	105.00
	10600 HEART ACQUI SI TI ON	0	C		0	106.00
	10700 LIVER ACQUISITION	0	C) (0 0	107.00
	10800 LUNG ACQUISITION	0	C) (0 0	108.00
	10900 PANCREAS ACQUISITION	0	0			109.00
110.00	11000 I NTESTI NAL ACQUI SI TI ON 11100 I SLET ACQUI SI TI ON	0	(110. 00 111. 00
111 00						

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0102 Period: From 01/01/2018 To 12/31/2019 Worksheet B Part I Date/Time Prepared: 5/31/2019 4: 09 pm Cost Center Description SOCIAL SERVICE Subtotal Intern & Residents Cost & Post Stepdown Adjustments Total Date/Time Prepared: 5/31/2019 4: 09 pm 113.00 INTEREST EXPENSE 17.00 24.00 25.00 26.00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 113.00 0 0 114.00 116.00 11500 MOREL GENERAL SUBTOTALS (SUM OF LINES 1 through 117) 0 0 0 115.04 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 56.746 15.549.877 0 15.549.877 18.00 190.00 IPT. FLOWER, COFFEE SHOP & CANTEEN 0 39.940 0 191.00 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 29.153 29.153 192.00 193.00 19300 NONRER 0 0 0 193.00 194.00 07505 SPECI ALTY CLINICS / MOB 0 0	Health Financial Systems	STARKE MEMORIA	AL HOSPITAL		In Lieu of Form CMS-2552-10		
Image: Normal State State Residents Cost & Post Stepdown Adjustments Residents Cost & Post Stepdown Adjustments 113.00 113.00 INTEREST EXPENSE 17.00 24.00 25.00 26.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 113.00 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 116.00 11600 HOSPI CE 0 0 0 115.00 118.00 Substotation (SUM OF LINES 1 through 117) 56.746 15.549.877 118.00 118.00 Inform BURSABLE COST CENTERS 0 0 0 190.00 190.00 IPODO GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 39.940 0 39.940 190.00 191.00 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 29.153 29.153 192.00 192.00 19300 NONREI MORKERS 0 0 193.00 193.00 193.00 19300 NONANDAID WORKERS 0 0 193.00 193.00 193.00 <t< td=""><td>COST ALLOCATION - GENERAL SERVICE COSTS</td><td></td><td>Provider CO</td><td></td><td>From 01/01/2018</td><td>Part I Date/Time Prepared:</td></t<>	COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		From 01/01/2018	Part I Date/Time Prepared:	
113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 115.00 116.00 11600 HOSPI CE 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 56,746 15,549,877 0 15,549,877 118.00 NONREI MBURSABLE COST CENTERS 0 39,940 0 39,940 190.00 191.00 19	Cost Center Description	SOCI AL SERVI CE		Residents Cos & Post Stepdown			
114.00 114.00 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 116.00 11600 HOSPI CE 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 56,746 15,549,877 0 15,549,877 118.00 NONREI MBURSABLE COST CENTERS 190.00 1917, FLOWER, COFFEE SHOP & CANTEEN 0 39,940 0 39,940 190.00 191.00 19100 RESEARCH 0 0 0 191.00 192.00 PHYSI CLANS' PRI VATE OFFICES 0 29,153 29,153 192.00 192.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.00 193.00 193.00 194.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00		17.00	24.00	25.00	26.00		
116.00 HOSPI CE 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 56,746 15,549,877 0 15,549,877 118.00 NONREI MBURSABLE COST CENTERS 190.00 IGFT, FLOWER, COFFEE SHOP & CANTEEN 0 39,940 0 39,940 190.00 191.00 19100 RESEARCH 0 0 0 191.00 192.00 192.00 PHYSI CI ANS' PRI VATE OFFICES 0 29,153 0 29,153 192.00 193.00 NONPAI D WORKERS 0 0 0 193.00 193.00 193.00 193.01,503,119 194.00 200.00 200.00 Cross Foot Adj ustments 0 0 0 0 200.00 200.00							
SUBTOTALS (SUM OF LINES 1 through 117) 56,746 15,549,877 0 15,549,877 118.00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 118.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 39,940 0 39,940 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 191.00 192.00 192.00 PHYSI CI ANS' PRI VATE OFFICES 0 29,153 0 29,153 192.00 193.00 NONPAI D WORKERS 0 0 0 193.00 193.00 193.00 194.00 194.00 200.00	115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	115.00	
NONREI MBURSABLE COST CENTERS 0 39,940 0 39,940 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 29,153 0 29,153 192.00 193.00 NONPAI D WORKERS 0 0 0 193.00 193.00 194.00 07950 SPECIALTY CLINICS / MOB 0 1,503,119 194.00 194.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00	116. 00 11600 HOSPI CE	0	0		0 0	116.00	
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 39,940 0 39,940 190. 00 191. 00 19100 RESEARCH 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 29, 153 0 29, 153 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 193. 00 194. 00 07950 SPECI ALTY CLI NI CS / MOB 0 1, 503, 119 1, 503, 119 194. 00 200. 00 Cross Foot Adjustments 0 0 0 0 200. 00	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	56, 746	15, 549, 877	1	0 15, 549, 877	118.00	
191.00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 29, 153 0 29, 153 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 194.00 07950 SPECI ALTY CLI NI CS / MOB 0 1, 503, 119 194.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00	NONREI MBURSABLE COST CENTERS						
192.00 PHYSI CI ANS' PRI VATE OFFICES 0 29, 153 0 29, 153 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 194.00 07950 SPECI ALTY CLINICS / MOB 0 1, 503, 119 1, 503, 119 194.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	39, 940		0 39, 940	190.00	
193.00 193.00 NONPAI D WORKERS 0 0 0 193.00 194.00 07950 SPECI ALTY CLINICS / MOB 0 1,503,119 0 1,503,119 194.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00	191. 00 19100 RESEARCH	0	0		0 0	191.00	
194.00 07950 SPECIALTY CLINICS / MOB 0 1,503,119 0 1,503,119 194.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00	192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	29, 153		0 29, 153	192.00	
200.00 Cross Foot Adjustments 0 0 0 200.00	193.00 19300 NONPALD WORKERS	0	0		0 0	193.00	
	194.0007950 SPECIALTY CLINICS / MOB	0	1, 503, 119		0 1, 503, 119	194.00	
	200.00 Cross Foot Adjustments		0		0 0	200.00	
	201.00 Negative Cost Centers	0	0		0 0	201.00	
202.00 TOTAL (sum Lines 118 through 201) 56,746 17,122,089 0 17,122,089 202.00	202.00 TOTAL (sum lines 118 through 201)	56, 746	17, 122, 089		0 17, 122, 089	202.00	

	Financial Systems TION OF CAPITAL RELATED COSTS	STARKE MEMORI	AL HOSPITAL Provider CO		eriod: rom 01/01/2018	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/31/2019 4:0	pared:
	Cost Center Description	Di rectl y	CAPITAL REL BLDG & FIXT	ATED COSTS	Subtotal	EMPLOYEE	
		Assigned New Capital Related Costs				BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 191	1, 529	2, 720	2, 720	1
5.00	00500 ADMI NI STRATI VE & GENERAL	0	40, 289	51, 747	92, 036	329	•
7.00	00700 OPERATION OF PLANT	0	137, 947	177, 176	315, 123	178	
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	0 14, 651	18, 818	0 33, 469	0 83	8.00 9.00
10.00	01000 DI ETARY	0	15, 486	19, 889	35, 375	37	10.00
11.00	01100 CAFETERI A	0	4, 221	5, 421	9, 642	43	
13.00	01300 NURSING ADMINISTRATION	0	1, 946	2, 500	4, 446	25	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	9, 910	12, 729	22, 639	86	
15.00 16.00		0	6, 773	8, 699	15, 472	36	
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	5, 582 0	7, 170	12, 752 0	15 0	
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	0	9	0	17.00
30.00	03000 ADULTS & PEDIATRICS	0	55, 468	71, 243	126, 711	349	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	0	0	0	0	0	
43.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0	0	Ч	0	43.00
50.00	05000 OPERATI NG ROOM	0	60, 302	77, 452	137, 754	187	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0 E0 404	1	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	0	25, 602	32, 884	58, 486	295 40	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	40	
56.00	05600 RADI OI SOTOPE	0	0	0	0	14	56.00
57.00	05700 CT SCAN	0	3, 422	4, 395	7, 817	31	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	9, 026	11, 593	20, 619	24	1
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 13, 988	17, 966	0 31, 954	0 213	59.00 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	13, 900	17, 900	31, 934	213	62.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
65.00	06500 RESPI RATORY THERAPY	0	6, 060	7, 784	13, 844	134	65.00
66.00	06600 PHYSI CAL THERAPY	0	15, 300	19, 651	34, 951	117	66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	
	06900 ELECTROCARDI OLOGY	0	3, 137	4, 029	7, 166	0 37	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0,107	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	0	0	
	07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	
	03020 ACUPUNCTURE	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00 90.00
	09100 EMERGENCY	0	29, 153	37, 444	66, 597	445	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		,		0		92.00
	OTHER REIMBURSABLE COST CENTERS			-			1
	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	95.00 96.00
	09700 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	
	09900 CMHC	0	0	0	0	0	1
99.10	09910 CORF	0	0	0	0	0	99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
105 00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION		0	0	0	0	105.00
	10600 HEART ACQUISITION	0	0	0	0		105.00
	10700 LIVER ACQUISITION	0	0	0	0		107.00
	10800 LUNG ACQUI SI TI ON	0	0	0	0		108.00
	10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	11000 INTESTINAL ACQUISITION	<u>ا</u> ا	0	0	U	0	110.00

					u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provider CCN: 15-0102		Period: From 01/01/2018 To 12/31/2018 _			
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
111. 00 11100 I SLET ACQUI SI TI ON 113. 00 11300 I NTEREST EXPENSE	0	0		0 0	0	111. 00 113. 00
114.00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	459, 454	590, 11	9 1, 049, 573	2, 720	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 551	4, 56	0 8, 111	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	-	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 SPECIALTY CLINICS / MOB	0	133, 623	171, 62	5 305, 248	0	194.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	596, 628	766, 30	4 1, 362, 932	2, 720	202.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2018	Worksheet B Part II	
			T	b 12/31/2018	Date/Time Pre 5/31/2019 4:0	pared: 9 pm
Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-BLDG & FIXT						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINI STRATI VE & GENERAL	92, 365					5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	15, 221 366	330, 522 0				7.00 8.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	2, 732	11, 607	366	47, 920		9.00
10. 00 01000 DI ETARY	1, 251	12, 268		1, 843	50, 774	10.00
11. 00 01100 CAFETERI A	831	3, 344		502	33, 492	11.00
13. 00 01300 NURSING ADMINISTRATION	855	1, 542		232	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	1, 041 1, 759	7, 851 5, 366	0	1, 180 806	0	14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1, 296	4, 423		665	0	16.00
17. 00 01700 SOCIAL SERVICE	271	0	0	0	0	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	11, 844	43, 944	116	6, 603	13, 172	30.00
31. 00 03100 INTENSIVE CARE UNIT	11, 044	43, 944	0	0, 003	13, 172	30.00
40. 00 04000 SUBPROVI DER – I PF	0	0	0	0	0	40.00
41. 00 04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
43. 00 04300 NURSERY	0	0	0	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	5, 930	47, 773	49	7, 178	0	50.00
51. 00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	1,972	0	0	0	0	53.00 54.00
54. 01 05400 KADI OLOGI - DI AGNOSTI C 54. 01 05401 ULTRASOUND	7, 104 809	20, 283 0		3, 048 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	549	0	0	0	0	56.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	822 637	2, 711 7, 151		407 1, 074	0	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	037	7, 151	0	1, 0/4	0	59.00
60. 00 06000 LABORATORY	7, 420	11, 082	0	1, 665	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0 2, 770	0 4, 801	0	0 721	0	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	3, 214	12, 121	2	1, 821	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	832 0	2, 485	0	373 0	0	69.00 70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	19	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 795	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS 75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	74.00 75.00
76. 00 03020 ACUPUNCTURE	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS	1					
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
90. 00 09000 CLINIC	23	0	0	0	0	90.00
91. 00 09100 EMERGENCY	17,806	23, 096	162	3, 470	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
94.00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	94.00 95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0	0	97.00
99. 00 09900 CMHC 99. 10 09910 CORF	0	0	0	0	0	99.00 99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0		105.00
106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON	0	0		0		106. 00 107. 00
108. 00 10800 LUNG ACQUI SI TI ON	0	0	0	0		107.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 I SLET ACQUI SI TI ON 113. 00 11300 I NTEREST EXPENSE	0	0	0	0	0	111.00 113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		eriod:	Worksheet B	
				rom 01/01/2018 0 12/31/2018	Part II Date/Time Pre	aarad
			1	0 12/31/2010	5/31/2019 4:0	
Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DIETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
116.00 11600 H0SPI CE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through	n 117) 90, 169	221, 848	366	31, 588	46, 664	118.00
NONREI MBURSABLE COST CENTERS			_			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTI	EEN 57	2, 813	0	423	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	4, 110	192.00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
194.0007950 SPECIALTY CLINICS / MOB	2, 139	105, 861	0	15, 909	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)) 92, 365	330, 522	366	47, 920	50, 774	202.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2018	Worksheet B Part II	
			Te		Date/Time Pre	pared:
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/31/2019 4:0 MEDI CAL	9 pm
'		ADMI NI STRATI ON			RECORDS &	
	11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
GENERAL SERVICE COST CENTERS					10100	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERIA	47,854					11.00
13.00 01300 NURSING ADMINI STRATI ON	923					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	986		33, 783			14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	1, 483		45 118	24, 967 0	20, 917	15.00 16.00
17. 00 01700 SOCIAL SERVICE	274		18	0	20, 917	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			-			
30. 00 03000 ADULTS & PEDIATRICS	7,886		2, 231	0	877	30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF		-	0	0	0	31.00 40.00
41. 00 04100 SUBPROVIDER - IRF		-	0	0	0	41.00
43. 00 04300 NURSERY	C	0	0	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	4.046	1.01(40.447		0.000	50.00
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	4, 213			0	2, 293 0	50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0	0	0	52.00
53.00 05300 ANESTHESI OLOGY	45		616	0	444	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 632		906	0	1, 499	
54. 01 05401 ULTRASOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C	719		86 0	0	869 0	54.01 55.00
56. 00 05600 RADI 01 SOTOPE	331		59	0	37	56.00
57. 00 05700 CT SCAN	636		1, 009	0	2, 835	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	484		56	0	715	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	5, 505	-	0 12, 743	0	0 3, 919	59.00 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	5, 505		12, 743	0	3, 919	62.00
64.00 06400 I NTRAVENOUS THERAPY	C		0	0	0	64.00
65.00 06500 RESPI RATORY THERAPY	3, 112		256	0	194	65.00
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	2,889		120 0	0	547 0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY		-	0	0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	796	0	122	0	263	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			160 147	0	86	71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0	0	24, 967	2, 151	
74.00 07400 RENAL DIALYSIS	C	0	0	0	0	74.00
75. 00 07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	
76. 00 03020 ACUPUNCTURE OUTPATI ENT SERVI CE COST CENTERS	0	0 0	0	0	0	76.00
88. 00 08800 RURAL HEALTH CLINIC	C	0 0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0	0	0	0	89.00
90. 00 09000 CLINIC	19		0	0	0	90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 273	3, 608	4, 944	0	4, 001	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	C	-	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD			0	0	0	96.00 97.00
99. 00 09900 CMHC		0	0	0	0	99.00
99. 10 09910 CORF	C	0	0	0	0	99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0		0	0		100.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	(<u> </u>	0	0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	C	0 0	0	0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	C	0	0	0		106.00
107.00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION		0	0	0		107.00 108.00
109. 00 10900 PANCREAS ACQUISITION			0	0		108.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON		0	0	0		110.00
111.00 11100 I SLET ACQUI SI TI ON	C	0	0	0	0	111.00
113. 00 11300 INTEREST_EXPENSE 114. 00 11400 UTI LI ZATI ON_REVI EW-SNF						113.00
114. UUI 114UUI UTI LI ZATI UN KEVIEW-SNF						114.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B	
				From 01/01/2018 To 12/31/2018	Part II Date/Time Pre	narod
				10 12/31/2010	5/31/2019 4:0	9 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116. 00 11600 H0SPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	47, 854	8, 023	33, 78	3 24, 967	20, 917	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 SPECIALTY CLINICS / MOB	0	0		0 0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	47, 854	8, 023	33, 78	3 24, 967	20, 917	202.00

	Financial Systems	STARKE MEMORIA		<u></u>		u of Form CMS-2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der C	1	Period: From 01/01/2018 To 12/31/2018	
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern &	Total	5/31/2019 4:09 pm
			ous to tu.	Residents Cos		
				& Post Stepdown		
				Adj ustments		
		17.00	24.00	25.00	26.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-MUBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL					5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7.00
9.00	00900 HOUSEKEEPING					9.00
10.00	01000 DI ETARY					10.00
						11.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY					13.00
	01500 PHARMACY					15.00
	01600 MEDI CAL RECORDS & LI BRARY					16.00
17.00	01700 SOCIAL SERVICE	733				17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	733	217, 695		0 217, 695	30.00
	03100 I NTENSI VE CARE UNI T	0	217,095		0 217, 043	30.00
	04000 SUBPROVI DER – I PF	0	C		0 0	40.00
41.00	04100 SUBPROVIDER - IRF	0	C		0 0	41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	C		0 0	43.00
50.00	05000 OPERATI NG ROOM	0	216, 540		0 216, 540	50.00
51.00	05100 RECOVERY ROOM	0	C		0 0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	3, 078 98, 258		0 3, 078 0 98, 258	53.00 54.00
	05401 ULTRASOUND	0	2, 523		0 98, 238	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	2, 020 C		0 0	55.00
56.00	05600 RADI OI SOTOPE	0	990		0 990	56.00
57.00	05700 CT SCAN	0	16, 268		0 16, 268	57.00
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	30, 760		0 30, 760 0 0	58.00 59.00
	06000 LABORATORY	0	74, 501		0 74, 501	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	34	Ļ	0 34	62.00
64.00		0	C 25, 835)		64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	25, 835		0 25,835 0 55,782	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0 0	67.00
	06800 SPEECH PATHOLOGY	0	C		0 0	68.00
	06900 ELECTROCARDI OLOGY	0	12, 074	-	0 12, 074	69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	313		0 0 313	70.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	252		0 252	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	29, 913		0 29, 913	73.00
	07400 RENAL DI ALYSI S	0	C		0 0	74.00
75.00 76.00	07500 ASC (NON-DI STI NCT PART) 03020 ACUPUNCTURE	0	0		0 0	75.00 76.00
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		, 	0 0	/0.00
	08800 RURAL HEALTH CLINIC	0	C		0 0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	89.00
	09000 CLINIC 09100 EMERGENCY	0	43 133, 402		0 43 0 133, 402	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	155, 402		0 133, 402	92.00
	OTHER REIMBURSABLE COST CENTERS	·				
	09400 HOME PROGRAM DI ALYSI S	0	C		0 0	94.00
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	C			95.00 96.00
	09700 DURABLE MEDICAL EQUIP-RENTED	0	0		o 0	98.00
99.00	09900 СМНС	0	C		0 0	99.00
	09910 CORF	0	C		0 0	99.10
	10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0	C		0 0 0 0	100. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	U		1	0	101.00
	10500 KIDNEY ACQUISITION	0	C		0 0	105.00
	10600 HEART ACQUI SI TI ON	0	C		0 0	106.00
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION	0	C		0 0	107.00 108.00
	10900 PANCREAS ACQUISITION	0	C		0 0	108.00
110.00	11000 INTESTINAL ACQUISITION	0	C		0 0	110.00
111.00	11100 I SLET ACQUI SI TI ON	0	C		0 0	111.00

Health Financial Systems	STARKE MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B
				From 01/01/2018 To 12/31/2018	
				10 12/31/2010	5/31/2019 4:09 pm
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern &	Total	
			Residents Cos	t	
			& Post		
			Stepdown		
			Adjustments		
	17.00	24.00	25.00	26.00	
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	115.00
116. 00 11600 H0SPI CE	0	0		0 0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	733	918, 261		0 918, 261	118.00
NONREI MBURSABLE COST CENTERS			-	-	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 404		0 11, 404	190. 00
191. 00 19100 RESEARCH	0	0		0 0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	4, 110		0 4, 110	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	193.00
194.00 07950 SPECIALTY CLINICS / MOB	0	429, 157		0 429, 157	194.00
200.00 Cross Foot Adjustments		0		0 0	200.00
201.00 Negative Cost Centers	0	0		0 0	201.00
202.00 TOTAL (sum lines 118 through 201)	733	1, 362, 932		0 1, 362, 932	202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	STARKE MEMORI	AL HOSPITAL Provider CO	CN: 15-0102 P	Period:	u of Form CMS-: Worksheet B-1	
					rom 01/01/2018 o 12/31/2018		
		CAPI TAL REI	LATED COSTS			5/31/2019 4:0	9 pm
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	83, 683	1				1.00
2.00 4.00 5.00 7.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	167 5, 651 19, 348	83, 683 167 5, 651 19, 348	6, 293, 106 762, 703 411, 824	-3, 944, 279 0	2, 171, 625	2.00 4.00 5.00 7.00
8.00 9.00 10.00 11.00 13.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	0 2, 055 2, 172 592 273 1, 200	2, 055 2, 172 592 273	85, 381 98, 919 57, 936		52, 207 389, 854 178, 448 118, 527 121, 950	9.00 10.00 11.00 13.00
14.00 15.00 16.00 17.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	1, 390 950 783 0	950 783 0	82, 321 35, 654 C		148, 521 250, 895 184, 845 38, 695	15.00 16.00 17.00
30. 00 31. 00 40. 00 41. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY ANCILLARY SERVICE COST CENTERS	7, 780 0 0 0	0 0 0	808, 451 C C C C		1, 689, 835 0 0 0 0	31.00 40.00
50.00	05000 OPERATI NG ROOM	8, 458	8, 458	432, 006	0	846, 058	50.00
51.00 52.00 53.00 54.00 54.01 55.00	05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	0 0 3, 591 0 0		91, 565 C	8 0 0 0 0 0	0 281, 303 1, 013, 530 115, 361 0 20 21/	52.00 53.00 54.00 54.01 55.00
56.00 57.00 58.00 59.00 60.00	05600 RADIOISOTOPE 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY	480 1, 266 0 1, 962	1, 266 0	56, 696 C		78, 316 117, 209 90, 859 0 1, 058, 639	57.00 58.00 59.00
62.00 64.00 65.00 66.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 0 850 2, 146	0 0 850	C C 310, 084	0 0 0	1, 038, 039 0 395, 147 458, 578	62.00 64.00 65.00
67.00 68.00 69.00 70.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0 0 440 0	0	C C	0 0 0 0	0 0 118, 771 0	67.00 68.00 69.00 70.00
71.00 72.00 73.00 74.00 75.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)					0 2, 717 398, 781 0 0	72.00 73.00 74.00
76.00	03020 ACUPUNCTURE	0	0	C C		0	1
88.00 89.00 90.00 91.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY	0 0 0 4,089	0	C C 2, 745 1, 026, 945	0 0	0 0 3, 313 2, 540, 467	89.00
92.00 94.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	0	C	0	0	92.00 94.00
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD 09900 CMHC 09910 CORF 10000 I &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY						97.00 99.00 99.10
105.00 106.00 107.00 108.00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION 10700 LIVER ACQUISITION 10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION		-		1	0 0 0 0	101.00 105.00 106.00 107.00 108.00 109.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2018 To 12/31/2018		epared:
	CAPI TAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	& GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5.00	
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	64, 443	64, 443	6, 293, 10	6 -3, 944, 279	12, 864, 451	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	498	498		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 SPECIALTY CLINICS / MOB	18, 742	18, 742		0 0	305, 248	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	596, 628	766, 304	858, 45	2	3, 944, 279	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	7. 129620	9. 157224	0. 13641	1	0. 299312	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			2, 72	0	92, 365	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 00043	2	0. 007009	205.00
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

Health Financial Systems	STARKE MEMORI				u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2018 o 12/31/2018	Worksheet B-1 Date/Time Pre	
Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/31/2019 4:0 CAFETERI A	9 pm
	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(FTE)	
	7.00	LAUNDRY) 8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS	1	I	l			
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	58, 517					7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	2,055	,				8.00 9.00
10. 00 01000 DI ETARY	2, 172	18				10.00
	592				7, 519	
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	273		273 1, 390		145 155	
15. 00 01500 PHARMACY	950		950		233	
16.00 01600 MEDICAL RECORDS & LIBRARY	783				259	
17.00 01700 SOCIAL SERVICE	0	0	0	0	43	17.00
30. 00 03000 ADULTS & PEDIATRICS	7, 780	23, 486	7, 780	6, 909	1, 239	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	0		0	31.00
40. 00 04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0	0	0		0	41.00
ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	43.00
50. 00 05000 OPERATI NG ROOM	8, 458	9, 862	8, 458	0	662	50.00
51.00 05100 RECOVERY ROOM	0	0	0	-	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	52.00 53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	3, 591	916	3, 591	0	7 1, 042	
54. 01 05401 ULTRASOUND	0	0	0	0	113	•
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN	480		0 480	0	52 100	56.00 57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 266		1, 266		76	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
	1, 962	0	1, 962	0	865	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 64.00 06400 INTRAVENOUS THERAPY	0			0	0	62.00 64.00
65. 00 06500 RESPI RATORY THERAPY	850	-		0	489	
66. 00 06600 PHYSI CAL THERAPY	2, 146	467		0	454	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	440		440	0	0 125	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0			0	0	
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
76.00 03020 ACUPUNCTURE OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00 09000 CLINIC	0	0	0	0	3	90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 089	32, 978	4, 089	0	1, 457	91.00 92.00
OTHER REI MBURSABLE COST CENTERS						/2.00
94.00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	•
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0		0	0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-KENTED	0	0	0	0	0	97.00
99. 00 09900 CMHC	0	0	0	0	0	99.00
99.10 09910 CORF	0	0	0	0	0	
100.00100001&R SERVICES-NOT APPRVD PRGM 101.0010100 HOME HEALTH AGENCY	0			0		100. 00 101. 00
SPECIAL PURPOSE COST CENTERS					0	
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0		105.00
106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		106. 00 107. 00
108. 00 10800 LUNG ACQUISITION	0	0	0	0		107.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
111. 00 11100 I SLET ACQUI SI TI ON 113. 00 11300 I NTEREST EXPENSE	0			0	0	111.00 113.00
	1			. I		

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		eriod:	Worksheet B-1	
				rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared:
					5/31/2019 4:0	9 pm
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(FTE)	
	(SQUARE FEET)	(POUNDS OF				
		LAUNDRY)				
	7.00	8.00	9.00	10.00	11.00	
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	C	0		115.00
116. 00 11600 HOSPI CE	0	0	C	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	39, 277	74, 080	37, 222	24, 476	7, 519	118.00
NONREI MBURSABLE COST CENTERS		·				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	498	0	498	0	0	190.00
191. 00 19100 RESEARCH	0	0	C	0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	2, 156	0	192.00
193. 00 19300 NONPALD WORKERS	0	0	C	0	0	193.00
194.0007950 SPECIALTY CLINICS / MOB	18, 742	0	18, 742	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	2, 821, 618	67, 833	610, 926	360, 108	426, 490	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	48. 218774	0. 915672	10. 820127	13. 521628	56. 721639	203.00
204.00 Cost to be allocated (per Wkst. B,	330, 522	366	47, 920	50, 774	47, 854	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	5. 648307	0. 004941	0. 848712	1. 906503	6. 364410	205.00
11)						
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)						

	Financial Systems LLOCATION - STATISTICAL BASIS	STARKE MEMORIA	AL HOSPITAL Provider CC	N· 15-0102	In Lie Period:	u of Form CMS-: Worksheet B-1	2552-10
0001 7					From 01/01/2018 To 12/31/2018	Date/Time Pre	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		5/31/2019 4:0 SOCIAL SERVICE	
		ADMI NI STRATI ON (TOTAL NURSI NG	SERVICES & SUPPLY (COSTED	(COSTED REQUI S.)	RECORDS & LI BRARY (GROSS	(TIME SPENT)	
		SALARY)	REQUIS.)	15.00	CHARGES)	17.00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00	00700 OPERATI ON OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY 01100 CAFETERI A						10.00 11.00
	01300 NURSI NG ADMI NI STRATI ON	1, 737, 305					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	657, 360				14.00
	01500 PHARMACY	0	871	408, 05			15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0 36, 870	2, 298 350		0 70, 414, 967 0 0	1, 227	16.00 17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	30,070			0	1,227	17.00
	03000 ADULTS & PEDIATRICS	699, 147	43, 414		2, 952, 530	1, 227	30.00
	03100 I NTENSI VE CARE UNI T	0	0		0 0	0	31.00
	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	0	0			0	40.00 41.00
	04300 NURSERY	0	0		0 0	0	43.00
	ANCILLARY SERVICE COST CENTERS		1				
	05000 OPERATING ROOM	219, 962	197, 441		0 7, 719, 527	0	50.00
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	51.00 52.00
	05300 ANESTHESI OLOGY	0	11, 990		0 1, 493, 536	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	17, 627	(5, 047, 227	0	54.00
	05401 ULTRASOUND	0	1, 666		2, 925, 668	0	54.01
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0 1, 153		0 0 0 122, 991	0	55.00 56.00
	05700 CT SCAN	0	19, 635		9, 544, 128	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 082	(2, 406, 716	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0 10 101 005	0	59.00
	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	247, 979 0		0 13, 194, 035 0 115, 123	0	60.00 62.00
	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
	06500 RESPI RATORY THERAPY	0	4, 983	(0 652, 692	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	2, 338		1, 840, 435	0	66.00
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0			0	67.00 68.00
	06900 ELECTROCARDI OLOGY	0	2, 367		885,654	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	(0 0	0	70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	3, 110	(515, 309	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	2, 857 0	408, 05	0 289, 621 7 7, 241, 660	0	72.00 73.00
	07400 RENAL DIALYSIS	0	0	400, 05	0 0	0	74.00
	07500 ASC (NON-DI STINCT PART)	0	0		o o	0	75.00
76.00		0	0	(0 0	0	76.00
88.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	(0 0	0	89.00
	09000 CLINIC	0	0	(268	0	90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	781, 326	96, 199	(0 13, 467, 847	0	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>					92.00
	09400 HOME PROGRAM DI ALYSI S	0	0	(0 0	0	94.00
	09500 AMBULANCE SERVICES	0	0	(0 0	0	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0	0			0	96.00 97.00
	09900 CMHC	0	0		0 0	0	99.00
99.10	09910 CORF	0	0	(0 0	0	99. 10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	(0 0		100.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	(0 0	0	101.00
105.00	10500 KI DNEY ACQUI SI TI ON	0	0	(0 0	0	105.00
106.00	10600 HEART ACQUI SI TI ON	0	0	(o o	0	106.00
	10700 LIVER ACQUISITION	0	0	(0 0		107.00
	10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION	0	0				108. 00 109. 00
	11000 I NTESTI NAL ACQUI SI TI ON	0	0				110.00
111.00	11100 I SLET ACQUI SI TI ON	0	0	(0 0	0	111.00

Health Financial Systems	STARKE MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2552-1	10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1	_
				From 01/01/2018 To 12/31/2018	Date/Time Prepared:	ı.
				10 12/31/2010	5/31/2019 4:09 pm	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LIBRARY	(TIME SPENT)	
	(TOTAL NURSING	(COSTED		(GROSS		
	SALARY) 13.00	REQUIS.) 14.00	15.00	CHARGES) 16.00	17.00	<u> </u>
113.0011300 INTEREST EXPENSE	13.00	14.00	15.00	16.00	113.0	20
114. 0011400 UTI LI ZATI ON REVIEW-SNF					113.0	
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	(0	0 115. 0	
116. 00 11600 HOSPI CE	0	0			0 116.0	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 737, 305	657, 360	408, 05	7 70, 414, 967	1, 227 118. 0	
NONREI MBURSABLE COST CENTERS	1 1 1 1 1 1 1 1					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0	0 190. 0	00
191. 00 19100 RESEARCH	0	0	(0 0	0 191. 0	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0 0	0 192. 0	
193. 00 19300 NONPALD WORKERS	0	0	(0 0	0 193. 0	
194.00 07950 SPECIALTY CLINICS / MOB	0	0	(0 0	0 194. 0	
200.00 Cross Foot Adjustments					200. 0	
201.00 Negative Cost Centers	100 704	000 001	005 (7		201.0	
202.00 Cost to be allocated (per Wkst. B, Part I)	182, 794	283, 831	395, 670	302, 081	56, 746 202. 0	00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 105217	0. 431774	0.96964	0. 004290	46. 247759 203. 0	00
204.00 Cost to be allocated (per Wkst. B,	8, 023	33, 783	24, 96	7 20, 917	733 204. 0	00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 004618	0. 051392	0.06118	5 0. 000297	0. 597392 205. 0)0
206.00 NAHE adjustment amount to be allocated					206. 0	00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,					207. 0	00
Parts III and IV)		l		1		

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0102	Period: From 01/01/2018	Worksheet C Part I	
				To 12/31/2018	Date/Time Pre	
		Title	e XVIII	Hospi tal	5/31/2019 4:0 PPS	19 pm
				Costs	<u> </u>	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col. 26)					
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.001.0/0	1	0.001.07		0.001.0/0	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSIVE CARE UNIT	3, 001, 869		3, 001, 86	0 0	3, 001, 869 0	1
40. 00 04000 SUBPROVI DER – I PF	0			0 0	0	
41. 00 04100 SUBPROVIDER - IRF	0			0 0	0	1
43.00 04300 NURSERY	0			0 0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	1, 786, 735		1, 786, 73	5 0	1, 786, 735	50.00
51. 00 05100 RECOVERY ROOM	1,780,733		1,700,73	0 0	1, 780, 735	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	1
53.00 05300 ANESTHESI OLOGY	377, 481		377, 48		377, 481	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	1, 618, 108		1, 618, 10		1, 618, 108	
54. 01 05401 ULTRASOUND 55. 00 05500 RADI 0L0GY-THERAPEUTI C	169, 570 0		169, 57		169, 570 0	1
56. 00 05600 RADI 0I SOTOPE	105, 733		105, 73		105, 733	1
57.00 05700 CT SCAN	235, 724		235, 72		235, 724	1
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	207,900		207, 90		207, 900	
59. 00 05900 CARDIAC CATHETERIZATION 60. 00 06000 LABORATORY	0 1, 704, 073		1, 704, 07	0 0	0 1, 704, 073	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	494		49		494	
64.00 06400 I NTRAVENOUS THERAPY	0			0 0	0	
65. 00 06500 RESPIRATORY THERAPY	596, 814				596, 814	
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	757, 617		757, 61	7 0 0 0	757, 617 0	1
68. 00 06800 SPEECH PATHOLOGY	0			0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	192, 209		192, 20		192, 209	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 554 6, 006		3, 55		3, 554 6, 006	
73. 00 07200 DRUGS CHARGED TO PATIENTS	944, 878		944, 87		944, 878	
74.00 07400 RENAL DIALYSIS	0			0 0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0			0 0	0	
76.00 03020 ACUPUNCTURE OUTPATI ENT SERVICE COST CENTERS	0			0 0	0	76.00
88. 00 08800 RURAL HEALTH CLINIC	0			0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
90. 00 09000 CLINIC	4, 476		4, 47		4, 476	1
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	3, 836, 636 658, 809		3, 836, 63 658, 80		3, 836, 636 658, 809	
OTHER REIMBURSABLE COST CENTERS	030,007		030, 00		000,007	/2.00
94.00 09400 HOME PROGRAM DI ALYSI S	0			0 0	0	
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0				0	
99. 00 09900 CMHC	0			0	0	
99. 10 09910 CORF	0			0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			0		100.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0			0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0			0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0			0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0			0		107.00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION	0			0		108. 00 109. 00
110. 00 110900 PANCREAS ACQUISITION 110. 00 11000 I NTESTI NAL ACQUI SI TI ON				0		1109.00
111. 00 11100 I SLET ACQUI SI TI ON	0			0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF	_				_	114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE				0		115. 00 116. 00
200.00 Subtotal (see instructions)	16, 208, 686	C	16, 208, 68	6 0	16, 208, 686	
201.00 Less Observation Beds	658, 809		658, 80	19	658, 809	201.00
202.00 Total (see instructions)	15, 549, 877	0	15, 549, 87	7 0	15, 549, 877	202.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2018	Worksheet C Part I	
				To 12/31/2018	Date/Time Pre	
			e XVIII	Hospi tal	5/31/2019 4:0 PPS	19 pm
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. d		TEFRA	
			+ col. 7)	Ratio	Inpati ent	
	6.00	7.00	8.00	9.00	Ratio 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	1100	0.00	7100	10100	
30. 00 03000 ADULTS & PEDI ATRI CS	2, 644, 090		2, 644, 09	0		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0			0		31.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0			0		40.00
43. 00 04300 NURSERY	0			0		43.00
ANCI LLARY SERVI CE COST CENTERS				-		
50. 00 05000 OPERATI NG ROOM	608, 698				0.00000	
51.00 05100 RECOVERY ROOM	0	0		0 0. 000000	0.000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	109, 169	1, 384, 367	7 7 1, 493, 53	0 0. 000000 6 0. 252743	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	139, 920	4, 907, 307			0. 000000	
54. 01 05401 ULTRASOUND	258, 090	2, 667, 578	2, 925, 66	8 0. 057959	0. 000000	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	(0 0.00000	0.00000	
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN	0 838, 626	122, 991 8, 705, 502			0.000000	•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	97, 213	2, 309, 503			0. 000000	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	(0 0. 000000	0. 000000	
60. 00 06000 LABORATORY	1, 594, 179				0. 000000	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	55, 408	59, 715	5 115, 12		0.00000	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	446, 548	206, 144	652,69	0 0.000000 2 0.914388	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	134, 667	1, 705, 768			0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	(0 0. 000000	0. 000000	
68.00 06800 SPEECH PATHOLOGY	0	0	D	0 0. 000000	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	122, 153	763, 501	885, 65		0.000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	137, 874	377, 435	5 515, 30	0 0. 000000 9 0. 006897	0. 000000 0. 000000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 432	269, 189			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 916, 194				0. 000000	
74.00 07400 RENAL DIALYSIS	0	C		0 0. 000000	0. 000000	
75. 00 07500 ASC (NON-DI STINCT PART)	0	0		0 0. 000000	0.000000	
76. 00 03020 ACUPUNCTURE OUTPATI ENT SERVI CE COST CENTERS	0	(<u>/</u>	0 0.000000	0.000000	76.00
88. 00 08800 RURAL HEALTH CLINIC	0	(0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
90. 00 09000 CLINIC	0	268				
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 297, 043 378, 945				0. 000000	
OTHER REI MBURSABLE COST CENTERS	570, 743	470,73	+ 077,07	0.750020	0.00000	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	(0 0. 000000	0.00000	94.00
95. 00 09500 AMBULANCE SERVICES	0	(D	0 0. 000000		
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	0		2	0 0. 000000 0 0. 000000	0.000000	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 99. 00 09900 CMHC	0			0 0.000000	0.000000	97.00
99. 10 09910 CORF	0			0		99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	D	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	(0		101.00
SPECIAL PURPOSE COST CENTERS	0	(7	0		105 00
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON	0		ő	0		105.00 106.00
107. 00 10700 LI VER ACQUI SI TI ON	0		D	0		107.00
108.00 10800 LUNG ACQUISITION	0	(ס	0		108.00
109.00 10900 PANCREAS ACQUISITION	0		2	0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 111. 00 11100 I SLET ACQUI SI TI ON	0			0		110.00 111.00
113.00/11300/INTEREST EXPENSE			1	č		113.00
114. OO 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	(ן ע	0		115.00
116.00 11600 HOSPI CE	0			0		116.00
200.00Subtotal (see instructions)201.00Less Observation Beds	10, 799, 249	60, 184, 957	7 70, 984, 20	0		200.00
202.00 Total (see instructions)	10, 799, 249	60, 184, 957	70, 984, 20	6		202.00
	•					•

Health Financial Systems	STARKE MEMORIA	I HOSPITAI	Inlie	」of Form CMS-255	52-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	STARLE MEMORIA	Provi der CCN: 15-0102	Peri od:	Worksheet C	2 10
			From 01/01/2018 To 12/31/2018	Part I Date/Time Prepar	red:
		Title XVIII	Hospi tal	5/31/2019 4:09 p PPS	om
Cost Center Description	PPS Inpatient		nospi tui		
	Rati o 11.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDI ATRI CS					0.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF					1.00 0.00
41. 00 04100 SUBPROVI DER – I RF				4	1.00
43. 00 04300 NURSERY				4	3.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0. 231457			5	0. 00
51.00 05100 RECOVERY ROOM	0. 000000			5	1. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0.00000				2.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 252743 0. 320593				3.00 4.00
54.01 05401 ULTRASOUND	0. 057959				4. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.00000				5.00
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN	0. 859681 0. 024698				6.00 7.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 086383				8.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.00000				9.00
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 129155 0. 004291				0.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000				4.00
65.00 06500 RESPI RATORY THERAPY	0. 914388				5.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0. 411651 0. 000000				6.00 7.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				8.00
69.00 06900 ELECTROCARDI OLOGY	0. 217025				9.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000 0. 006897				0.00 1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 020737				2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 130478				3.00
74.00 07400 RENAL DIALYSIS 75.00 07500 ASC (NON-DISTINCT PART)	0. 000000 0. 000000				4.00 5.00
76. 00 03020 ACUPUNCTURE	0. 000000				6.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					8.00 9.00
90. 00 09900 CLINIC	16. 701493				0.00
91.00 09100 EMERGENCY	0. 284874				1. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	0. 750626			9	2.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000			9	4.00
95. 00 09500 AMBULANCE SERVICES	0. 000000				5.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0.000000				6.00 7.00
99. 00 09900 CMHC	0.00000				9.00
99. 10 09910 CORF					9. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY					0.00 1.00
SPECIAL PURPOSE COST CENTERS				10	1.00
105.00 10500 KI DNEY ACQUI SI TI ON					5.00
106. 00 10600 HEART ACQUISITION 107. 00 10700 LIVER ACQUISITION					6.00 7.00
108. 00 10800 LUNG ACQUISITION					8.00
109. 00 10900 PANCREAS ACQUI SI TI ON					9.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 111. 00 11100 I SLET ACQUI SI TI ON					0. 00 1. 00
113. 00 11300 I NTEREST EXPENSE					3.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				11	4.00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116. 00 11600 HOSPI CE					5.00 6.00
200.00 Subtotal (see instructions)					0.00
201.00 Less Observation Beds				20	1.00
202.00 Total (see instructions)				20	2.00

Health Financial Systems	STARKE MEMORI				u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre	
			e XIX	Hospi tal	5/31/2019 4:0 PPS)9 pm
		1111		Costs	FF3	
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	3, 001, 869		3, 001, 86		3, 001, 869	30.00
31. 00 03100 I NTENSI VE CARE UNI T	3,001,009			0 0	3, 001, 889	
40. 00 04000 SUBPROVIDER - IPF	0			0 0	0	
41. 00 04100 SUBPROVIDER - IRF	0			0 0	0	
43. 00 04300 NURSERY	0			0 0	0	43.00
ANCI LLARY SERVI CE COST CENTERS			1	-		
50. 00 05000 OPERATI NG ROOM	1, 786, 735		1, 786, 73		1, 786, 735	
51.00 05100 RECOVERY ROOM	0			0 0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	
53. 00 05300 ANESTHESI OLOGY	377, 481		377, 48		377, 481	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	1, 618, 108 169, 570		1, 618, 10 169, 57		1, 618, 108 169, 570	
55. 00 05500 RADI OLOGY-THERAPEUTI C	109, 570			0 0	109, 570	
56. 00 05600 RADI OLSOT MERALESTIC	105, 733		105, 73	-	105, 733	
57. 00 05700 CT SCAN	235, 724		235, 72		235, 724	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	207, 900		207, 90		207, 900	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	1, 704, 073		1, 704, 07	3 0	1, 704, 073	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	494		49	4 0	494	62.00
64.00 06400 INTRAVENOUS THERAPY	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	596, 814	0			596, 814	1
66. 00 06600 PHYSI CAL THERAPY	757, 617	0	757, 61		757, 617	
67. 00 06700 OCCUPATIONAL THERAPY	0	0		0 0	0	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0 192, 209	0	192, 20	0 0	0 192, 209	
70. 00 07000 ELECTROENCEPHALOGRAPHY	192, 209			0 0	192, 209	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 554		3, 55	-	3, 554	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	6,006		6, 00		6, 006	
73.00 07300 DRUGS CHARGED TO PATIENTS	944, 878		944, 87		944, 878	
74.00 07400 RENAL DIALYSIS	0			0 0	0	74.00
75.00 07500 ASC (NON-DI STI NCT PART)	0			0 0	0	75.00
76. 00 03020 ACUPUNCTURE	0			0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0			0 0	0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0 4, 476		4, 47	0 0 6 0	0 4, 476	
91. 00 09100 EMERGENCY	3, 836, 636		3, 836, 63		3, 836, 636	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	658, 809		658, 80		658, 809	
OTHER REI MBURSABLE COST CENTERS	000,007	<u> </u>	000,00		000,007	72.00
94.00 09400 HOME PROGRAM DI ALYSI S	0			0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	
99.00 09900 CMHC	0			0	0	
99. 10 09910 CORF	0			0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			0		100.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0			0	0	101.00
105.00 10500 KI DNEY ACQUI SI TI ON	0			0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0			0		106.00
107.00 10700 LIVER ACQUISITION	0			0		107.00
108.00 10800 LUNG ACQUISITION	0			0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0			0		109.00
110.00 11000 INTESTINAL ACQUISITION	0			0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0			0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					~	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			0		115.00
116. 00 11600 HOSPI CE	1 0	1		v l		116.00
	16 200 604	<u>م</u>	1 1 2 2 0 0 2 0		16 200 202	
200.00 Subtotal (see instructions)	16, 208, 686 658, 809				16, 208, 686 658, 809	
	16, 208, 686 658, 809 15, 549, 877		658, 80	9	658, 809	201.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2018	Worksheet C Part I	
				To 12/31/2018	Date/Time Pre	
			e XIX	Hospi tal	5/31/2019 4:0 PPS	19 pm
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. d		TEFRA	
			+ col. 7)	Ratio	Inpati ent	
	6.00	7.00	8.00	9.00	Ratio 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	1100	0.00	7100	10100	
30. 00 03000 ADULTS & PEDI ATRI CS	2, 644, 090		2, 644, 09	0		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0			0		31.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0			0		40.00
43. 00 04300 NURSERY	0			0		43.00
ANCI LLARY SERVI CE COST CENTERS			1	-		
50. 00 05000 OPERATI NG ROOM	608, 698	7, 110, 829			0.00000	
51.00 05100 RECOVERY ROOM	0	0		0 0. 000000	0.000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	109, 169	1, 384, 367	7 7 1, 493, 53	0 0.000000 6 0.252743	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	139, 920	4, 907, 307			0. 000000	
54. 01 05401 ULTRASOUND	258, 090	2, 667, 578			0. 000000	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	(0 0.000000	0.00000	
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN	0 838, 626	122, 991 8, 705, 502			0. 000000	•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	97, 213	2, 309, 503			0. 000000	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	2,007,000		0 0.000000	0. 000000	
60. 00 06000 LABORATORY	1, 594, 179	11, 599, 856	5 13, 194, 03	5 0. 129155	0. 000000	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	55, 408	59, 715	5 115, 12		0.00000	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	204 14	652,69	0 0.000000 2 0.914388	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	446, 548 134, 667	206, 144 1, 705, 768			0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	(0 0. 000000	0. 000000	
68.00 06800 SPEECH PATHOLOGY	0	C	D	0 0. 000000	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	122, 153	763, 501	885, 65		0.00000	
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	137, 874	277 426	5 515, 30	0 0.000000 9 0.006897	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 432	377, 435 269, 189			0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 916, 194	5, 325, 466			0. 000000	
74.00 07400 RENAL DIALYSIS	0	(D	0 0. 000000	0. 000000	
75.00 07500 ASC (NON-DI STINCT PART)	0	(0 0. 000000	0.000000	
76. 00 03020 ACUPUNCTURE OUTPATI ENT SERVI CE COST CENTERS	0	(יייייי	0 0.000000	0.00000	76.00
88.00 08800 RURAL HEALTH CLINIC	0	(ol	0 0. 000000	0. 000000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(b	0 0. 000000	0. 000000	
90. 00 09000 CLINIC	0	268			0. 000000	
91.00 09100 EMERGENCY	1, 297, 043	12, 170, 804			0.000000	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	378, 945	498, 734	4 877,67	9 0.750626	0.000000	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	(b	0 0. 000000	0. 000000	94.00
95. 00 09500 AMBULANCE SERVI CES	0	C	D	0 0. 000000	0.00000	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	(0 0. 000000	0.00000	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 99. 00 09900 CMHC	0	(0 0.000000	0. 000000	97.00 99.00
99. 10 09910 CORF	0			0		99.00
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	(0		100.00
101.00 10100 HOME HEALTH AGENCY	0	(0		101.00
SPECIAL PURPOSE COST CENTERS			1			1105 00
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON	0	(0		105.00 106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	(Ď	ŏ		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	C	D I	0		108.00
109.00 10900 PANCREAS ACQUISITION	0	C	ס	0		109.00
110. 00 11000 INTESTINAL ACQUISITION	0	(0		110.00
111. 00 11100 ISLET ACQUISITION 113. 00 11300 INTEREST EXPENSE	0	(0		111.00 113.00
114. 00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	C	p	0		115.00
116. 00 11600 HOSPI CE	0	(2	0		116.00
200.00Subtotal (see instructions)201.00Less Observation Beds	10, 799, 249	60, 184, 957	7 70, 984, 20	6		200.00
201.00 Less observation Beds 202.00 Total (see instructions)	10, 799, 249	60, 184, 957	70, 984, 20	6		201.00
	1 10,777,247	00, 104, 707	1 , 5, 704, 20	~	I	1-02.00

Health Financial Systems	STARKE MEMORIAI	L HOSPI TAL	In Lieu	ı of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0102	Peri od:	Worksheet C	
			From 01/01/2018 To 12/31/2018	Part I Date/Time Pre	pared:
		Title XIX	Hospi tal	5/31/2019 4:0 PPS	9 pm
Cost Center Description	PPS Inpatient				
	Rati o 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF					31.00 40.00
41. 00 04100 SUBPROVIDER - IRF					41.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS	0. 231457				50.00
51. 00 05100 RECOVERY ROOM	0. 000000				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 252743				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	0. 320593 0. 057959				54.00 54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
56. 00 05600 RADI OI SOTOPE	0. 859681				56.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 024698 0. 086383				57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60. 00 06000 LABORATORY	0. 129155				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 64.00 06400 INTRAVENOUS THERAPY	0. 004291				62.00 64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000 0. 914388				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 411651				66.00
67. 00 06700 OCCUPATIONAL THERAPY	0. 000000				67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0. 000000 0. 217025				68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 006897				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 020737 0. 130478				72.00 73.00
74. 00 07400 RENAL DIALYSIS	0. 130478				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000				75.00
76.00 03020 ACUPUNCTURE	0. 000000				76.00
OUTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89.00
90. 00 09000 CLINIC	16. 701493				90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0. 284874 0. 750626				91.00 92.00
OTHER REI MBURSABLE COST CENTERS	0.700020				72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000				94.00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000				95.00 96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97.00
99. 00 09900 CMHC					99.00
99.10 09910 CORF 100.00 10000 L&R SERVLCES-NOT APPRVD PRGM					99. 10 100. 00
101.00 10100 HOME HEALTH AGENCY					100.00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KI DNEY ACQUI SI TI ON					105.00
106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON					106. 00 107. 00
108.00 10800 LUNG ACQUI SI TI ON					108.00
109.00 10900 PANCREAS ACQUISITION					109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON 111. 00 11100 SLET ACQUI SI TI ON					110. 00 111. 00
113. 00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTILIZATION REVIEW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)					115.00
116.00 11600 HOSPICE 200.00 Subtotal (see instructions)					116. 00 200. 00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE F	RATIOS NET OF	Provider C	CN: 15-0102	Period: From 01/01/2018	Worksheet C Part II	
EDUCTIONS FOR MEDICAID ONLY				To 12/31/2018	Date/Time Pre 5/31/2019 4:0	
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost	
	(Wkst. B, Part				Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
	1.00	2.00	col. 2) 3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
D. 00 05000 OPERATING ROOM	1, 786, 735	216, 540	1, 570, 19	95 0	0	50.0
1. 00 05100 RECOVERY ROOM	0	(0 0	0	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	(0 0	0	52.0
3. 00 05300 ANESTHESI OLOGY	377, 481	3, 078	3 374, 40	03 0	0	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 618, 108	98, 258	1, 519, 8	50 0	0	54.0
4. 01 05401 ULTRASOUND	169, 570	2, 523	3 167, 04	47 0	0	54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.0
6. 00 05600 RADI OI SOTOPE	105, 733				0	56.0
7.00 05700 CT SCAN	235, 724				0	57.0
B. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	207, 900	30, 760	177, 14		0	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	()	0 0	0	59.0
D. 00 06000 LABORATORY	1, 704, 073				0	60.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	494			50 0	0	62.0
4. 00 06400 I NTRAVENOUS THERAPY	0	05.005		0 0	0	64.0
5. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY	596, 814	25, 835			0	65.0
6. 00 06600 PHYSI CAL THERAPY 7. 00 06700 0CCUPATI ONAL THERAPY	757, 617	55, 782		0 0	0	66.0 67.0
B. 00 06800 SPEECH PATHOLOGY	0			0 0	0	68.0
9. 00 06900 ELECTROCARDI OLOGY	192, 209	12, 074	180, 13	° °	0	69.0
0. 00 07000 ELECTROENCEPHALOGRAPHY	192,209	12,072	100, 1		0	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 554	313	3, 24	0	0	71.0
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	6, 006				0	
3. 00 07300 DRUGS CHARGED TO PATIENTS	944, 878				0	73.0
4. 00 07400 RENAL DI ALYSI S	0	(0 0	0	74.0
5. 00 07500 ASC (NON-DISTINCT PART)	0			0 0	0	
6. 00 03020 ACUPUNCTURE	0	0		0 0	0	76.0
OUTPATIENT SERVICE COST CENTERS						
B. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.0
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
D. 00 09000 CLINIC	4, 476				0	
1.00 09100 EMERGENCY	3, 836, 636				0	91. C
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	658, 809	47, 777	611, 03	32 0	0	92. C
OTHER REIMBURSABLE COST CENTERS						
4. 00 09400 HOME PROGRAM DI ALYSI S 5. 00 09500 AMBULANCE SERVI CES	0			0 0	0	94. C
6. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0	96.0
7. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0	97.0
9. 00 09900 CMHC	0			0 0	0	99.0
9. 10 09910 CORF	0			0 0	0	
00.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	(0 0		100. C
D1. 00 10100 HOME HEALTH AGENCY	0			0 0		101. C
SPECIAL PURPOSE COST CENTERS			1			
D5. 00 10500 KIDNEY ACQUISITION	0	(0 0	0	105.0
D6. 00 10600 HEART ACQUI SI TI ON	0	(0 0	0	106. C
07.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.0
D8.00 10800 LUNG ACQUISITION	0	0		0 0		108.0
D9. 00 10900 PANCREAS ACQUISITION	0	()	0 0		109. (
IO. 00 11000 INTESTINAL ACQUISITION	0	(ן ע	0 0		110. C
11.00 11100 I SLET ACQUI SI TI ON	0	(ן ע	0 0	0	111. (
13.00 11300 INTEREST EXPENSE						113. (
14.00 11400 UTILIZATION REVIEW-SNF						114.0
15.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	(2	0 0		115. (
16. 00 11600 HOSPI CE	0			0 0		116. (
00.00 Subtotal (sum of lines 50 thru 199)	13, 206, 817					200.0
01.00 Less Observation Beds	658, 809				0	201.0
02.00 Total (line 200 minus line 201)	12, 548, 008	700, 566	11, 847, 44	42 0	0	202.

LCULATION OF OUTPATIENT SERVICE COST TO CHARGE F DUCTIONS FOR MEDICAID ONLY	ATIOS NET OF		CN: 15-0102	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part II Date/Time Prepare 5/31/2019 4:09 pt
Cost Costar Description	Coot Not of		e XIX	Hospi tal	PPS
Cost Center Description	Cost Net of Capital and	Total Charges (Worksheet C,		or	
	Operating Cost				
	Reduction	8)	/ col . 7)		
	6.00	7.00	8.00	-	
ANCILLARY SERVICE COST CENTERS					
00 05000 OPERATI NG ROOM	1, 786, 735	7, 719, 527	0. 23145	57	50
00 05100 RECOVERY ROOM	0	C	0.0000	00	51
00 05200 DELIVERY ROOM & LABOR ROOM	0	C	0.0000	00	52
00 05300 ANESTHESI OLOGY	377, 481	1, 493, 536	0. 25274	13	53
00 05400 RADI OLOGY-DI AGNOSTI C	1, 618, 108				54
01 05401 ULTRASOUND	169, 570	2, 925, 668			54
00 05500 RADI OLOGY-THERAPEUTI C	0	C			55
00 05600 RADI OI SOTOPE	105, 733				56
00 05700 CT SCAN	235, 724	9, 544, 128			57
00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	207, 900	2, 406, 716			58
00 05900 CARDI AC CATHETERI ZATI ON	0				59
	1, 704, 073				60
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 00 06400 INTRAVENOUS THERAPY	494	115, 123			62
00 06500 RESPIRATORY THERAPY	-	652, 692			65
00 06600 PHYSI CAL THERAPY	596, 814 757, 617	1, 840, 435			66
00 06700 OCCUPATIONAL THERAPY	0	1, 640, 435			67
00 06800 SPEECH PATHOLOGY	0		1		68
00 06900 ELECTROCARDI OLOGY	192, 209	885, 654			69
00 07000 ELECTROENCEPHALOGRAPHY	192,209	000,004			70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 554	515, 309	1		71
00 07200 I MPL. DEV. CHARGED TO PATIENTS	6,006		1		72
00 07300 DRUGS CHARGED TO PATIENTS	944, 878	7, 241, 660	1		73
00 07400 RENAL DIALYSIS	0	, 211, 000	1		74
00 07500 ASC (NON-DI STINCT PART)	0	C	1		75
00 03020 ACUPUNCTURE	0	C			76
OUTPATIENT SERVICE COST CENTERS	- I				
00 08800 RURAL HEALTH CLINIC	0	C	0.0000	00	88
00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0.0000	00	89
00 09000 CLINIC	4, 476	268	16. 70149	93	90
00 09100 EMERGENCY	3, 836, 636	13, 467, 847	0. 28487	74	91
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	658, 809	877, 679	0. 75062	26	92
OTHER REIMBURSABLE COST CENTERS					
00 09400 HOME PROGRAM DI ALYSI S	0	C			94
00 09500 AMBULANCE SERVICES	0	C			95
00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0.0000		96
00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	C	0.0000		97
00 09900 CMHC	0	C	0.0000		99
10 09910 CORF	0	C			99
D. 00 10000 I &R SERVICES-NOT APPRVD PRGM	0		0.00000		100
1.00 10100 HOME HEALTH AGENCY	0	C	0.0000	00	101
SPECIAL PURPOSE COST CENTERS 5. 00 10500 KI DNEY ACQUI SI TI ON	0		0.0000		105
5. 00 10600 HEART ACQUISITION	0		0.00000		105
7. 00 10700 LIVER ACQUISITION			0.00000		100
3. 00 10800 LUNG ACQUISITION			0.00000		108
9. 00 10900 PANCREAS ACQUISITION			0.00000		109
D. 0011000 INTESTINAL ACQUISITION	0		0.00000		110
1. 00 11100 I SLET ACQUI SI TI ON	0	r c	0.00000		111
3. 00 11300 I NTEREST EXPENSE			0.00000		113
4. 00 11400 UTI LI ZATI ON REVI EW-SNF					114
5. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C	0. 00000	00	115
5. 00 11600 HOSPI CE	0		0. 00000		116
D.00 Subtotal (sum of lines 50 thru 199)	13, 206, 817	68, 340, 116			200
1.00 Less Observation Beds	658, 809				201
2.00 Total (line 200 minus line 201)	12, 548, 008		1	1	202

Health Financial Systems	STARKE MEMORI			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	CCN: 15-0102	Period: From 01/01/2018 To 12/31/2018		pared: 9 pm
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cos	t		
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		•	·			
30. 00 ADULTS & PEDIATRICS	217, 695	(217, 6	95 1, 572	138.48	30.00
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	31.00
40. 00 SUBPROVIDER - IPF	0	(D	0 0	0.00	40.00
41.00 SUBPROVIDER - IRF	0	(D	0 0	0.00	41.00
43.00 NURSERY	0			0 0	0.00	43.00
200.00 Total (lines 30 through 199)	217, 695		217, 69	95 1, 572		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	740	102, 475	5			30.00
31.00 INTENSIVE CARE UNIT	0	(D			31.00
40. 00 SUBPROVIDER - IPF	0	(D			40.00
41.00 SUBPROVIDER - IRF	0	(D			41.00
43.00 NURSERY	0	(b			43.00
200.00 Total (lines 30 through 199)	740	102, 475	5			200. 00

Health Financial Systems	STARKE MEMORI	AL_HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0102	Period: From 01/01/2018 To 12/31/2018		
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		1	1		I	
50. 00 05000 OPERATI NG ROOM	216, 540	7, 719, 527				50.00
51.00 05100 RECOVERY ROOM	0					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0				-	52.00
53. 00 05300 ANESTHESI OLOGY	3, 078					1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	98, 258	5,047,227			1, 935	54.00
54. 01 05401 ULTRASOUND	2, 523	2, 925, 668			113	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0.0000		0	55.00
56. 00 05600 RADI 0I SOTOPE	990	122, 991	0.00804	49 0	0	56.00
57.00 05700 CT SCAN	16, 268	9, 544, 128	0. 00170	05 433, 174	739	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	30, 760	2, 406, 716	0. 0127	81 47, 503	607	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 0000	0 00	0	59.00
60. 00 06000 LABORATORY	74, 501	13, 194, 035	0. 0056	47 815, 342	4, 604	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	34	115, 123	0. 0002	95 24, 392	7	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0. 0000	0 00	0	64.00
65. 00 06500 RESPI RATORY THERAPY	25, 835	652, 692	0. 0395	32 286, 933	11, 357	65.00
66. 00 06600 PHYSI CAL THERAPY	55, 782	1, 840, 435	0. 0303	90, 627	2, 747	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	(0. 0000	0 00	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0. 0000	0 00	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	12,074	885, 654			1, 125	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0		0. 0000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	313	515, 309			48	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	252					
73.00 07300 DRUGS CHARGED TO PATIENTS	29, 913					1
74.00 07400 RENAL DIALYSI S	0					74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	c c			0	75.00
76. 00 03020 ACUPUNCTURE	0					1
OUTPATIENT SERVICE COST CENTERS	-	-			-	
88.00 08800 RURAL HEALTH CLINIC	0	(0.0000	0 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(-	89.00
90. 00 09000 CLINIC	43				-	90.00
91. 00 09100 EMERGENCY	133, 402				-	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	47,777					
OTHER REIMBURSABLE COST CENTERS	,,,,,	0.1,071	0.0011			1 00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0, 0000	0 00	0	94.00
95. 00 09500 AMBULANCE SERVICES				· · ·		95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	(0.0000	0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0.0000		0	97.00
200.00 Total (lines 50 through 199)	748, 343	68, 340, 116		3, 998, 487	-	
······································			1	-,, 10,	,	

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COST	rs Provider C		Peri od:	Worksheet D	
				From 01/01/2018	Part III	
				To 12/31/2018	Date/Time Pre 5/31/2019 4:0	pared:
		Title	e XVIII	Hospi tal	PPS	9 piii
Cost Center Description	Nursing School			Allied Health	All Other	
obst center beschiption	Post-Stepdown	Nul Sing School	Post-Stepdowr		Medi cal	
	Adjustments		Adjustments	0031	Education Cost	
	1A	1.00	2A	2,00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	I		1			
30. 00 03000 ADULTS & PEDIATRICS	0	C)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	C		0 0	0	31.00
40. 00 04000 SUBPROVI DER - I PF	0	C		o o	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	C		0 0	0	
43.00 04300 NURSERY	0	C		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	C		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)					
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	C	1, 57	2 0.00	740	30.00
31.00 03100 INTENSIVE CARE UNIT		C		0.00	0	31.00
40. 00 04000 SUBPROVIDER - IPF	0	C		0.00	0	40.00
41.00 04100 SUBPROVIDER – IRF	0	C		0.00	0	41.00
43. 00 04300 NURSERY		C		0.00	0	43.00
200.00 Total (lines 30 through 199)		C	1, 57	2	740	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	-					
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 I NTENSI VE CARE UNI T	0					31.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
41.00 04100 SUBPROVIDER - IRF	0					41.00
43.00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	STARKE MEMORI				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider CC		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2018 To 12/31/2018		narodi
				10 12/31/2010	5/31/2019 4:0	9 nm
		Title	XVIII	Hospi tal	PPS	<u>, bui</u>
Cost Center Description	Non Physician			Allied Health	Allied Health	
		Post-Stepdown	J	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	(0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	(0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	0	(0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
54. 01 05401 ULTRASOUND	0	0	(0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0			0	56.00
57. 00 05700 CT SCAN	0	0			0	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
	0	0				
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	(0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	(0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	(0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0	(0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	(0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	(0 0	0	75.00
76. 00 03020 ACUPUNCTURE	0	0	(0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	_					
88.00 08800 RURAL HEALTH CLINIC	0	0	(0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0 0	0	89.00
90. 00 09000 CLINIC	0	0	(0 0	0	90.00
91. 00 09100 EMERGENCY	0	0	(0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		(D	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0	(0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(0 0	0	96.00
90.00 U9000 DURADLE MEDICAL EQUIP-RENIED						
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0	0	(0 0	0	97.00

Health Financial Systems	STARKE MEMORI				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	ERVICE OTHER PAS	S Provider C	CN: 15-0102	Period: From 01/01/2018	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2018		pared.
				10 12/01/2010	5/31/2019 4:0	9 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
	4.00	F 00	and 4)	7.00	0.00	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00 05000 OPERATI NG ROOM	0	C		0 7, 719, 527	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0	-		0 7,719,527		1
52. 00 05200 DELIVERY ROOM & LABOR ROOM					0.000000	
53. 00 05300 ANESTHESI OLOGY	0			0 1, 493, 536		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 5, 047, 227		
54. 01 05401 ULTRASOUND	0			0 2, 925, 668		1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0 2, 723, 000	0.000000	1
56. 00 05600 RADI OLSOTOPE	0			0 122, 991	0.000000	
57. 00 05700 CT SCAN	0			0 9, 544, 128		1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 2, 406, 716		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0. 000000	
60. 00 06000 LABORATORY	0			0 13, 194, 035		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 115, 123		
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0		1
65. 00 06500 RESPI RATORY THERAPY	0			0 652, 692		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 840, 435		1
67.00 06700 OCCUPATI ONAL THERAPY	0	C)	0 0		
68.00 06800 SPEECH PATHOLOGY	0	c		0 0	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	c)	0 885, 654	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0)	0 0	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0 515, 309	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 289, 621	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 7, 241, 660	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0.000000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0.000000	75.00
76. 00 03020 ACUPUNCTURE	0	0		0 0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS		I	-	T	1	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-		0 0		
90. 00 09000 CLINIC	0	0		0 268		
91. 00 09100 EMERGENCY	0			0 13, 467, 847		1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 877, 679	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS		1	1	-		
94.00 09400 HOME PROGRAM DI ALYSI S	0	0	1	0 0	0.000000	
95. 00 09500 AMBULANCE SERVICES	_	_		-		95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	-		0 0		
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0. 000000	1
200.00 Total (lines 50 through 199)	0	0	1	0 68, 340, 116	I	200. 00

Health Financial Systems	STARKE MEMORIAI				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-0102	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Pre 5/31/2019 4:0	
		Title	XVIII	Hospi tal	PPS	<u>, biii</u>
Cost Center Description	Outpatient	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	5	Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	203, 874		0 1, 973, 884	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	50, 838		0 409, 903	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	99, 387		0 1, 462, 925	0	54.00
54.01 05401 ULTRASOUND	0. 000000	131, 120		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	433, 174		0 2, 827, 793	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	47, 503		0 715,029	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	815, 342		0 1, 904, 972	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	24, 392		0 39, 834	0	62.00
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	286, 933		61,961	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	90, 627		0 3, 325	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0,010		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	82, 516		0 571, 299	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	02,010		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	78, 781		0 101, 876	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	11, 309		0 88, 956	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	858, 260		0 1, 726, 615	0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	030, 200		0 1,720,013	0	74.00
75. 00 07500 ASC (NON-DI STI NCT PART)	0. 000000	0		0 0	0	75.00
76. 00 03020 ACUPUNCTURE	0. 000000	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0	/0.00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89.00
90. 00 09000 CLINIC	0. 000000	0		0 123	0	90.00
91. 00 09100 EMERGENCY	0. 000000	624, 838		0 3,007,214	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	159, 593		0 3,007,214	0	92.00
OTHER REIMBURSABLE COST CENTERS	0.000000	107, 070	<u> </u>	5 107, 325	0	, ,2.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0.000000	0		0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	97.00
200.00 Total (lines 50 through 199)	0.000000	3, 998, 487		0 15,063,034		200.00
	1	5, 770, 407	I	15,005,054	0	1200.00

PPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0102	Peri od:	Worksheet D	
					From 01/01/2018 To 12/31/2018	Date/Time Pre	
			Title	• XVIII	Hospi tal	5/31/2019 4:0 PPS	19 pm
				Charges	nospi tai	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed		(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS	0.001/57	1 070 001	1		454.040	1 - 0 - 04
	O OPERATING ROOM	0. 231457			0 0	456, 869	
	O RECOVERY ROOM	0. 000000			0 0		
	O DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	
	O ANESTHESI OLOGY	0. 252743			0 0	103, 600	
	0 RADI OLOGY-DI AGNOSTI C 1 ULTRASOUND	0. 320593			0 0	469, 004	
		0. 057959			0 0	0	
	0 RADI OLOGY-THERAPEUTI C 0 RADI OI SOTOPE	0. 859681	0		0 0 0 0		
	O CT SCAN	0. 859681	, v		0 0	69, 841	
	O MAGNETIC RESONANCE IMAGING (MRI)	0. 024698			0 0	61, 766	
9.00 0590	O CARDI AC CATHETERI ZATI ON	0. 000000			0 0	01,700	1
	O LABORATORY	0. 129155			0 0	246, 037	
	O WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 004291	39, 834		0 0	171	
	O I NTRAVENOUS THERAPY	0. 000000			0 0	0	
	0 RESPI RATORY THERAPY	0. 914388			0 0	56, 656	
	0 PHYSI CAL THERAPY	0. 411651	3, 325		0 0	1, 369	
	0 OCCUPATIONAL THERAPY	0. 000000			0 0	0	
	O SPEECH PATHOLOGY	0. 000000			0 0	0	
	0 ELECTROCARDI OLOGY	0. 217025			0 0	123, 986	
0.00 0700	0 ELECTROENCEPHALOGRAPHY	0.00000			0 0	0	70.0
1.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 006897	101, 876		0 0	703	71.0
2.00 0720	OIMPL. DEV. CHARGED TO PATIENTS	0. 020737			0 0	1, 845	72.0
	O DRUGS CHARGED TO PATIENTS	0. 130478	1, 726, 615		0 12, 735	225, 285	73.0
	O RENAL DI ALYSI S	0. 000000			0 0	0	74.0
	O ASC (NON-DISTINCT PART)	0. 000000			0 0	0	
	0 ACUPUNCTURE	0. 000000	0		0 0	0	76.0
	ATIENT SERVICE COST CENTERS						
	O RURAL HEALTH CLINIC	0. 000000				0	
	O FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
		16. 701493			0 0	2, 054	
	O EMERGENCY	0. 284874			0 0	856, 677	
	0 OBSERVATION BEDS (NON-DISTINCT PART)	0. 750626	167, 325		0 0	125, 598	92.00
	R REIMBURSABLE COST CENTERS	0,000000	1	1	0		
	0 HOME PROGRAM DI ALYSI S 0 AMBULANCE SERVI CES	0. 000000			0		94.0
	O DURABLE MEDICAL EQUIP-RENTED	0. 000000				0	95. 0 96. 0
	O DURABLE MEDICAL EQUIP-RENTED	0.000000					
00.00	Subtotal (see instructions)	0.00000	15, 063, 034		0 12, 735		
01.00	Less PBP Clinic Lab. Services-Program		15,005,034		0 12,735	2,001,401	200.0
01.00	Only Charges				0		201.00
	10	1	1	1	1	1	202.00

Health Financial Systems	STARKE MEMORI				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C	CN: 15-0102	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pre 5/31/2019 4:0	epared:)9 pm
		Title	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANCILLADY SEDVICE COST CENTERS	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0					51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
53. 00 05300 ANESTHESI OLOGY	0					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0					54.00
54. 01 05401 ULTRASOUND	0					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	-				55.00
56. 00 05600 RADI 0I SOTOPE	0					56.00
57. 00 05700 CT SCAN	0		•			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	-				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0					59.00
60. 00 06000 LABORATORY	0	-				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0					62.00
64.00 06400 INTRAVENOUS THERAPY	0					64.00
65. 00 06500 RESPIRATORY THERAPY	0					65.00
66. 00 06600 PHYSI CAL THERAPY	0					66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0	ol III III III III III III III III III I			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	(c				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	D			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 662	2			73.00
74.00 07400 RENAL DIALYSIS	0	0	D			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0					75.00
76.00 03020 ACUPUNCTURE	0	C				76.00
OUTPATIENT SERVICE COST CENTERS			1			_
88.00 08800 RURAL HEALTH CLINIC	0					88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-				89.00
90. 00 09000 CLINIC	0					90.00
91.00 09100 EMERGENCY	0					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	C	<u>л</u>			92.00
OTHER REI MBURSABLE COST CENTERS	0	0				04.00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0					94.00 95.00
95.00 09500 AMBULANCE SERVICES 96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0					95.00
97.00 09700 DURABLE MEDICAL EQUIP-RENTED	0	-				97.00
200.00 Subtotal (see instructions)	0	-				200.00
	0	1,002	-1			1200.00
	0					201 00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201.00

Health Financial Systems	STARKE MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	TAL COSTS	Provider C	-	Period: From 01/01/2018 To 12/31/2018		pared: 9 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	217, 695	0	217, 69	5 1, 572	138.48	30.00
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	31.00
40. 00 SUBPROVIDER - IPF	0	0		0 0	0.00	40.00
41.00 SUBPROVIDER - IRF	0	0		0 0	0.00	41.00
43.00 NURSERY	0			0 0	0.00	43.00
200.00 Total (lines 30 through 199)	217, 695		217, 69	5 1, 572		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	48	6, 647				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
40.00 SUBPROVIDER - IPF	0	0				40.00
41.00 SUBPROVIDER - IRF	0	0				41.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	48	6, 647				200.00

Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Total Charges (from Wkst. C, Part I, col. 26) Ratio of Cost to Charges (col. 1 + col. 2) Inpatient Program (col. 2) Capital Program (col. 2) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5 50.00 05000 OPERATING ROOM 0 05100 RECOVERY ROOM 0 05200 DELIVERY ROOM 0 05200 DELIVERY ROOM 0 05300 ANESTHESI OLOGY 54.00 216,540 0,5400 RADI OLOGY-DI AGNOSTIC 7,719,527 0,028051 0 0.028051 0 0,000000 0 0	heet D II Time Prepared 2019 4:09 pm PPS al Costs Jmn 3 x Jmn 4)
Cost Center Description Capital Related Cost (from Wkst. C, Part I, col. 26) Total Charges (from Wkst. C, Part I, col. 2) Ratio of Cost to Charges (col. 1 + col. 2) Inpatient Program (col. 1 + col. 2) Capital Program (col. 1 + col. 2) Capital Program (col. 1 + col. 2) Capital Program (col. 2) Capital Col (col. 2) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5 50.00 05000 OPERATING ROOM 216,540 7,719,527 0.028051 0 51.00 05100 RECOVERY ROOM 0 0 0 0.000000 0 52.00 05200 DELI VERY ROOM ANESTHESI OLOGY 3,078 1,493,536 0.002061 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 98,258 5,047,227 0.019468 378	al Costs umn 3 x umn 4)
ANCI LLARY SERVICE COST CENTERS Program (from Wkst. B, Part I, col. 2) Violation (from Wkst. B, Part I, col. 2) Program (col response) Col response (col response) Col response) Col response) Col response (col resp	umn 3 x umn 4)
ANCI LLARY SERVICE COST CENTERS (from Wkst. B, Part I, col. 2) (col. 1 ÷ col. 2) Charges col 1 4.00 2.00 3.00 4.00 5 50.00 05000 OPERATI NG ROOM 216,540 7,719,527 0.028051 0 51.00 05100 RECOVERY ROOM 0 0 0.000000 0 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0.000000 0 53.00 05300 ANESTHESI OLOGY 3,078 1,493,536 0.002061 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 98,258 5,047,227 0.019468 378	umn 4)
Part II, col. 8) 2) 0 26) 1.00 2.00 3.00 4.00 5 50.00 05000 OPERATI NG ROOM 216,540 7,719,527 0.028051 0 51.00 05100 RECOVERY ROOM 0 0 0.000000 0 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0.000000 0 53.00 05300 ANESTHESI OLOGY 3,078 1,493,536 0.002061 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 98,258 5,047,227 0.019468 378	
26) 1 26) 1 26) 1 26) 1 26) 1 26) 1 200 3.00 4.00 55 50.00 05000 OPERATI NG ROOM 0 0.008051 0 0 0 0.000000 0 51.00 05100 RECOVERY ROOM 0 0 0.000000 0 53.00 05300 ANESTHESI OLOGY 3,078 1,493,536 0.002061 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 98,258 5,047,227 0.019468 378 378	. 00
I.00 2.00 3.00 4.00 5 ANCI LLARY SERVICE COST CENTERS 50.00 05000 0PERATI NG ROOM 216,540 7,719,527 0.028051 0 51.00 05100 RECOVERY ROOM 0 0 0.000000 0 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0.000000 0 53.00 05300 ANESTHESI OLOGY 3,078 1,493,536 0.002061 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 98,258 5,047,227 0.019468 378	. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 216, 540 7, 719, 527 0. 028051 0 51. 00 05100 RECOVERY ROOM 0 0 0.000000 0 52. 00 05200 DELI VERY ROOM 0 0 0.000000 0 53. 00 05300 ANESTHESI OLOGY 3, 078 1, 493, 536 0. 002061 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 98, 258 5, 047, 227 0. 019468 378	. 00
50. 00 05000 0PERATI NG ROOM 216, 540 7, 719, 527 0. 028051 0 51. 00 05100 RECOVERY ROOM 0 0 0 0 0 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 53. 00 05300 ANESTHESI OLOGY 3, 078 1, 493, 536 0. 002061 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 98, 258 5, 047, 227 0. 019468 378	
51.00 05100 RECOVERY ROOM 0 0.000000 0 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0.000000 0 53.00 05300 ANESTHESI OLOGY 3,078 1,493,536 0.002061 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 98,258 5,047,227 0.019468 378	
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0.000000 0 53.00 05300 ANESTHESI OLOGY 3,078 1,493,536 0.002061 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 98,258 5,047,227 0.019468 378	0 50.0
53. 00 05300 ANESTHESI OLOGY 3, 078 1, 493, 536 0. 002061 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 98, 258 5, 047, 227 0. 019468 378	0 51.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C 98, 258 5, 047, 227 0. 019468 378	0 52.0
	0 53.0
	7 54.0
54. 01 05401 ULTRASOUND 2, 523 2, 925, 668 0.000862 5, 811	5 54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0.000000 0	0 55.0
56. 00 05600 RADI 0I SOTOPE 990 122, 991 0. 008049 0	0 56.0
57. 00 05700 CT_SCAN 16, 268 9, 544, 128 0. 001705 4, 222	7 57.0
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 30,760 2,406,716 0.012781 0	0 58.0
59. 00 05900 CARDI AC_CATHETERI ZATI ON 0 0 0.000000 0	0 59.0
60. 00 06000 LABORATORY 74, 501 13, 194, 035 0. 005647 7, 690	43 60.0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 34 115,123 0.000295 0	0 62.0
64. 00 06400 I NTRAVENOUS THERAPY 0 0 0.000000 0	0 64.0
65.00 06500 RESPI RATORY THERAPY 25,835 652,692 0.039582 210	8 65.0
66.00 06600 PHYSI CAL THERAPY 55, 782 1, 840, 435 0. 030309 0	0 66.0
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0.000000 0	0 67.0
68. 00 06800 SPEECH PATHOLOGY 0 0 0.000000 0	0 68.0
69. 00 06900 ELECTROCARDI OLOGY 12, 074 885, 654 0. 013633 419	6 69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0	0 70.0
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 313 515, 309 0.000607 0	0 71.0
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 252 289, 621 0. 000870 0	0 72.0
73. 00 07300 DRUGS CHARGED TO PATIENTS 29, 913 7, 241, 660 0. 004131 14, 562	60 73.0
74. 00 07400 RENAL DI ALYSI S 0 0 0.000000 0	0 74.0
75.00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 0	0 75.0
76.00 03020 ACUPUNCTURE 0 0 0.000000 0	0 76.0
OUTPATIENT SERVICE COST CENTERS	
88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0	0 88.0
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0	0 89.0
90.00 09000 CLINIC 43 268 0.160448 0	0 90.0
91. 00 09100 EMERGENCY 133, 402 13, 467, 847 0. 009905 5, 682	56 91.0
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 47, 777 877, 679 0. 054436 2, 403	131 92.0
OTHER REIMBURSABLE COST CENTERS	
94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0.000000 0	0 94.0
95.00 09500 AMBULANCE SERVICES	95.0
96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0.000000 0	0 96.0
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0.000000 0	0 97.0
200.00 Total (lines 50 through 199) 748,343 68,340,116 41,377	323 200. 0

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	ER PASS THROUGH COST	rs Provider C		Period: From 01/01/2018	Worksheet D Part III	
				To 12/31/2018		pared: 9 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown	-	Post-Stepdowr	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	C)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	C		0 0	0	31.00
40. 00 04000 SUBPROVIDER - IPF	0	C		o o	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0		0 0	0	
43.00 04300 NURSERY	0	0		0	0	
200.00 Total (lines 30 through 199)	0	0			-	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
Cost Center Description	Adjustment	(sum of cols.	Days	$5 \div col. 6$	Program Days	
	Amount (see	1 through 3,	Days	5 . cor. o)	riogram bays	
	i nstructi ons)					
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1, 57	2 0.00	48	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		1, 37	0.00		
40. 00 04000 SUBPROVI DER – I PF	0	0		0.00		1
41. 00 04100 SUBPROVI DER - I RF	0			0.00	0	
	0				-	
43. 00 04300 NURSERY		U		0.00		
200.00 Total (lines 30 through 199)		0	1, 57	2	48	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	<u>col. 8)</u>					
INDATIENT DOUTINE CEDVICE COCT CENTERC	9.00		-			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						00.00
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
41.00 04100 SUBPROVIDER – IRF	0					41.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2018 To 12/31/2018		narad
				10 12/31/2016	5/31/2019 4:0	pareu. 9 nm
		Titl	e XIX	Hospi tal	PPS	<u>, bui</u>
Cost Center Description	Non Physician			Allied Health		
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 05401 ULTRASOUND	0	0		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	C		0 0	0	56.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
76. 00 03020 ACUPUNCTURE	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS				_		
88.00 08800 RURAL HEALTH CLINIC	0	C		0 0	-	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	, o	89.00
90. 00 09000 CLINIC	0	C		0 0	0	90.00
91.00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			C	0	92.00
OTHER REIMBURSABLE COST CENTERS	1		1	1	1	
94.00 09400 HOME PROGRAM DI ALYSI S	0	C		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0	0	97.00
200.00 Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

Health Financial Systems	STARKE MEMORI				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0102	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	
		Ti +1	e XIX	Hospi tal	5/31/2019 4:0 PPS	9 pili
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
cost center bescription	Medi cal	(sum of cols.	Outpatient			
	Educati on Cost		Cost (sum o		$(col. 5 \div col.$	
		4)	col s. 2, 3,		7)	
		.,	and 4)	0)		
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS		1	-		-	
50.00 05000 OPERATING ROOM	0	0		0 7, 719, 527	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 1, 493, 536	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 5, 047, 227	0.000000	54.00
54. 01 05401 ULTRASOUND	0	0		0 2, 925, 668	0.000000	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0.000000	55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 122, 991	0. 000000	56.00
57.00 05700 CT SCAN	0	0		0 9, 544, 128	0. 000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0 2, 406, 716	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0. 000000	59.00
60. 00 06000 LABORATORY	0	C		0 13, 194, 035	0. 000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	c c		0 115, 123	0. 000000	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 652, 692	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0			0 1, 840, 435	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0			0 0	0. 000000	
68.00 06800 SPEECH PATHOLOGY	0			0 0	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0			0 885, 654	0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 515, 309	0. 000000	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 289, 621	0. 000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0 7, 241, 660	0. 000000	73.00
74. 00 07400 RENAL DI ALYSI S	0			0 0	0. 000000	74.00
75.00 07500 ASC (NON-DI STINCT PART)	0			0 0	0. 000000	
76.00 03020 ACUPUNCTURE	0	-		0 0	0.000000	
OUTPATIENT SERVICE COST CENTERS				<u> </u>	0.000000	10100
88.00 08800 RURAL HEALTH CLINIC	0	C		0 0	0.000000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l d)	0 0	0.000000	89.00
90. 00 09000 CLINIC	0	l d)	0 268	0.000000	90,00
91. 00 09100 EMERGENCY	0	0		0 13, 467, 847	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 877, 679	0. 000000	92.00
OTHER REI MBURSABLE COST CENTERS		-	1			
94. 00 09400 HOME PROGRAM DI ALYSI S	0	C		0 0	0.000000	94.00
95. 00 09500 AMBULANCE SERVICES	1					95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0.000000	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	-		0 0	0. 000000	97.00
200.00 Total (lines 50 through 199)	0			0 68, 340, 116		200.00
	1 0		1		I	

	ncial Systems	STARKE MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTI ONME THROUGH COS	NT OF INPATIENT/OUTPATIENT ANCILLARY SEI TS	RVICE OTHER PASS	Provider C	CN: 15-0102	Period: From 01/01/2018 To 12/31/2018		nared [.]
					10 12/01/2010	5/31/2019 4:0	
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	LARY SERVICE COST CENTERS			1			
	OPERATING ROOM	0.00000	0		0 0		
	RECOVERY ROOM	0.00000	0		0 0	-	
	DELIVERY ROOM & LABOR ROOM	0.00000	0		0 0	0	52.00
	ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
	RADI OLOGY-DI AGNOSTI C	0. 000000	378		0 0	0	54.00
	ULTRASOUND	0. 000000	5, 811		0 0	0	
	RADI OLOGY-THERAPEUTI C	0.000000	0		0 0	0	
	RADI OI SOTOPE	0. 000000	0		0 0	0	
	CT SCAN	0. 000000	4, 222		0 0		
	MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	
	CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
	LABORATORY	0. 000000	7, 690		0 C	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 C	0	62.00
64.00 06400	INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
	RESPI RATORY THERAPY	0. 000000	210		0 0	0	65.00
66.00 06600	PHYSI CAL THERAPY	0. 000000	0		0 0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69.00 06900	ELECTROCARDI OLOGY	0. 000000	419		0 0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
	IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0. 000000	14, 562		0 0	0	73.00
74.00 07400	RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
76.00 03020	ACUPUNCTURE	0. 000000	0		0 0	0	76.00
OUTPA	TIENT SERVICE COST CENTERS					-	
88.00 08800	RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89.00
90.00 09000		0. 000000	0		0 0	0	90.00
91.00 09100	EMERGENCY	0. 000000	5, 682		0 0	0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2, 403		0 0	0	92.00
	REIMBURSABLE COST CENTERS					1	
	HOME PROGRAM DI ALYSI S	0.000000	0		0 C	0	
	AMBULANCE SERVICES						95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0		0 0		96.00
	DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0		
200.00	Total (lines 50 through 199)		41, 377	1	0 0	I 0	200.00

51.00 05100 RECOVERY ROOM 0	Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
Unit of the set of th	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0102	From 01/01/2018	Part V Date/Time Pre	epared:
Cost Center Description Cost to Charges Ratio From Worksheet C, Part I, col. 9 Cost to Charges Cost Services (see inst.) Cost Cost Services (see Services (see inst.) Cost Cost Services (see Services (see Services (see inst.) 05000 05000 0064.8 Coins, Services (see Services (0. VI V	lleonitel		19 pm
Cost Conter Description Cost to Charge PPS Rel nbursed Worksheet C, Part I, col. 9 Cost cost Rel nbursed Subject To Ded. & Coins. Cost Rel nbursed Subject To Ded. & Coins. PPS Services (see inst.) PPS Services Subject To Ded. & Coins. PPS Services Services (see inst.) PPS Services Subject To Ded. & Coins. PPS Services Subject To Ded. & Coins. 50.00 D65000 (PERAITIGE ROM DESCOMPERATION COMM 0.20000 0					HOSPITAL	1	
Ratio From Part I, col. Services (see inst.) Reinbursed Services (see sources to subject To bed, & Coins. Reinbursed Services (see inst.) Reinbursed Services (see sources to subject To bed, & Coins. (see inst.) 50:00 05000 (PERATI NC ROOM 0.231457 0 0 6.00 5.00 50:00 05000 (PERATI NC ROOM 0.231457 0 0 6.00 0 5.00 50:00 05000 (PERATI NC ROOM 0.231457 0 0 6.00 0 5.00 50:00 05000 ARESTHESI OLOGY 0.252743 0 0 11.221 6.30 50:00 05600 ARUILLEY KOWA & LABOR ROOM 0.257733 0 0 11.8,734 0.54.00 50:00 05600 ARUILLEY KOWA & LABOR ROOM 0.256793 0 0 0 55.00 50:00 05600 ARUILLEY KOWA & LABOR ROOM 0.264793 0 0 0 55.00 50:00 05600 ARUILLEY KOWA & LABOR ROMA 0.024648 0 0 2.66.23 65.00 50:00 05600 ARUILLEY KOWA & LABOR ROMA 0.124548	Cost Center Description	Cost to Charge	DDS Daimbursad		Cost		
Worksheet C, Part I, col. 9 inst.)* Services Subject To Ded. & Colns. (see inst.) Services Subject To Ded. & Colns. (see inst.) MCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 QPERATING ROOM 0.231457 0 0 668,653 0 50.00 05200 QPERATING ROOM 0.000000 0 0 65.00 55.00 51.00 05100 QNESTOPE NOM 0.000000 0 0 65.00 55.00 52.00 05200 QHELIVERY ROOM & LADOR ROOM 0.000000 0 0 148,734 054.00 51.00 05400 RADI (LOGY - HERAPEUTI C 0.000000 0 0 55.00	cost center bescription						
Part I., col. 9 Subject To Ded. & Coins. 1.00 2.00 3.00 4.00 5.00 50.00 05000 (PEERATINE ROOM 0.231457 0 0 68,653 0 50.00 51.00 05100 (RECOVERY ROM 0.000000 0 0 0 52.00 51.00 05100 (RECOVERY ROM 0.223743 0 0 11.221 0 53.00 52.00 05200 (ARDIOLGOV-THERAPEUTIC 0.325938 0 0 14,734 0 54.01 54.01 05401 (SATINES) LOCY 0.252743 0 0 16.00 0 55.00 50.01 05401 (SATINES) LOCY 0.2550789 0 0 16.00 0 55.00 50.01 05500 (RADIOSOT-THERAPEUTIC 0.000000 0 0 0 0 55.00 50.00 05500 (RADIOSOT-THERAPEUTIC 0.000000 0 0 0 65.00 55.00 50.00 05500 (RADIOSOT-THERAPEUTIC 0.0000000 0 0 <							
Dect. % Coins. Dect. % Coins							
Inclutary SERVICE COST CENTERS (see inst.) (see inst.) (see inst.) (see inst.) ANCILLARY SERVICE COST CENTERS 0 0.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 0 0 66.653 0 5.00 51.00 05100 RECOVERY ROOM 0.231457 0 0 66.653 0 5.00 52.00 05300 AMESTHESI OLGAY 0.252743 0 11.221 0 53.00 53.00 05300 AMESTHESI OLGAY 0.252933 0 11.48.734 0.54.00 55.00 05600 RADI OLSOTY-THERAPEUTI C 0.000000 0 0 55.00 56.00 05600 RADI OLSOTY-THERAPEUTI C 0.000000 0 0 55.00 50.00 05600 RADI OLSOTY-THERAPEUTI C 0.000000 0 0 55.00 50.00 05600 RADI OLSOTY-THERAPEUTI C 0.000000 0 0 55.00 50.00 05600 RADI OLSOTY-THERAPEUTI C 0.000000 0 0 55.00 50.00 05600 RADI					-		
ANCILLARY SERVICE COST CENTERS 0 3.00 4.00 5.00 50.00 05000 (DPECATI NG ROOM 0.231457 0 0 66.63 0 50.00 50.00 05200 (DPECATI NG ROOM 0.000000 0 0 0 51.00 51.00 05200 (DELUYERY ROOM ALBOR ROOM 0.000000 0 0 0 53.00 53.00 05300 (RADI LOGY 0.252743 0 0 148.734 0 54.00 54.00 05400 (RADI LOGY - HERAPEUTI C 0.000000 0 0 0 55.00 55.00 05500 (RADI LOGY - HERAPEUTI C 0.000000 0 0 0 0 55.00 50.00 05600 (RADI LOGY - HERAPEUTI C 0.000000 0 0 0 0 55.00 50.00 05600 (RADI LOGY - HERAPEUTI C 0.000000 0 0 0 0 55.00 50.00 05600 (RADI LOGY - HERAPEUTI C 0.000000 0 0 0 56.00 55.00							
AKCILLARY SERVICE COST CENTERS 0.00 05000 000000 0 68.653 0 50.0 51.00 05000 000000 0 0 0 0 51.00 05000 000000 0 0 0 52.00 05200 05200 05200 05200 05200 0 0 0 0 0 0 52.00 05200 0 0 0 0 53.00 0 0 11.221 0 53.00 0 0.00 0 0 54.01 0.00 0 0 55.00 0 0.00 0 0 55.00 0 56.00 0 0.00 0 0 55.00 0 0.00 0 0 55.00 0 0.00000 0 0 0 55.00 0 0.00000 0 0 0 55.00 0 0.00000 0 0 0 0.00000 0 0 0.00000 0 0 0.		1.00	2.00			5.00	
50.00 05000 0FC0VERY ROM 0.231457 0 0 66.853 0 50.00 51.00 05100 05200 0 0 0 0 51.00 52.00 05200 DELIVERY ROM & LABOR ROM 0.000000 0 0 0 53.00 53.00 05300 ANESTHESILOLOGY 0.252743 0 0 148,734 0 54.00 54.00 05400 RADIOLOGY-THERAPEUTIC 0.000000 0 0 0 55.00 05500 RADIOLOGY-THERAPEUTIC 0.024698 0 0 0 55.00 05600 RADIOLOGY-THERAPEUTIC 0.0264698 0 0 268.02 0 57.00 50.00 05500 RADIOLOGY-THERAPEUTIC 0.0264698 0 0 268.02 0 57.00 50.00 05600 RADIOLOGY-THERAPEUTIC 0.0264969 0 0 0 0 57.00 50.00 05600 RADIOLOGY-THERAPEUTIC 0.000000 0	ANCI LLARY SERVI CE COST CENTERS						
52:00 05200 DELIVERY ROM & LABOR ROM 0.000000 0 0 0 0 53:0 50:00 05300 ANESTHESILOGY 0.252743 0 0 11,221 0 53:0 54:00 05400 RADILOGY-DIAGNOSTIC 0.320593 0 0 0 0 54:0 55:00 05500 05000 C0 0 0 0 55:0 05:00 05000 CADOCT THERAPEUTIC 0.000000 0 0 0 55:0 05:00 05000 05600 05600 0 0 0 55:0 0 0 0 0 0 57:0 0		0. 231457	0		0 68, 653	0	50.00
53:00 05300 ANESTHESI OLOGY 0.252743 0 0 11, 221 0 53.00 54:00 05400 ANDIOLOGY-THEAPEUTIC 0.320593 0 0 0 0 54.01 55:00 05500 RADIOLOGY-THEAPEUTIC 0.000000 0 0 0 55.00 55:00 05500 RADIOLOGY-THEAPEUTIC 0.000000 0 0 0 55.00 05:00 05000 RADIOLOGY-THEAPEUTIC 0.000000 0 0 55.00 05:00 05000 GADIOLACCATHETERIZATION 0.024698 0 26.8, 42.3 0 57.00 05:00 05000 CARDIA CATHETERIZATION 0.000000 0 0 424.378 0 60.00 06:00 06000 0.00000 0 0 0 64.00 64.00 64.00 64.00 64.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00	51.00 05100 RECOVERY ROOM	0.000000	0 0		0 0	0	51.00
53:00 05300 ANESTHESI OLOGY 0.252743 0 0 11, 221 0 53.00 54:00 05400 ANDIOLOGY-THEAPEUTIC 0.320593 0 0 0 0 54.01 55:00 05500 RADIOLOGY-THEAPEUTIC 0.000000 0 0 0 55.00 55:00 05500 RADIOLOGY-THEAPEUTIC 0.000000 0 0 0 55.00 05:00 05000 RADIOLOGY-THEAPEUTIC 0.000000 0 0 55.00 05:00 05000 GADIOLACCATHETERIZATION 0.024698 0 26.8, 42.3 0 57.00 05:00 05000 CARDIA CATHETERIZATION 0.000000 0 0 424.378 0 60.00 06:00 06000 0.00000 0 0 0 64.00 64.00 64.00 64.00 64.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00	52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0 0		0 0	0	52.00
54.00 05400 RADIOLOGY-DIACNOSTIC 0.320593 0 148,734 0 54.00 54.01 05401 ULTRASOUND 0.057959 0 0 0 55.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0.000000 0 0 0 55.00 56.00 05600 RADIOLOGY-THERAPEUTIC 0.000000 0 0 55.00 57.00 05700 CT CAN 0.024698 0 268.423 0.57.00 57.00 05700 CARDIAC CATHETERIZATION 0.000000 0 0 0 58.00 50.00 05000 MHOLE BLOOD & PACKED RED BLOOD CELLS 0.004291 0 0 0 62.00 60.00 06400 INTRAVENOUS THERAPY 0.914388 0 9.060 0 66.00 61.00 06600 PHSICAL THERAPY 0.010000 0 0 0 66.00 62.00 06200 CCUPATIONAL THERAPY 0.010000 0 0 0 67.00 63.00 06600 PHSICAL THERAPY 0.0100000 0 0					0 11, 221	0	53.00
54.01 054.01 ULTRASOUND 0.077959 0 0 0 0 55.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0.000000 0 0 0 55.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0.020000 0 0 0 55.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0.024968 0 268, 423 0 55.00 50.00 05900 CARDIAC CATHETERIZATION 0.000000 0 424, 378 0 60.00 60.00 06000 INTRAVEOUND THERAPY 0.91129155 0 424, 378 0 60.00 60.00 06000 INTRAVEOUND THERAPY 0.914388 0 9,066 65.00 61.00 06600 PHYSICAL THERAPY 0.011651 0 0 67.00 67.00 61.00 06600 PHYSICAL THERAPY 0.914388 0 9,066 65.00 66.00 06600 PHYSICAL THERAPY 0.01116151 0 67.00							
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56.00 056.00 RADIOLISOTOPE 0.859681 0 0 0 0 57.00 57.00 05700 CTSCAN 0.024698 0 0 268.423 0 57.00 58.00 05900 CARDIAC CATHETERIZATION 0.004098 0 0 0 0 0 0 58.00 60.00 06000 LABORATORY 0.129155 0 0.424,378 0 60.00 66.00 60.00 INTRAVENDUS THERAPY 0.914388 0 0 9.660 65.00 66.00 67.00 68.073 68.073 68.073 68.073 69.07 70.00 70.00 70.00 70.00 70.00 71.00 71.00 71.00						-	
57.00 057.00 CT SCAN 0.024698 0 268.423 0 57.00 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0.086383 0 45.658 0 58.00 60.00 05800 CARDI AC CATHETERI ZATION 0.000000 0 0 0 0 59.00 60.00 06000 LABORATORY 0.129155 0 424.378 0 60.00 06400 INTRAVENOUS THERAPY 0.000000 0 0 0 62.0 06500 RESPI RATORY THERAPY 0.914388 0 9,0660 64.00 66.00 65.00 66.00 66.00 66.00 66.00 65.07 66.00 66.00 67.00 0 0 0 66.00 66.00 67.00 0 66.00 67.00 0 66.00 68.073 6 67.00 67.00 67.00 67.00 67.00 67.00 67.00 70.00 71.00 70.00 71.00 70.00 71.00 71.00					-	-	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.066383 0 45,658 0 58.00 59.00 05900 CARDIA C CATHETERIZATION 0.000000 0 0 0 59.00 60.00 06000 LABORATORY 0.129155 0 0424,378 06.00 0					0 268 423	-	
59.00 05900 CARDIAC CATHETERIZATION 0.000000 0							
60.00 06000 LABRATORY 0.129155 0 424,378 0 60.00 62.00 06200 WHOLE BLOOD & PACKD RED BLOOD CELLS 0.004291 0 0 0 62.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 0 0 64.00 65.00 06500 PESPI RATORY THERAPY 0.914388 0 9,060 65.00 66.00 06600 PHSI CAL THERAPY 0.11251 0 0 0 66.00 66.00 06000 PHSI CAL THERAPY 0.100000 0 0 0 67.00 67.00 06700 0CUPATI ONAL THERAPY 0.000000 0 0 0 67.00 68.00 06900 ELECTROCRABI OLOGY 0.217025 0 0 32.433 0 71.00 71.00 07100 IMEL ALS CRABED TO PATI ENTS 0.020737 0 0 4.433 0 72.00 73.00 07300 RUGS CHARGED TO PATI ENTS 0.000000	59. 00 05900 CARDI AC CATHETERI ZATI ON						
62.00 0k200 WHOLE BLODD & PACKED RED BLODD CELLS 0.004291 0 <					0 424.378	-	
64.00 06400 INTRAVENOUS THERAPY 0.00000 0							
65:00 06500 RESPI RATORY THERAPY 0.914388 0 0 9,060 0 65:00 66:00 06600 PHYSI CAL THERAPY 0.0411651 0 0 66:00 0 66:00 0 0 0 0 67:00 0 0 0 0 0 0 67:00 0					0 0	-	
66.00 06600 PHYSI CAL THERAPY 0.411651 0 0 86,073 0 66.00 67.00 06700 0CCUPATIONAL THERAPY 0.000000 0 0 0 67.00 0 0 0 0 67.00 0 0 0 0 0 67.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 68.00 0							65.00
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69:00 06900 ELECTROCARDIOLOGY 0.217025 0 32,433 0 69.00 70:00 07000 ELECTROENCEPHALOGRAPHY 0.00000 0 0 0 70.00 071:00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.006897 0 0 78.65 0 71.00 71:00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.020737 0 0 4,433 0 72.00 73:00 07300 DRUGS CHARGED TO PATIENTS 0.130478 0 0 117,000 0 73.00 74:00 07400 RENAL DI ALYSI S 0.000000 0 0 0 74.00 75.00 75.00 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 0 75.00 76.00 0 0 0 0 76.00 76.00 03020 ACUPUNCTURE 0.000000 0 0 0 0 0 0 0 0 0 0 0 0						-	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 70.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.006897 0 7.865 0 71.00 72.00 07300 MPL. DEV. CHARGED TO PATI ENTS 0.020737 0 0 4.433 0 72.00 73.00 07400 RENAL DI ALYSI S 0.130478 0 0 117.000 0 73.00 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 74.00 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 0 75.00 002020 ACUPUNCTURE 0.000000 0 0 0 75.00 01000 B800 RURAL HEALTH CLINIC 0.000000 0 0 88.00 08000 FEDERALLY QUALI FI ED HEALTH CENTER 0.000000 0 0 90.00 90.00 09100 EMERGENCY 0.284874 0 0 074,025 0						0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.006897 0 7,865 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.020737 0 0 4,433 0 72.00 73.00 07400 RENAL DI ALYSI S 0.130478 0 0 117,000 73.00 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 0 75.00 75.00 76.00 03202 ACUPUNCTURE 0.000000 0 0 0 75.00 76.00 01202 ACUPUNCTURE 0.000000 0 0 0 0 76.00 02800 RERALLY QUALI FIED HEALTH CENTER 0.000000 0 0 0 88.00 88.00 89.00 89.00 99.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00			-				
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OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 89.00 90.00 09000 CLINIC 16.701493 0 0 0 90.00 91.00 09100 EMERGENCY 0.284874 0 0 704,025 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.750626 0 0 10,205 0 92.00 07100 HER REIMBURSABLE COST CENTERS 0.000000 0 0 94.00 95.00 9500 AMBULANCE SERVICES 94.00 95.00 95.00 96.00 95.00 96.00 96.00 96.00 95.00 97.00 <td></td> <td></td> <td></td> <td></td> <td>0 0</td> <td>0</td> <td>76.00</td>					0 0	0	76.00
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90.00 09000 CLINIC 16.701493 0 0 0 90.00 90.00 91.00 09100 EMERGENCY 0.284874 0 0 704,025 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.750626 0 0 10,205 0 92.00 0THER REI MBURSABLE COST CENTERS 0 0 0 0 92.00 95.00 9600 HOME PROGRAM DIALYSIS 0.000000 0 95.00 95.00 9500 AMBULANCE SERVICES 0.000000 0 95.00 96.00 96.00 96.00 96.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 0 0 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00						0	89.00
91.00 09100 EMERGENCY 0.284874 0 0 704,025 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.750626 0 0 10,205 0 92.00 0THER REI MBURSABLE COST CENTERS 0.000000 0 0 94.00 95.00 9500 AMBULANCE SERVICES 0.000000 0 95.00 95.00 95.00 95.00 96.00 0 0 95.00 95.00 96.00 0 0 95.00 96.00 97.00 0.000000 0 0 95.00 96.00 97.00 0.000000 0 0 96.00 97.00 97.00 0.000000 0 0 96.00 97.00 0.000000 0 0 97.00 97.00 0 0 97.00 0 0 97.00 0 0 0 97.00 97.00 0 0 97.00 0 0 97.00 97.00 0 0 97.00 0 0 0 0 0 0 0 0 0 0					0 0	0	90.00
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96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 96.00 96.00 97.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 0 0 0 97.00 97.00 00 0 0 97.00 97.00 97.00 00 0 0 97.00					0		95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 0 0 0 97. 00 200. 00 Subtotal (see instructions) 0 0 0 1, 938, 161 0 200. 00 201. 00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 0 0 201. 00					0 0	0	96.00
200.00 Subtotal (see instructions) 0 0 1,938,161 0 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 0 201.00					0 0	0	
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges 0 0 201.00		1	0		0 1, 938, 161		
Only Charges		1					201.00
202.00 Net Charges (line 200 - line 201) 0 0 1,938,161 0202.00	5						
	202.00 Net Charges (line 200 - line 201)		0		0 1, 938, 161	0	202.00

	ancial Systems ENT OF MEDICAL, OTHER HEALTH SERVICES AND	STARKE MEMORI			CN: 15-0102	Peri od:	u of Form CMS Worksheet D	-2332-10
		WROOTHE COST		i ovruer o	SN. 15 0102	From 01/01/2018 To 12/31/2018	Part V Date/Time Pr 5/31/2019 4:	
				Ti tl	e XIX	Hospi tal	PPS	
		Cos	sts			- I		
	Cost Center Description	Cost	1	Cost				
		Reimbursed	Rei	mbursed				
		Servi ces	Serv	ices Not				
		Subject To		ject To				
		Ded. & Coins.		& Coins.				
		(see inst.)		e inst.)				
		6.00		7.00				
	LLARY SERVICE COST CENTERS		1		1			
	O OPERATING ROOM	0		15, 890				50.00
	O RECOVERY ROOM	0		0				51.00
	O DELIVERY ROOM & LABOR ROOM	0		0				52.00
	0 ANESTHESI OLOGY	0		2, 836				53.00
	0 RADI OLOGY-DI AGNOSTI C	0)	47, 683				54.00
	01 ULTRASOUND	0)	0				54.01
	0 RADI OLOGY-THERAPEUTI C	0)	0				55.00
	0 RADI OI SOTOPE	0)	0				56.00
57.00 0570	0 CT SCAN	0)	6, 630				57.00
	OMAGNETIC RESONANCE IMAGING (MRI)	0)	3, 944				58.00
	O CARDI AC CATHETERI ZATI ON	0)	0				59.00
	0 LABORATORY	0)	54, 811				60.00
	0 WHOLE BLOOD & PACKED RED BLOOD CELLS	0)	0				62.00
	0 INTRAVENOUS THERAPY	0)	0				64.00
	0 RESPI RATORY THERAPY	0)	8, 284				65.00
	0 PHYSI CAL THERAPY	0	1	35, 432				66.00
	O OCCUPATI ONAL THERAPY	0		0				67.00
	0 SPEECH PATHOLOGY	0		0				68.00
	0 ELECTROCARDI OLOGY	0)	7, 039				69.00
	0 ELECTROENCEPHALOGRAPHY	0		0				70.00
	OMEDICAL SUPPLIES CHARGED TO PATIENTS	0)	54				71.00
	O IMPL. DEV. CHARGED TO PATIENTS	0		92				72.00
	O DRUGS CHARGED TO PATIENTS	0		15, 266				73.00
	0 RENAL DIALYSIS	0		0				74.00
	O ASC (NON-DISTINCT PART)	0		0				75.00
		0)	0				76.00
	ATIENT SERVICE COST CENTERS				1			
	0 RURAL HEALTH CLINIC	0		0				88.00
	0 FEDERALLY QUALIFIED HEALTH CENTER	0		0				89.00
	O CLINIC	0		0				90.00
	O EMERGENCY	0		200, 558				91.00
	0000BSERVATION BEDS (NON-DISTINCT PART)	0)	7, 660				92.00
	R REIMBURSABLE COST CENTERS				1			-
	O HOME PROGRAM DI ALYSI S	0		0				94.00
	0 AMBULANCE SERVICES	0						95.00
	O DURABLE MEDICAL EQUIP-RENTED	0		0				96.00
	DO DURABLE MEDICAL EQUIP-SOLD	0		0				97.00
200.00	Subtotal (see instructions)	0		406, 179				200.00
201.00	Less PBP Clinic Lab. Services-Program	0	2					201.00
	Only Charges			404 470				
202.00	Net Charges (line 200 - line 201)	0	7	406, 179				202.00

	Financial Systems STARKE MEMORIAL HO ATION OF INPATIENT OPERATING COST F	Provider CCN: 15-0102	Period: From 01/01/2018	u of Form CMS-2 Worksheet D-1	
		T: +1	To 12/31/2018	Date/Time Prep 5/31/2019 4:00	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS		1		
1.00 2.00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be	0		1, 572 1, 572	
2.00 3.00	Private room days (excluding private room days, excluding swing-be		rivate room days,	1, 572	
4.00	do not complete this line.	dava	-	1 007	4.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		er 31 of the cost	1, 227 0	
(00	reporting period		21 -6		
6.00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7.00
8.00	reporting period Total swing-bed NF type inpatient days (including private room	days) after December 3	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)			7.10	
9.00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	740	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	0	10.00
11.00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII on		room davs) after	0	11.00
10.00	December 31 of the cost reporting period (if calendar year, ent				10.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including privat	e room days)	0	12.0
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.0
14.00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program			0	14.0
	Total nursery days (title V or XIX only)		5.	0	
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17.00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 d	of the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of	the cost	0.00	18.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	f the cost	0.00	19.0
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of 1	he cost	0.00	20. 0
21.00	Total general inpatient routine service cost (see instructions)			3, 001, 869	21.0
22.00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	31 of the cost report	ing period (line	0	22.0
23.00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	1 of the cost reportin	ng period (line 6	0	23. 0
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.0
25.00	7 x line 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 0
26.00	x line 20) Total swing-bed cost (see instructions)			0	26.0
27.00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		3, 001, 869	
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)	Lino 20)		0	•
31.00 32.00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	TTHE 28)		0. 000000 0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.0
34.00 35.00	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line		ctions)	0. 00 0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.0
37.00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	d private room cost di	fferential (line	3, 001, 869	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	TMENTS			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see i			1, 909. 59	38.00
38.00					
38. 00 39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	8)		1, 413, 097 0	39.00

OMPUT	Financial Systems TATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0102	Period: From 01/01/2018	eu of Form CMS- Worksheet D-1	
					To 12/31/2018		
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costlr	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	+
. 00	NURSERY (title V & XIX only)	0	C	0.	00 0	C) 42.
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.	00 0	0) 43
. 00	CORONARY CARE UNIT	0	0	0.	00 0		44
. 00	BURN INTENSIVE CARE UNIT						45
	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
	cost center bescription					1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			947, 852	2 48
. 00	Total Program inpatient costs (sum of lines	41 through 48)(se	e instructio	ns)		2, 360, 949	9 49
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing s	prvicos (from	Wkst D su	m of Parts 1 and	102, 475	5 50
. 00	111)		ervices (II on	WKSL. D, SU	II OF PAILS F ANU	102, 473	50
. 00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	47, 538	3 51
~~	and IV)					450.015	
. 00 . 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non-nh	sician anost	hetist and	150, 013 2, 210, 936	
. 00	medical education costs (line 49 minus line	5 1	atea, non-phy		notist, anu	2, 210, 930	1 33
	TARGET AMOUNT AND LIMIT COMPUTATION						
. 00	Program di scharges					C	
00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 C	
00	Difference between adjusted inpatient operat	ing cost and tar	net amount (l	ine 56 minus	line 53)		
00	Bonus payment (see instructions)					C C	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period en	nding 1996, ι	pdated and c	ompounded by the	0.00	59
00	market basket	and report und	stad by the m	arkat baakat		0.00	
. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0.00	
. 00	which operating costs (line 53) are less that						10
	amount (line 56), otherwise enter zero (see				5		
						C	
. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see Instruc	tions)			C) 63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	per 31 of the	cost report	ing period (See	C	64
	instructions)(title XVIII only)	Ũ			0.1		
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	- 31 of the c	ost reportin	g period (See	C) 65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	1 nlus line 6	5)(title XVI	ll only) For	C	66
. 00	CAH (see instructions)			5)(11110 XVI	ri oniy). Toi		
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through [December 31 c	f the cost r	eporting period	C	67
00	(line 12 x line 19)	C t D					
. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs arter Dec	cemper 31 of	the cost rep	briing period		68
. 00	Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	68)		C	69
	PART III - SKILLED NURSING FACILITY, OTHER N					Γ	
. 00	Skilled nursing facility/other nursing facil	5)		70
. 00 . 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ie 70 ÷ Trhe	2)			71
. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv						74
. 00	Capital-related cost allocated to inpatient	routine service o	costs (from W	orksheet B,	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minu	s line 77)					78
00	Aggregate charges to beneficiaries for exces	· · ·		,			79
00 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st limitation	(line 78 mi	nus line 79)		80
00	Inpatient routine service cost per drem film Inpatient routine service cost limitation (I						82
00	Reasonable inpatient routine service costs ()				83
. 00	Program inpatient ancillary services (see in	structions)					84
	1 5						85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)				86
. 00	Total observation bed days (see instructions					345	5 87
	Adjusted general inpatient routine cost per		ine 2)			1, 909. 59	
. 00	Observation bed cost (line 87 x line 88) (se	•				658, 809	

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2018	Worksheet D-1	
				To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	217, 695	3, 001, 869	0. 07252	0 658, 809	47, 777	90.00
91.00 Nursing School cost	0	3, 001, 869	0.00000	0 658, 809	0	91.00
92.00 Allied health cost	0	3, 001, 869	0.00000	0 658, 809	0	92.00
93.00 All other Medical Education	0	3, 001, 869	0.00000	0 658, 809	0	93.00

	Financial Systems STARKE MEMORIA ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0102	Period: From 01/01/2018 To 12/31/2018	u of Form CMS-2 Worksheet D-1 Date/Time Prep 5/31/2019 4:00	pared:
	Cost Center Description	Title XIX	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed da			1, 572	
2.00 3.00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed o		rivate room days	1, 572 0	2.00 3.00
5.00	do not complete this line.	aays). Ti you nave only pi	i vate i oom days,	0	5.00
4.00	Semi-private room days (excluding swing-bed and observation		1, 227	4.00	
5.00	Total swing-bed SNF type inpatient days (including private r reporting period	room days) through Decembe	er 31 of the cost	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private r	room days) after December	31 of the cost	0	6.00
7 00	reporting period (if calendar year, enter 0 on this line)	an dave) through December	a 21 of the east	0	7 00
7.00	Total swing-bed NF type inpatient days (including private ro reporting period	oom days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private ro	oom days) after December 3	31 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	to the Dragnom (avaluding	rowing had and	40	0.00
9.00	Total inpatient days including private room days applicable newborn days)	to the program (excluding	g swing-bed and	48	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.00
11.00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		coom days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year,		oom days) arter	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or >	(IX only (including privat	te 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 >	(IX only (including privat	te room dave)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar	year, enter 0 on this lin	ne)	0	13.00
14.00	Medically necessary private room days applicable to the Prog	gram (excluding swing-bed	days)	0	
15.00 16.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15.00 16.00
10.00	SWING BED ADJUSTMENT			0	10.00
17.00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 d	of the cost	0.00	17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to servic reporting period	ces through December 31 of	f the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	ces after December 31 of	the cost	0.00	20.00
21 00	reporting period			2 001 040	21 00
21.00 22.00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem		ting period (line	3, 001, 869 0	21.00
	5 x line 17)		0 1 1	, c	
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	er 31 of the cost reportin	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)	· · · · · · · · · · · · · · · · · · ·			
25.00	Swing-bed cost applicable to NF type services after December x line 20)	r 31 of the cost reporting	g 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	t (line 21 minus line 26)		3, 001, 869	27.00
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ed and observation bed ch	narges)	0	28.00
	Private room charges (excluding swing-bed charges)		lai ges)	0	29.00
	Semi-private room charges (excluding swing-bed charges)			0	30.00
	General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
	Average per diem private room charge differential (line 32 m		ctions)	0.00	
	Average per diem private room cost differential (line 34 x l		/	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35))		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost	t and private room cost di	fferential (line	3, 001, 869	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD				
38.00	Adjusted general inpatient routine service cost per diem (se	-		1, 909. 59	
39.00 40.00	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Proc			91, 660 0	39.00 40.00
		, , , , , , , , , , , , , , , , , , , ,			

OMPUT	Financial Systems FATION OF INPATIENT OPERATING COST		L HOSPITAL Provider C	CN: 15-0102	Period: From 01/01/2018	eu of Form CMS- Worksheet D-1	
					To 12/31/2018		
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costlr	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	-
. 00		0	C	0.	00 0	C) 42.
00	Intensive Care Type Inpatient Hospital Units		0	0	00 0	C	1 42
. 00 . 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	0	U	0.	00 0		43.
. 00	BURN I NTENSI VE CARE UNI T						45
	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	+
. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	Line 200)			7, 161	48
. 00				ns)		98, 821	
	PASS THROUGH COST ADJUSTMENTS						
. 00		atient routine s	ervices (from	Wkst. D, su	m of Parts I and	6, 647	50
. 00	<pre>III) Pass through costs applicable to Program inp</pre>	ationt ancillary	services (fr	om Wkst D	sum of Parts II	323	3 51
. 00	and IV)	attent and traiy	Services (II	on wkst. D,		520	
. 00	Total Program excludable cost (sum of lines					6, 970	52
. 00	Total Program inpatient operating cost exclu	5 1	ated, non-phy	sician anest	hetist, and	91, 851	53
	medical education costs (line 49 minus line	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					C	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					C	56
00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	C	
. 00	Bonus payment (see instructions)					0 00	
. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period e	naing 1996, t	poated and c	ompounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upda	ated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of line					C	61
	which operating costs (line 53) are less that		(lines 54 x	60), or 1% o	f the target		
. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	Instructions)				C	62
. 00		ent (see instruc	tions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST		,				
. 00	5 1	ts through Decem	ber 31 of the	cost report	ing period (See	C	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	r 31 of the c	ost reportin	a period (See	c	65
. 00	instructions) (title XVIII only)			ust reporting	g period (see		/ 03
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	4 plus line 6	5)(title XVI	II only). For	C	66
	CAH (see instructions)						
. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through I	December 31 c	f the cost r	eporting period	C	67
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rep	orting period		68
	(line 13 x line 20)				or tring porrod		
. 00	Total title V or XIX swing-bed NF inpatient					C	69
~~	PART III - SKILLED NURSING FACILITY, OTHER N				<u>`````````````````````````````````````</u>		1 70
. 00 . 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	5		•)		70
. 00	5 5			2)			72
. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv	•					74
. 00	Capital -related cost allocated to inpatient	routine service (costs (from W	orksheet B,	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital -related costs (line 75 + 11						77
00	Inpatient routine service cost (line 74 minu	s line 77)					78
00	Aggregate charges to beneficiaries for exces	· ·					79
00 00	Total Program routine service costs for comp		st limitation	(IINE /8 mi	nus line 79)		80
00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81
00	Reasonable inpatient routine service cost ()				83
. 00	Program inpatient ancillary services (see in						84
	1 5						85
. 00			ough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					345	5 87
			lino 2)			1, 909. 59	
8. 00	Adjusted general inpatient routine cost per	arem (rine z/ ÷)				I, 707. J7	1 00

Health Financial Systems	STARKE MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	217, 695	3, 001, 869	0. 07252	0 658, 809	47, 777	90.00
91.00 Nursing School cost	0	3, 001, 869	0.00000	0 658, 809	0	91.00
92.00 Allied health cost	0	3, 001, 869	0.00000	0 658, 809	0	92.00
93.00 All other Medical Education	0	3, 001, 869	0.00000	0 658, 809	0	93.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	HOSPITAL	CN: 15-0102	In Lie Period:	Worksheet D-3	
			From 01/01/2018	D ((T) D	
			To 12/31/2018	Date/Time Pre 5/31/2019 4:0	
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDI ATRI CS			1, 479, 937		30. 0
1.00 03100 INTENSIVE CARE UNIT			0		31.0
0. 00 04000 SUBPROVIDER - IPF			0		40.0
1.00 04100 SUBPROVIDER - IRF			0		41.0
3. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS					
00.00 05000 OPERATING ROOM		0.2314		47, 188	
1.00 05100 RECOVERY ROOM		0.0000		0	
22.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000			
33. 00 05300 ANESTHESI OLOGY 44. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2527		12, 849 31, 863	
4. 01 05400 RADIOLOGI-DIAGNOSTIC 4. 01 05401 ULTRASOUND		0. 0579			
5. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000		0	
6. 00 05600 RADI 0I SOTOPE		0. 8596		0	
7. 00 05700 CT SCAN		0. 0246			
88.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0863			
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
0. 00 06000 LABORATORY		0. 1291		105, 305	60.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0042	91 24, 392	105	62.0
4. 00 06400 I NTRAVENOUS THERAPY		0.0000	00 00	0	64.0
5. 00 06500 RESPI RATORY THERAPY		0. 9143	88 286, 933	262, 368	65.0
6. 00 06600 PHYSI CAL THERAPY		0. 4116	51 90, 627	37, 307	66.0
57. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	
8.00 06800 SPEECH PATHOLOGY		0.0000		0	
9. 00 06900 ELECTROCARDI OLOGY		0. 2170			
0.00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0068		543	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0207		235	
 3. 00 07300 DRUGS CHARGED TO PATIENTS 4. 00 07400 RENAL DIALYSIS 		0. 1304		111, 984 0	
5. 00 07500 ASC (NON-DI STINCT PART)		0.0000		0	
6. 00 03020 ACUPUNCTURE		0.0000			
OUTPATI ENT SERVI CE COST CENTERS		0.0000	00 0	0	1 /0.0
18. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88. 0
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
0. 00 09000 CLI NI C		16. 7014		0	
01.00 09100 EMERGENCY		0. 2848	74 624, 838	178, 000	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7506	26 159, 593	119, 795	92.0
OTHER REIMBURSABLE COST CENTERS					
09400 HOME PROGRAM DI ALYSI S		0.0000	00 00	0	
5. 00 09500 AMBULANCE SERVI CES					95.0
6.00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.0000			
77.00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.0000		0	
Total (sum of lines 50 through 94 and 96 through 98)	(1)		3, 998, 487	947, 852	
Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.0
202.00 Net charges (line 200 minus line 201)		1	3, 998, 487		202.0

ealth Financial Systems STARKE MEMORIAL NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0102	Peri od:	Worksheet D-3	<u>2552-1</u>
ATTENT ANOTEENINT SERVICE COST ATTORTIONMENT		0102	From 01/01/2018		
			To 12/31/2018		
		e XIX	Hospi tal	5/31/2019 4:0 PPS	19 pm
Cost Center Description	1111	Ratio of Cos		Inpatient	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS		1	15, 900		30.0
81. 00 03100 I NTENSI VE CARE UNI T			0		31.0
10. 00 04000 SUBPROVIDER - IPF			0		40.0
11. 00 04100 SUBPROVI DER – I RF			0		41.0
13. 00 04300 NURSERY			0		43.0
ANCI LLARY SERVICE COST CENTERS					1
0. 00 05000 OPERATI NG ROOM		0. 2314	57 0	0	50.0
1. 00 05100 RECOVERY ROOM		0.0000	00 0	0	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000	00 0	0	52.0
3. 00 05300 ANESTHESI OLOGY		0. 2527	43 0	0	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 3205	93 378	121	54.0
54. 01 05401 ULTRASOUND		0.0579	59 5, 811	337	54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000	00 0	0	55.0
6. 00 05600 RADI OI SOTOPE		0.8596		0	
57. 00 05700 CT SCAN		0. 0246	98 4, 222	104	57.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0863		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
00.00 06000 LABORATORY		0. 1291		993	
22.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0042		0	
04. 00 06400 I NTRAVENOUS THERAPY		0.0000			
55. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0.9143		192	
66.00 06600 PHYSI CAL THERAPY 57.00 06700 OCCUPATI ONAL THERAPY		0. 4116		0	
v8. 00 06800 SPEECH PATHOLOGY		0.0000		0	
9. 00 06900 ELECTROCARDI OLOGY		0.0000			
70. 00 07000 ELECTROERCEPHALOGRAPHY		0.2170			
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0068			
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0207		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1304		1,900	
74.00 07400 RENAL DIALYSIS		0.0000		0	
75.00 07500 ASC (NON-DI STINCT PART)		0.0000			
76.00 03020 ACUPUNCTURE		0.0000			
OUTPATIENT SERVICE COST CENTERS			I.		
38. 00 08800 RURAL HEALTH CLINIC		0.0000	00 0	0	88.0
39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00 0	0	89.0
20. 00 09000 CLINIC		16. 7014	93 0	0	90.0
01.00 09100 EMERGENCY		0. 2848		1, 619	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7506	26 2, 403	1, 804	92.0
		0.0000	00 0	0	
04.00 09400 HOME PROGRAM DI ALYSI S		0.0000	00 0	0	
25. 00 09500 AMBULANCE SERVICES 26. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.0000	00	0	95.0 96.0
70.00 09600 DURABLE MEDICAL EQUIP-RENTED		0.0000		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.0000	41, 377		200. 0
	(1) (1)		41, 377	1, 101	200. 0
201.00 [Less PBP Clinic Laboratory Services-Program only charge					

ALCUL	Financial Systems STARKE MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0102	Peri od: From 01/01/2018 To 12/31/2018		pared:
		Title XVIII	Hospi tal	PPS	, b
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
00	DRG Amounts Other than Outlier Payments		,	0	
01	DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1	(see	1, 003, 905	1.0
02	DRG amounts other than outlier payments for discharges occurr	1 (see	360, 469	1.02	
	instructions)	- 			
03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	or discharges occurring	prior to Uctober	0	1.03
04	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	on or after	0	1.04
00	October 1 (see instructions)			0	2 00
00	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	
02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	
00	Managed Care Simulated Payments			348, 185	3.00
00	Bed days available divided by number of days in the cost repo	rting period (see instru	uctions)	14.05	4.00
00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending on	0.00	5.00
00	or before 12/31/1996. (see instructions)	t recent cost reporting	period charny on	0.00	0.00
00	FTE count for allopathic and osteopathic programs that meet t	he criteria for an add-o	on to the cap for	0.00	6.00
00	new programs in accordance with 42 CFR 413.79(e)	under 12 CED \$412 105(E)	(1)(1)(1)(1)	0.00	7.00
00	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under			0.00 0.00	
01	cost report straddles July 1, 2011 then see instructions.		()(b)(2) 11 the	0.00	/.0
00	Adjustment (increase or decrease) to the FTE count for allopa			0.00	8.0
	affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).	79(c)(2)(iv), 64 FR 2634	40 (May 12,		
01	The amount of increase if the hospital was awarded FTE cap sl	0.00	8.0		
-	report straddles July 1, 2011, see instructions.				
02	The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teachi	ng hospital	0.00	8. 0
00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin	$e_{\rm S}$ (8 8 01 and 8 02)	(500	0.00	9.00
00	instructions)			0.00	7.00
0. 00	FTE count for allopathic and osteopathic programs in the curr	ent year from your recou	rds		10.00
1.00	FTE count for residents in dental and podiatric programs.				11.00
2.00 3.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.				12.0
4.00	Total allowable FTE count for the penultimate year if that ye	ar ended on or after Se	otember 30, 1997,		14.0
	otherwise enter zero.				
	Sum of lines 12 through 14 divided by 3.				15.0
	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital clo	SULLA			16. 0 17. 0
	Adjusted rolling average FTE count	Sule			18.0
9.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	
D. 00	Prior year resident to bed ratio (see instructions)			0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions)			0	
2.01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42:	2 of the MMA		0	22.0
3.00	Number of additional allopathic and osteopathic IME FTE resid		CFR 412.105	0.00	23.00
	(f)(1)(iv)(C).				
4.00 5.00	IME FTE Resident Count Over Cap (see instructions)	Lower of Line 22 or Line	24 (coo	0.00	
5.00	If the amount on line 24 is greater than -O-, then enter the instructions)	Tower of Time 23 of Time	e 24 (See	0.00	25.0
5.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.0
7.00	IME payments adjustment factor. (see instructions)			0.000000	27.0
	IME add-on adjustment amount (see instructions)	、 、		0	
3.01	IME add-on adjustment amount - Managed Care (see instructions))		0	
9.00 9.01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	
	Di sproporti onate Share Adjustment	·/		0	1 2 / . 0
0. 00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instruc	ctions)	4.48	30.0
1.00	Percentage of Medicaid patient days (see instructions)	-			31.0
	Sum of lines 30 and 31	\			32.0
3.00	Allowable disproportionate share percentage (see instructions)		6.49	33.0

	Financial Systems STARKE MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0102	Period: From 01/01/2018 To 12/31/2018		
		Title XVIII	Hospi tal	PPS	² piii
			Prior to 10/1	0n/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00 35.01	Total uncompensated care amount (see instructions)		0. 00000000	0 0. 00000000	35. 00 35. 01
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter	zero on this line) (see		317, 473	35.01
55. UZ	instructions)		175,010	317,473	55. UZ
35.03	Pro rata share of the hospital uncompensated care payment amoun	nt (see instructions)	131, 351	80, 021	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		211, 372		36.00
	Additional payment for high percentage of ESRD beneficiary disc				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding di	scharges for MS-DRGs	0		40.00
41.00	652, 682, 683, 684 and 685 (see instructions)	681 an 685 (see	0		41.00
41.00	00 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see 0 instructions)				
41.01					
	an 685. (see instructions)				
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify	3	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by	line 41 divided by 7	0. 000000		44.00
11.00	days)		0.000000		11.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.0)1)	0		46.00
47.00	Subtotal (see instructions)		1, 597, 883		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, sma	all rural hospitals	1, 296, 528		48.00
	only. (see instructions)			Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			1, 597, 883	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			110, 761	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. I			0	51.00
52.00 53.00	Direct graduate medical education payment (from Wkst. E-4, line	e 49 see instructions).		0	52.00 53.00
53.00 54.00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0	53.00 54.00
54.00	Islet isolation add-on payment			0	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intruc	tions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III		rough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	/, col. 11 line 200)		0	58.00
59.00 60.00	Total (sum of amounts on lines 49 through 58) Primary payer payments			1, 708, 644 17, 155	
61.00	Total amount payable for program beneficiaries (line 59 minus l	ine 60)		1, 691, 489	61.00
62.00	Deductibles billed to program beneficiaries	·/		221, 052	
63.00	Coinsurance billed to program beneficiaries			1, 005	63.00
64.00	Allowable bad debts (see instructions)			5, 574	
	Adjusted reimbursable bad debts (see instructions)			3, 623	
66.00	Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		5, 574	66.00
67.00 68.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for ap	unlicable to MS DDCs (cs	a instructions)	1, 473, 055 0	67.00 68.00
68.00 69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (F			0	68.00 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		,	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstra	ation) adjustment (see i	nstructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70. 87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instru	ictions)			70.89
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70. 90 70. 91
70.91	Bundled Model 1 discount amount (see instructions)			0	70.91
70. 92	HVBP payment adjustment amount (see instructions)			10, 879	
70. 94	HRR adjustment amount (see instructions)			-3, 326	70. 94
70.95	Recovery of accelerated depreciation			0	70. 95

	Provider CO	CN: 15-0102	Peri od:	Worksheet E	2552
			From 01/01/2018 To 12/31/2018	Part A Date/Time Pre	pare
				5/31/2019 4:0	9 pm
	Title	XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
0.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0 2018	1.00 298,153	70.
the corresponding federal year for the period prior to 10/1)			2010	270, 155	/0.
). 97 Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			2018	118, 879	70.
0.98 Low Volume Payment-3				0	70.
). 99 HAC adjustment amount (see instructions)				15, 369	
1.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			1, 882, 271	
I.01 Sequestration adjustment (see instructions)				37, 645	
I. 02 Demonstration payment adjustment amount after sequestration				0	71.
2.00 Interim payments				1, 855, 536	
3.00 Tentative settlement (for contractor use only) 4.00 Balance due provider/program (line 71 minus lines 71.01, 71.0	22 72 and			10 010	73.
 4.00 Balance due provider/program (line 71 minus lines 71.01, 71.0 73) 5.00 Protested amounts (nonallowable cost report items) in accorda 				-10, 910 1, 226, 162	
CMS Pub. 15-2, chapter 1, §115.2	ance with			1, 220, 102	/ / J.
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			I		1
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	of 2.03			0	90.
.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91
.00 Operating outlier reconciliation adjustment amount (see instr				0	92
.00 Capital outlier reconciliation adjustment amount (see instruc				0	93
.00 The rate used to calculate the time value of money (see instr				0.00	
0.00 Time value of money for operating expenses (see instructions)				0	95
5.00 Time value of money for capital related expenses (see instruc	ctions)		Dui au ta 10/1	0	96
			Prior to 10/1 1.00	2.00	
HSP Bonus Payment Amount			1.00	2.00	
0.00 HSP bonus amount (see instructions)			0	0	100
HVBP Adjustment for HSP Bonus Payment					
1.00 HVBP adjustment factor (see instructions)			1.0108361087	0.000000000	101
2.00 HVBP adjustment amount for HSP bonus payment (see instruction	ıs)		0		102
UDD Adjustment for UCD Denue Deimert			0	0	1102
HRR Adjustment for HSP Bonus Payment					
3.00 HRR adjustment factor (see instructions)			0. 9978	0. 9969	103
3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions				0. 9969	103
 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 	ration) Adju		0. 9978	0. 9969	103 104
 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0.00 Is this the first year of the current 5-year demonstration per 	ration) Adju		0. 9978	0. 9969	103 104
 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. 	ration) Adju		0. 9978	0. 9969	103 104
 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 	ration) Adju eriod under t		0. 9978	0. 9969 0	103 104 200
 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0.000 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 	ration) Adju eriod under t		0. 9978	0. 9969 0	103 104 200 201
 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 2. 00 Medicare discharges (see instructions) 	ration) Adju eriod under t		0. 9978	0. 9969 0	103 104 200 201 202
 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 5. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, ling 2. 00 Medicare discharges (see instructions) 	eration) Adju eriod under t ne 49)	he 21st	0. 9978	0. 9969 0	103 104 200 201 202
 13.00 HRR adjustment factor (see instructions) 14.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 11.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 22.00 Medicare discharges (see instructions) 13.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 14.00 Medicare target amount 	eration) Adju eriod under t ne 49)	he 21st	0. 9978	0.9969 0 ration	103 104 200 201 202 203 203
 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 	eration) Adju eriod under t ne 49) n first year o	he 21st	0. 9978	0.9969 0 ration	103 104 200 201 202 203 203 204 205
 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0. 00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 2. 00 Medicare discharges (see instructions) 3. 00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times line 204) 6. 00 Medicare inpatient routine cost cap (line 202 times line 205) 	eration) Adju eriod under t ne 49) n first year o	he 21st	0. 9978	0.9969 0 ration	103 104 200 201 202 203 203 204 205
 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 	eriod under t ne 49) n first year	he 21st	0. 9978	0.9969 0 ration	103 104 200 201 202 203 203 204 205 206
 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0.00 Is this the first year of the current 5-year demonstration pecentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instruction) 	ration) Adju eriod under t ne 49) n first year) tructions)	he 21st	0. 9978	0.9969 0	103 104 200 201 202 203 204 205 206 207
 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Medicare target amount 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see inst 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 	ration) Adju eriod under t ne 49) n first year) tructions)	he 21st	0. 9978	0.9969 0 ration	103 104 200 201 202 203 204 205 206 207 207 208
 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst of Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 9.00 Adjustment to Medicare IPPS payments (see instructions) 	ration) Adju eriod under t ne 49) n first year) tructions)	he 21st	0. 9978	0.9969 0 rati on	103 104 200 201 202 203 204 205 206 207 208 207 208 209
 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst of Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 204) 6.00 Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstrations) 9.00 Adjustment to Medicare IPPS payments (see instructions) 	ration) Adju eriod under t ne 49) n first year tructions) line 59)	he 21st	0. 9978	0.9969 0 ration	103 104 200 201 202 203 204 205 206 207 208 209 210
 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst of Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 0.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 9.00 Adjustment to Medicare IPPS payments (see instructions) 	ration) Adju eriod under t ne 49) n first year tructions) line 59)	he 21st	0. 9978	0.9969 0 ration	103 104 200 201 202 203 204 205 206 207 208 207 208 209 210
 13.00 HRR adjustment factor (see instructions) 14.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration 0 Is this the first year of the current 5-year demonstration percentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 11.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir 200 Medicare discharges (see instructions) 13.00 Case-mix adjustment factor (see instructions) 13.00 Case-mix adjustment factor (see instructions) 14.00 Medicare target amount 15.00 Case-mix adjustment factor (see instructions) 15.00 Case-mix adjusted target amount (line 203 times line 204) 16.00 Medicare inpatient routine cost cap (line 202 times line 205) 17.00 Program reimbursement under the §410A Demonstration (see instructions) 17.00 Program reimbursement under the §410A Demonstration (see instructions) 18.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 99.00 Adjustment to Medicare IPPS payments (see instructions) 10.00 Total adjustment to Medicare Part A IPPS payments (from line 	ration) Adju eriod under t ne 49) n first year tructions) line 59)	he 21st	0. 9978	0.9969 0	103 104 200 201 202 203 204 205 206 207 207 208
 13.00 HRR adjustment factor (see instructions) 14.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration period) 10.00 Is this the first year of the current 5-year demonstration period. Cost Reimbursement 11.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) 13.00 Case-mix adjustment factor (see instructions) 13.00 Case-mix adjustment factor (see instructions) 14.00 Medicare target amount 15.00 Case-mix adjustment factor (see instructions) 15.00 Case-mix adjustment factor (see instructions) 15.00 Case-mix adjustment routine cost cap (line 202 times line 204) 16.00 Medicare Part A Inpatient Reimbursement 17.00 Program reimbursement under the §410A Demonstration (see instructions) 18.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 99.00 Adjustment to Medicare IPPS payments (see instructions) 10.00 Reserved for future use 10.01 Total adjustment to Medicare IPPS payments (see instructions) 	ration) Adju eriod under t ne 49) n first year tructions) line 59)	he 21st	0. 9978	0. 9969 0	103 104 200 201 202 203 204 205 206 207 208 209 210 211

DW VO	DLUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2018	Worksheet E Part A Exhibi	+ <i>1</i>
						o 12/31/2018		pare
				Title	xvi i	Hospi tal	PPS	9 pii
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line 0	<u>E, Part A)</u> 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
00	DRG amounts other than outlier	1.00	0	0			0	1.
01	payments DRG amounts other than outlier payments for discharges	1. 01	1, 003, 905	0	1, 003, 905	5	1, 003, 905	1.
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	360, 469	0		360, 469	360, 469	1.
)3	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	C		0	1
)4	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1
00	Outlier payments for	2.00	0	0	c	0	0	2
01	discharges (see instructions) Outlier payments for	2. 02	0	0			0	2
51	di scharges for Model 4 BPCI	2.02	0	0		, 0	0	
00	Operating outlier reconciliation	2. 01	0	0	C	0	0	3
00	Managed care simulated payments	3.00	348, 185	0	261, 139	87, 046	348, 185	4
00	Indirect Medical Education Adju Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0. 000000		5
	A, line 21 (see instructions)		0.000000	0.000000		0.000000		
00	IME payment adjustment (see instructions)	22.00	0	0	C	0 0	0	6
)1	IME payment adjustment for managed care (see instructions)	22.01	0	0	C	0 0	0	6
	Indirect Medical Education Adju	ustment for the	e Add-on for Se	ction 422 of t	he MMA			
00	IME payment adjustment factor	27.00	0. 000000	0.00000	0.00000	0. 000000		7
00	(see instructions) IME adjustment (see	28.00	0	0	C	0	0	8
1	instructions)	20.01					0	
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0	0	8
00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	C	0	0	9
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	C	0 0	0	Ģ
	Disproportionate Share Adjustme				1			1
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0649	0. 0649	0. 0649	0. 0649		10
00	Di sproporti onate share	34.00	22, 137	0	16, 288	5, 849	22, 137	11
01	adjustment (see instructions) Uncompensated care payments	36.00	211, 372	0	131, 351	80, 021	211, 372	11
00	Additional payment for high per Total ESRD additional payment							12
	(see instructions)							
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47.00 48.00	1, 597, 883 0	0 0	1, 151, 544 (446, 339 0 0	1, 597, 883 0	
00	<pre>small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see</pre>	49.00	1, 597, 883	0	1, 151, 544	446, 339	1, 597, 883	15
00	instructions) Payment for inpatient program	50.00	110, 761	0	81, 585	29, 176	110, 761	16
00	capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for	54.00	0	0	C	0	0	17
01	new technologies							17
. 01 . 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	О	0	C	0	0	17 17

Heal th	Financial Systems		STARKE MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2018 To 12/31/2018		pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.00
19 00	SUBTOTAL			0	1, 233, 12	9 475, 515	1, 708, 644	19 00
17.00	JOBTOTAL	W/S L, line	(Amounts from L)		1,200,12	7 473, 513	1,700,044	17.00
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	110, 761	0			110, 761	20.00
	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	
21.00	Capital DRG outlier payments	2.00	0	0		0 0	0	21.00
	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21.01
22. 00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0 0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0 0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	110, 761	0	81, 58	5 29, 176	110, 761	26.00
		W/S E, Part A						
		line	Part A)					
	r	0	1.00	2.00	3.00	4.00	5.00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 24178 298, 15		298, 153	27.00 28.00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				118, 879	118, 879	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2018 To 12/31/2018	Date/Time Prep 5/31/2019 4:09	pared:
				XVIII Davi ad ta	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1, 003, 905	1, 003, 90	5	1, 003, 905	1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	360, 469		360, 469	360, 469	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	0		0 0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	348, 185	261, 13	9 87,046	-	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0 0. 000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0		0 0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0		0 0	0	6. 01
	Indirect Medical Education Adjustment for the						
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0 0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0		0 0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9. 01
	Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage (see instructions)	33.00	0.0649	0.064	9 0.0649		10. 00
11.00	Disproportionate share adjustment (see instructions)	34.00	22, 137	16, 28	8 5, 849	22, 137	11.00
11.01	Uncompensated care payments	36.00	211, 372	131, 35	1 80, 021	211, 372	11.01
	Additional payment for high percentage of ESF	D beneficiary	di scharges				
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
13.00	Subtotal (see instructions)	47.00	1, 597, 883	1, 151, 54	4 446, 339	1, 597, 883	13.00
	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0		0 0		
15.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	1, 597, 883	1, 151, 54	4 446, 339	1, 597, 883	15.00
16.00	Payment for inpatient program capital (from	50.00	110, 761	81, 58	5 29, 176	110, 761	16.00
17. 00 17. 01	Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost	54.00	0		0 0	0	17.00 17.01
17.01	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.01
18.00	Capital outlier reconciliation adjustment	93.00	0		o o	0	18. 00
	amount (see instructions)				1		

ATION EXHIBIT 5	Provider CO				
			Period: From 01/01/2018 To 12/31/2018		pared:
	Title	XVIII	Hospi tal	PPS	
Wkst. L, line	(Amt. from Wkst. L)				
0	1.00	2.00	3.00	4.00	
1.00	110, 761	81, 58	35 29, 176	110, 761	20.00
1.01	0		0 0	0	20.01
2.00	0		0 0	0	21.00
2.01	0		0 0	0	
	0,0000	0, 000	0,000	-	22.00
6.00	0		0 0	0	23.00
10.00	0.0000	0.000	0. 0000		24.00
11.00	0		0 0	0	25.00
12.00	110, 761	81, 58	35 29, 176	110, 761	26.00
Wkst F Pt	(Amt from				
A, line	Wkst. E, Pt.				
0		2 00	3 00	4 00	
0	1.00	2.00	5.00	4.00	27.00
70.96	208 153	208 1	52	208 153	
	10, 079	0, 1.	0 2,742		1
70. 90	0		0	0	30.01
70.04	_3 274	_2 40	020	_3 274	31 00
	-3, 320	-2,40	-030		1
70.91	0		0	0	31.01
				(Amt. to Wkst.	
				E, Pt. A)	
0	1.00	2.00	3.00	4.00	
70. 99		15, 30	59 0	15, 369	32.00
	Y				100. 00
	0 1.00 1.01 2.00 2.01 5.00 6.00 10.00 11.00 12.00 Wkst. E, Pt. A, Line 0 70.96 70.97 70.93 70.90 70.94 70.91	Wkst. L, line (Amt. from Wkst. L) 0 1.00 1.00 110,761 1.01 0 2.00 0 2.01 0 5.00 0.0000 6.00 0 110.00 0.0000 10.00 0.0000 110.00 0 12.00 110,761 Wkst. E, Pt. A, line (Amt. from Wkst. E, Pt. A) 0 1.00 70.96 298,153 70.97 118,879 70.93 10,879 70.94 -3,326 70.91 0 0 1.00	Wkst. L) Wkst. L) 0 1.00 2.00 1.00 110,761 81,56 1.01 0 0 2.00 0 0 2.01 0 0 5.00 0.0000 0.000 6.00 0 0 110.00 0.0000 0.000 11.00 0 0 12.00 110,761 81,58 Wkst. E, Pt. (Amt. from A, line A) 0 0 1.00 2.00 70.96 298,153 298,15 70.97 118,879 8,13 70.90 0 0 70.94 -3,326 -2,48 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00	Wkst. L, line (Amt. from Wkst. L) 2.00 3.00 1.00 110,761 81,585 29,176 1.01 0 0 0 0 2.00 0 0 0 0 2.01 0 0 0 0 5.00 0.0000 0.0000 0.0000 6.00 0 0 0 0 10.00 0.0000 0.0000 0.0000 0.0000 11.00 0 0 0 0 0 12.00 110,761 81,585 29,176 Wkst. E, Pt. A, line (Amt. from Wkst. E, Pt. A) 118,879 118,879 70.96 298,153 298,153 298,153 70.97 118,879 118,879 118,879 70.90 0 0 0 0 70.94 -3,326 -2,488 -838 70.91 0 0 0 0 0 1.00 2.00 3.00	Title XVIII Hospital PPS Wkst. L, line (Amt. from Wkst. L) 0 1.00 2.00 3.00 4.00 1.00 110,761 81,585 29,176 110,761 1.01 0 0 0 0 0 2.00 0 0 0 0 0 2.01 0 0 0 0 0 6.00 0 0 0 0 0 11.00 0 0 0 0 0 110.00 0.0000 0.0000 0.0000 0 0 11.00 0 0 0 0 0 0 11.00 0 0 0 0 0 0 11.00 0 0 0 0 0 0 110,761 81,585 29,176 110,761 81,585 29,176 110,761 Wkst. E, Pt. (Amt. from Kst. E, Pt. A)

	Financial Systems STARKE MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0102	Period:	u of Form CMS-2 Worksheet E	2002-10
0,12002			From 01/01/2018 To 12/31/2018	Part B Date/Time Pre	
		Title XVIII	Hospi tal	5/31/2019 4:04 PPS	9 pm
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			1, 662	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	ctions)		2, 801, 461 2, 090, 930	
4.00	Outlier payment (see instructions)			2, 090, 930	
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00 6.00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	uctions)		0. 000 0	5.00 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.00
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)		1, 662	10.00 11.00	
	COMPUTATION OF LESSER OF COST OR CHARGES			.,	
12 00	Reasonable charges			12. 735	12 00
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		12, 735	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			12, 735	
15 00	Customary charges	normant for convious on	a abarga basi a	0	15 00
15.00 16.00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for	0	15.00 16.00		
	had such payment been made in accordance with 42 CFR §413.13(1 5			
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	nlvifline 18 exceeds li	ne 11) (see	12, 735 11, 073	
	instructions)	,	17100		
20.00	Excess of reasonable cost over customary charges (complete on	ne 18) (see	0	20.00	
21.00	instructions) Lesser of cost or charges (see instructions)			1, 662	21.00
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			2, 121, 646	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	-			25.00
26.00	Deductibles and Coinsurance amounts relating to amount on lin		,	448, 424	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	prus the sum of times 2.		1, 674, 542	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, I	-		0	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 1, 674, 542	
30.00	Primary payer payments				31.00
32.00	Subtotal (line 30 minus line 31)			1, 674, 382	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11)	CES)		0	33.00
	Allowable bad debts (see instructions)			53, 625	
35.00	Adjusted reimbursable bad debts (see instructions)			34, 856	35.00
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		53, 625 1, 709, 238	
37.00	MSP-LCC reconciliation amount from PS&R			1, 709, 238	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instruction	ns)			39.50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla	nced devices (see instru	ctions)	0	
39.90	RECOVERY OF ACCELERATED DEPRECIATION			0	
40.00	Subtotal (see instructions)			1, 709, 238	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			34, 185 0	
	Interim payments			1, 641, 503	
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00 44.00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2	chapter 1	33, 550 0	
τ τ . 00	§115. 2			0	00
00.00	TO BE COMPLETED BY CONTRACTOR				00.05
90.00 91.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90.00 91.00
92.00	The rate used to calculate the Time Value of Money				92.00
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.0

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CO		Period: From 01/01/2018 To 12/31/2018	Date/Time Prep 5/31/2019 4:00	pare
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
00	Total interim payments paid to provider		1, 855, 5		1, 641, 503	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
D1	ADJUSTMENTS TO PROVIDER			0	0	3
02				0	0	3
03				0	0	3
04				0	0	3
05				0	0	3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 855, 5	36	1, 641, 503	4
00	(transfer to Wkst. E or Wkst. E-3, line and column as		1,000,0		1, 011, 000	Ι.
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5
)2	IENTATIVE TO PROVIDER			0	0	5
)2)3				0	0	5
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
01	the cost report. (1) SETTLEMENT TO PROVIDER			0	33, 550	6
)1)2	SETTLEMENT TO PROVIDER		10, 9	0	33, 550	6
)2)0	Total Medicare program liability (see instructions)		1, 844, 6		1, 675, 053	0
50			1, 044, 0	Contractor	NPR Date	-
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	
00	Name of Contractor					8

Heal th	Financial Systems STARKE MEMORI	AL HOSPITAL	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0102	Period: From 01/01/2018	Worksheet E-	1
			To 12/31/2018		
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				_
1.00	Total hospital discharges as defined in AARA §4102 from Wks		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12			2.00
3.00	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	Bline 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	on (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	lline 31) (see instruction	ns)		32.00

LANCE SHEE	ial Systems STARKE MEMORI (If you are nonproprietary and do not maintain counting records, complete the General Fund column	Provi der C		Period: From 01/01/2018	u of Form CMS-: Worksheet G	
ly)	countring records, comprete the General Fund corumn			o 12/31/2018	Date/Time Pre 5/31/2019 4:0	epare 19 pr
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
CURREN	T ASSETS	1.00	2.00	3.00	4.00	-
	on hand in banks	20, 445	C	0	0	1
00 Tempor	ary investments	C	C	0	0	2
	recei vabl e	0	C	0 0	0	
	nts receivable	8, 078, 157		0 0	0	
	recei vabl e		C	0	0	
	ances for uncollectible notes and accounts receivable	-4, 526, 499		0	0	
00 Invent 00 Prepai	d expenses	412, 653 120, 603		0	0	
	current assets	4, 595			0	
	om other funds	4, 373		-	0	
	current assets (sum of lines 1-10)	4, 109, 954		-	0	
	ASSETS	.,	-		-	
00 Land		0	C	0 0	0	12
1	mprovements	33, 465		-	0	
	Il ated depreciation	-4, 741		-	0	
00 Buildi	0	0	C	-	0	
	Il ated depreciation		C	-	0	
	nold improvements	1, 272, 368		-	0	
	Ilated depreciation equipment	-446, 521 86, 220		-	0	
1	I ated depreciation	-81, 430			0	
	bbiles and trucks	6, 880			0	
	I ated depreciation	-6, 498		-	0	1 - 1
.00 Major	movable equipment	2, 792, 456		0 0	0	23
00 Accumu	I ated depreciation	-2, 373, 202	C	0 0	0	24
00 Minor	equipment depreciable	1, 063, 157	C	0	0	25
	Il ated depreciation	-605, 807		-	0	
	esignated Assets	0	C	-	0	
	Il ated depreciation	0	C	-	0	1
	equipment-nondepreciable	1 724 247			0	
OTHER	fixed assets (sum of lines 12-29) ASSETS	1, 736, 347			0	30
00 Invest		C	C	0	0	3
	ts on leases	C	C C	0	0	
.00 Due fr	rom owners/officers	0	c c	0 0	0	33
.00 Other	assets	894, 925	C	0 0	0	34
1	other assets (sum of lines 31-34)	894, 925			0	
	assets (sum of lines 11, 30, and 35)	6, 741, 226	C	0 0	0	36
	T LI ABI LI TI ES		-			1
	nts payable	445, 909			0	
	es, wages, and fees payable I taxes payable	534, 218			0	
	and loans payable (short term)	25, 702			0	
	red income				0	
	erated payments				Ū.	42
.00 Due to	o other funds	2, 545, 691	c	0 0	0	
00 Other	current liabilities	178, 220		0 0	0	44
. 00 Total	current liabilities (sum of lines 37 thru 44)	3, 729, 740	C	0 0	0	45
	ERM LIABILITIES	L	1	1		
	ige payabl e	0	C	0	0	
1	payabl e			0	0	
	ıred loans long term liabilities	38, 253			0	
	long term liabilities (sum of lines 46 thru 49)	38, 253		-	0	
	liabilities (sum of lines 45 and 50)	3, 767, 993			0	
	L ACCOUNTS				-	
	I fund balance	2, 973, 233				52
	ic purpose fund		C			53
	created - endowment fund balance - restricted			0		54
1	created - endowment fund balance - unrestricted			0		55
	ning body created - endowment fund balance			0	-	56
	fund balance - invested in plant				0	
	fund balance - reserve for plant improvement,				0	58
	cement, and expansion fund balances (sum of lines 52 thru 58)	2, 973, 233			0	59
	liabilities and fund balances (sum of lines 51 and	6, 741, 226			0	
			, U		0	1 00

Heal th	Financial Systems	STARKE MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0102	Period: From 01/01/2018 To 12/31/2018	Worksheet G-1	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance		2,00 3,140,685 -236,942 2,903,743 0 2,903,743 0 2,903,743		4.00 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
2.00 3.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0102	Peric From To	od: 01/01/2018 12/31/2018	Worksheet G-2 Parts I & II Date/Time Pre 5/31/2019 4:0	pared:
	Cost Center Description		Inpati ent	0	utpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						-
	General Inpatient Routine Services		0.050.5			0.050.500	1
1.00	Hospital		2, 952, 5			2, 952, 530	
2.00	SUBPROVIDER - IPF			0		0	
3.00	SUBPROVIDER - IRF			0		0	
4.00	SUBPROVI DER			~		0	4.00
5.00	Swing bed - SNF			0		0	
5.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY						7.00
3.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE		2 052 5	20		2 052 520	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		2, 952, 5	30		2, 952, 530	10.00
11.00	Intensive Care Type Inpatient Hospital Services			0		0	1 1 1 00
12.00	CORONARY CARE UNIT			0		0	11.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGICAL INTENSIVE CARE UNIT						14.00
14.00							14.00
16.00	OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum of I	inoc		0		0	
10.00	11-15)	THES		0		0	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		2, 952, 5	20		2, 952, 530	17.00
18.00	Ancillary services		6, 479, 1		47, 515, 151	53, 994, 323	
19.00	Outpatient services		1, 675, 98		12, 669, 806	14, 345, 794	
20.00	RURAL HEALTH CLINIC		1,075,90	0	12, 009, 000	14, 345, 794	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
22.00	HOME HEALTH AGENCY			0	0	0	
23.00	AMBULANCE SERVICES			0	0	0	
24.00	CMHC			0	0	0	
24.00	CORF			0	0	0	
25.00	AMBULATORY SURGICAL CENTER (D. P.)			0	0	0	
26.00	HOSPICE			0	0	0	
27.00	OTHER (SPECIFY)			0	0	0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	to Wkst	11, 107, 69	-	60, 184, 957	71, 292, 647	
20.00	G-3, line 1)	to wkst.	11, 107, 0	70	00, 104, 757	11, 292, 047	20.00
	PART II - OPERATING EXPENSES		I				1
29.00	Operating expenses (per Wkst. A, column 3, line 200)				15, 951, 814		29.00
30.00	ADD (SPECIFY)			0	,		30.00
31.00				0			31.00
32.00				Ö			32.00
33.00				Ö			33.0
34.00				Ö			34.0
35.00				Ö			35.0
36.00	Total additions (sum of lines 30-35)			Ŭ	0		36.0
37.00	DEDUCT (SPECI FY)			0	0		37.0
38.00				0			38.0
39.00				0			39.00
10.00				0			40.00
40.00 41.00				0			40.0
12.00	Total deductions (sum of lines 37-41)			Ŭ	0		41.00
42.00 43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfor			15, 951, 814		42.0
+3.00	to Wkst. G-3, line 4)			1	13, 731, 014		43.00

Heal th	Financial Systems STARKE	MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provi der	CCN: 15-0102	Peri od:	Worksheet G-3	
					From 01/01/2018 To 12/31/2018	Date/Time Pre	oarod:
					10 12/31/2018	5/31/2019 4:09	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, colu					71, 292, 647	1.00
2.00	Less contractual allowances and discounts on patient	ts' accoun	ts			56, 103, 905	2.00
3.00	Net patient revenues (line 1 minus line 2)					15, 188, 742	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part		43)			15, 951, 814	4.00
5.00	Net income from service to patients (line 3 minus li	ne 4)				-763, 072	5.00
	OTHER I NCOME					-	
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					0	7.00
8.00	Revenues from telephone and other miscellaneous com	nunication	servi ces			0	8.00
9.00	Revenue from television and radio service					0	9.00
10.00						0	10.00
11.00						0	11.00
12.00	J					0	12.00
	Revenue from laundry and linen service					0	13.00
	Revenue from meals sold to employees and guests					0	14.00 15.00
	Revenue from rental of living quarters	to othor th	an notion	t o		0	15.00 16.00
	Revenue from sale of medical and surgical supplies 1 Revenue from sale of drugs to other than patients	to other th	ian patren	ts		-	
	Revenue from sale of medical records and abstracts					0	17.00 18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)					0	18.00
	Revenue from gifts, flowers, coffee shops, and canter					0	20.00
20.00	0	Sell				0	20.00
21.00						0	21.00
23.00						0	22.00
24.00						526, 130	
	Total other income (sum of lines 6-24)					526, 130	
	Total (line 5 plus line 25)					-236, 942	
	OTHER EXPENSES (SPECIFY)					-230, 942	27.00
	Total other expenses (sum of line 27 and subscripts))				0	28.00
	Net income (or loss) for the period (line 26 minus l					-236, 942	
					I		

ALCULATION OF CAPITAL PAYMENT STARKE N	IEMORIAL HOSPITAL Provider CCN: 15-0102	Peri od:	u of Form CMS-2 Worksheet L	2002-
LECOLATION OF CAPITAL PATMENT	Provider CCN. 15-0102	From 01/01/2018 To 12/31/2018	Parts I-III Date/Time Pre 5/31/2019 4:0	
	Title XVIII	Hospi tal	PPS	7 piii
			1.00	
PART I - FULLY PROSPECTIVE METHOD				-
CAPITAL FEDERAL AMOUNT			110 7/1	
00 Capital DRG other than outlier			110, 761	
01 Model 4 BPCI Capital DRG other than outlier 00 Capital DRG outlier payments			0	
01 Model 4 BPCI Capital DRG outlier payments			0	
	cost reporting pariod (see inst	tructions)	3.36	
00 Total inpatient days divided by number of days in the 00 Number of interns & residents (see instructions)	cost reporting period (see this	li uc li olis)	0.00	
00 Indirect medical education percentage (see instructions)	25)		0.00	
00 Indirect medical education adjustment (multiply line 5		columns 1 and	0.00	
1.01) (see instructions)	by the sum of times fand 1.0		0	0.
00 Percentage of SSI recipient patient days to Medicare F 30) (see instructions)	Part A patient days (Worksheet E	E, part A line	0.00	7.
00 Percentage of Medicaid patient days to total days (see	e instructions)		0.00	8
00 Sum of lines 7 and 8	·		0.00	9.
.00 Allowable disproportionate share percentage (see instr	ructions)		0.00	10
. 00 Disproportionate share adjustment (see instructions)			0	11
.00 Total prospective capital payments (see instructions)			110, 761	12.
			1.00	
PART II - PAYMENT UNDER REASONABLE COST			1.00	-
00 Program inpatient routine capital cost (see instruction	anc)		0	1 1
00 Program inpatient ancillary capital cost (see instruct	· · · · · · · · · · · · · · · · · · ·		0	
00 Total inpatient program capital cost (line 1 plus line	· · · · · · · · · · · · · · · · · · ·		0	1 -
00 Capital cost payment factor (see instructions)	2)		0	
00 Total inpatient program capital cost (line 3 x line 4))		0	
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS 00 Program inpatient capital costs (see instructions)			0	1 1
00 Program inpatient capital costs (see instructions) 00 Program inpatient capital costs for extraordinary circ	sumstances (see instructions)		0	
00 Net program inpatient capital costs for extraordinary circ			0	
00 Applicable exception percentage (see instructions)	= 2)		0.00	-
00 Capital cost for comparison to payments (line 3 x line	- 4)		0.00	
00 Percentage adjustment for extraordinary circumstances			0.00	
00 Adjustment to capital minimum payment level for extrac	,	(line 6)	0.00	
00 Capital minimum payment level (line 5 plus line 7)			0	
00 Current year capital payments (from Part I, line 12, a	as applicable)		0	
.00 Current year comparison of capital minimum payment lev		less line 9)	0	10
.00 Carryover of accumulated capital minimum payment level Worksheet L, Part III, line 14)	over capital payment (from pri	or year	0	11.
.00 Net comparison of capital minimum payment level to cap	oital payments (line 10 plus lir	ne 11)	0	12.
.00 Current year exception payment (if line 12 is positive			0	13.
.00 Carryover of accumulated capital minimum payment level			0	14
(if line 12 is negative, enter the amount on this line				
.00 Current year allowable operating and capital payment ((see instructions)		0	
3	(see instructions) tions)		0 0 0	16