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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1329 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/29/2024 7: 24 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/29/2024 7:24 am] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 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 (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(4) Reopened(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARGARET MARY COMMUNITY HOSPITAL (15-1329) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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.

	SIGNATURE OF CHIEF FINA	ANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Crai	g Gilliland	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Craig Gilliland			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

		Title XVIII				
	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1. 00 HOSPI TAL	0	-413, 074	-1, 125, 772	0	-54, 956	1.00
2. 00 SUBPROVI DER - I PF	0	0	0		0	2.00
3. 00 SUBPROVI DER - I RF	0	0	0		0	3.00
5. 00 SWING BED - SNF	0	8, 096	0		92, 687	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		-41, 595		0	10.00
10.01 MEDICAL ARTS CENTER II	0		10, 138		0	10. 01
200. 00 TOTAL	0	-404, 978	-1, 157, 229	0	37, 731	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1329 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 7:24 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 321 MITCHELL 1.00 PO Box: 1.00 State: IN 2.00 City: BATESVILLE Zi p Code: 47006 County: RIPLEY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 MARGARET MARY COMMUNITY 151329 99915 01/07/1966 Ν 0 0 3.00 HOSPI TAL Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 0 MARGARET MARY COMMUNITY 157329 99915 l09/10/2020l N 0 7.00 7.00 HOSPI TAI 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospital -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce MARGARET MARY COMMUNITY 151551 99915 12/31/2003 14.00 14.00 HOSPI TAL 15.00 Hospital-Based Health Clinic - RHC MARGARET MARY COMMUNITY 158511 99915 09/03/2013 Ν 0 Ν 15.00 HOSPI TAL Hospital - Based Health Clinic - RHC MEDICAL ARTS CENTER 158567 99915 06/04/2022 0 Ν 15.01 15.01 Ν 16.00 Hospital-Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 2. 00 1.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22 01 N Ν 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be 22.02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 0 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

				5/29/2	024 7:2	4 am		
			Medi cai		ther			
		ate i cai d	HMO day		di cai d days			
		gi bl e		'	adys			
		pai d						
	1.00 2.00 3.00 4	. 00	5. 00		5. 00			
24.00	If this provider is an IPPS hospital, enter the 0 0	0		0	0	24.00		
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
25.00	If this provider is an IRF, enter the in-state 0 0 0	o		o		25.00		
	Medicaid paid days in column 1, the in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							
		 Jrban∕Ru	ıral SİI	Date of	Geogr			
		1. 00		2.		1		
26. 00	Enter your standard geographic classification (not wage) status at the beginning of the		2			26.00		
	cost reporting period. Enter "1" for urban or "2" for rural.							
27. 00	Enter your standard geographic classification (not wage) status at the end of the cost		2			27. 00		
	reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable,							
35 00	enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in		0			35.00		
33.00	effect in the cost reporting period.		٩			33.00		
	ported in the cost reporting period.	Begi nni	ng:	Endi	ng:			
		1.00)	2.		1		
36. 00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number					36.00		
	of periods in excess of one and enter subsequent dates.							
37. 00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status		0			37.00		
27 01	is in effect in the cost reporting period.					27.01		
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see					37. 01		
	instructions)							
38. 00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is					38.00		
	greater than 1, subscript this line for the number of periods in excess of one and							
	enter subsequent dates.							
		Y/N		Υ/				
20.00		1.00)	2.		20.00		
39. 00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column	N		N	N.	39. 00		
	1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in							
	accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes							
	or "N" for no. (see instructions)							
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or	N		N	J	40.00		
	"N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for							
	no in column 2, for discharges on or after October 1. (see instructions)		1 1/	V0/1-1-1	VIV			
			V 1 00	XVIII		-		
	Prospective Payment System (PPS)-Capital		1.00	2.00	3. 00			
45, 00	Does this facility qualify and receive Capital payment for disproportionate share in acc	ordance	l N	l N	N	45.00		
	with 42 CFR Section §412.320? (see instructions)		"	"	"			
46.00	Is this facility eligible for additional payment exception for extraordinary circumstance		N	N	N	46.00		
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I t	hrough						
	Pt. III.		1		1			
	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for	r no.	N N	N N	N	47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	l N	N	48. 00		
56 00	Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost rep	ortina	T N		T	56.00		
55.00	periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column		14			30.00		
	cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2)							
	the instructions. For column 2, if the response to column 1 is "Y", or if this hospital							
	involved in training residents in approved GME programs in the prior year or penultimate							
	and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction	? Enter						
E7 00	"Y" for yes; otherwise, enter "N" for no in column 2.	5 1/05				E7 00		
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is					57.00		
	is this the first cost reporting period during which residents in approved GME programs at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did	ıı aı ned						
residents start training in the first month of this cost reporting period? Enter "Y" for yes or								
"N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N",								
	complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting perio	ods						
	beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardle							
	which month(s) of the cost report the residents were on duty, if the response to line 56							
	for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet	L-4.	I	I	I	I		

	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.								
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62.00	2.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which								
	your hospital received HRSA PCRE funding (see instructions)								
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital	0. 00	62.01						
	during in this cost reporting period of HRSA THC program. (see instructions)								
	Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter	r facility trained residents in nonprovider settings during this cost reporting period? Enter N							
	"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)								

	Financial Systems			NITY HOSPITA			u of Form CMS-2	
HOSPI	FAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA	Provi der CC	CN: 15-1329	Peri od: From 01/01/2023 To 12/31/2023		pared:
					Unwei ghted FTEs Nonprovi dei Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
					1. 00	2. 00	3. 00	
	Section 5504 of the ACA Base Year period that begins on or after .				This base ye	ear is your cost	reporti ng	
64.00	Enter in column 1, if line 63 in the base year period, the num resident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column 2).	s yes, or your facili aber of unweighted no otations occurring in a number of unweighte our hospital. Enter i	ty traine n-primary all nonp d non-pri n column	d residents care crovider mary care 3 the ratio	0.	0. 00	0. 000000	64.00
	or (corumn r ar vraca by (corumn	Program Name		ram Code	Unwei ghted	Unweighted	Ratio (col.	
					FTEs Nonprovide Site	FTEs in Hospital	3/ (col. 3 + col. 4))	
		1. 00		2. 00	3. 00	4. 00	5. 00	
	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 FTEs	Unweighted FTEs in	Ratio (col. 1 +	
					Nonprovi dei Si te		col . 2))	
		V FTF D! d+- !	- N	.:	1.00	2.00	3.00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n wonprov	n der Setting	JSEITECTIVE	e for cost report	ing periods	
66. 00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 divided by 1 december 1)	unweighted non-prima occurring in all nonp unweighted non-prima al. Enter in column	rovider s ry care r 3 the rat	ettings. esident io of	0.	0. 00	0. 000000	66.00
		Program Name	Prog	ram Code	Unwei ghted FTEs Nonprovi dei Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
	In	1. 00		2. 00	3. 00	4. 00	5. 00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.	00 0.00	0. 000000	67.00

Health Financial Systems MARGARET MARY COMMUNICATION DATA MARGARET MARY COMMUNICATION DATA				u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Period: From 01/01/2023 To 12/31/2023	Worksheet S- Part I Date/Time Pro 5/29/2024 7:	epared:
			V 1.00	XI X 2. 00	-
98.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" focolumn 1 for title V, and in column 2 for title XIX.			Y	Y	98. 00
98.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.				Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o for title V, and in column 2 for title XIX.			Y	Υ	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.			N 1	N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add bawkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co				Y	98. 05
column 2 for title XIX. 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 column 2 for title XIX.			Y	Υ	98. 06
Rural Providers 105.00 Does this hospital qualify as a CAH?			Y		105. 00
106.00 If this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of paymen			106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cotraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IP	1. (see ins you train I&R	structions) Rs in an	N		107. 00
Enter "Y" for yes or "N" for no in column 2. (see instruction 107.01 If this facility is a REH (line 3, column 4, is "12"), is it reimbursement for I&R training programs? Enter "Y" for yes o instructions)	eligible for				107. 01
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	-ll -0 C 40			108.00
CFR Section 9412.113(c). Enter 1 for yes or in for no.		eaure? See 42	N		108.00
CFR Section 9412.113(c). Enter 1 101 yes of N 101 110.	Physi cal	Occupati onal	Speech	Respiratory	108.00
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				Respiratory 4.00 N	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	Physi cal 1.00	Occupati onal 2.00	Speech 3.00	4. 00 N	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	Physical 1.00 N I Demonstrati Y" for yes or	Occupational 2.00 N on project (§	Speech 3.00 N 410A If yes,	4.00	109.00
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, Lines 200 through 218, and Worksheet E, Part A, Lines 218, and Worksheet E, P	Physical 1.00 N I Demonstrati Y" for yes or	Occupational 2.00 N on project (§	Speech 3.00 N 410A If yes,	4. 00 N	109.00
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, Lines 200 through 218, and Worksheet E, Part A, Lines 218, and Worksheet E, P	Physical 1.00 N I Demonstrati Y" for yes or ksheet E-2, I he Frontier C st reporting Iumn 1 is Y, ticipating in	Occupational 2.00 N on project (§ "N" for no. i nes 200 thro community peri od? Enter enter the n column 2.	Speech 3,00 N 410A If yes, ugh 215, as	4. 00 N	109.00
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worlapplicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this come "Y" for yes or "N" for no in column 1. If the response to come integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for additional contents of the services	Physical 1.00 N I Demonstrati Y" for yes or ksheet E-2, I he Frontier C st reporting Iumn 1 is Y, ticipating in	Occupational 2.00 N on project (§ "N" for no. i nes 200 thro Community period? Enter enter the n column 2. s; and/or "C"	Speech 3.00 N 410A If yes, ugh 215, as 1.00 N	4. 00 N	109. 00
 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, Lines 200 through 218, and World applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this complete and the response to complete and t	Physical 1.00 N I Demonstrati Y" for yes or ksheet E-2, I he Frontier C st reporting lumn 1 is Y, ticipating ir ditional beds th Model porting lumn 1 is ating in the	Occupational 2.00 N on project (§ "N" for no. i nes 200 thro community peri od? Enter enter the n column 2.	Speech 3.00 N 410A If yes, ugh 215, as	4. 00 N	1109.00
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worlapplicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cometer "Y" for yes or "N" for no in column 1. If the response to come integration prong of the FCHIP demoniant which this CAH is participate all that apply: "A" for Ambulance services; "B" for addition tele-health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If come "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital ceans.	Physical 1.00 N I Demonstrati Y" for yes or ksheet E-2, I he Frontier C st reporting lumn 1 is Y, ticipating ir ditional beds th Model porting lumn 1 is ating in the sed "N" for no , or E only) 3" percent includes	Occupational 2.00 N on project (§ "N" for no. ines 200 thro community period? Enter enter the n column 2. s; and/or "C"	Speech 3.00 N 410A If yes, ugh 215, as 1.00 N	4.00 N	109. 00
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cometer "Y" for yes or "N" for no in column 1. If the response to come integration prong of the FCHIP demonstration for this CAH is pare Enter all that apply: "A" for Ambulance services; "B" for addition to tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If come "Y", enter in column 2, the date the hospital began participed demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider.	Physical 1.00 N I Demonstrati Y" for yes or ksheet E-2, I he Frontier C st reporting lumn 1 is Y, ticipating in ditional beds th Model porting lumn 1 is ating in the sed "N" for no , or E only) 3" percent includes s) based on	Occupational 2.00 N on project (§ "N" for no. i nes 200 thro community peri od? Enter enter the n col umn 2. s; and/or "C" 1.00 N	Speech 3.00 N 410A If yes, ugh 215, as 1.00 N	4.00 N	1109.000

117. 00 118. 00

117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.

If this facility is part of a	chain organization, enter on lines 1	41 through 143 the nai	me and address	s of the home	
office and enter the home office	ce contractor name and contractor nu	mber.			
141.00 Name:	Contractor's Name:	Contractor'	s Number:		141. 00
142.00 Street: P0 Box:					142.00
143.00 Ci ty:	00 City:				143.00
				1.00	
144.00 Are provider based physicians'	Υ	144.00			
			1. 00	2.00	
145.00 If costs for renal services are	e claimed on Wkst. A, line 74, are t	he costs for			145.00
inpatient services only? Enter	"Y" for yes or "N" for no in column	1. If column 1 is			
no, does the dialysis facility	include Medicare utilization for th	is cost reporting			
period? Enter "Y" for yes or'	'N" for no in column 2.				
146.00 Has the cost allocation methodo	ology changed from the previously fi	led cost report?	N		146.00
	o in column 1. (See CMS Pub. 15-2, c				
yes, enter the approval date (r	om /dd /vaaav) in ool umn 2				

Health Financial Systems	MARGARET MAR	Y COMM	UNITY HOSPITAI	L		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DAT	A	Provi der CC	Provider CCN: 15-1329 Period: From 01/01/20 To 12/31/20		od:	Worksheet S- Part I Date/Time Pr 5/29/2024 7:	2 epared:
							1. 00	-
147.00 Was there a change in the statist	ical basis? Enter "Y"	for v	es or "N" for	no no			N 1.00	147.00
148.00 Was there a change in the order o							N N	148. 00
149.00 Was there a change to the simplif					for no.		N	149.00
			Part A	Part	В	Title V	Title XIX	
			1. 00	2. 00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or							3. 13)	
155. 00 Hospi tal			N	N		N	N	155. 00
156. 00 Subprovi der – TPF			N	N N		N	N	156.00
157. 00 Subprovi der - I RF			N	N N		N	N	157.00
158. 00 SUBPROVI DER 159. 00 SNF			N	l N		N	N	158. 00 159. 00
160.00HOME HEALTH AGENCY			N	l N		N	N N	160.00
161. OOKHC			IN	l N		N	N N	161.00
		I					1.00	-
Mul ti campus								
165.00 s this hospital part of a Multic Enter "Y" for yes or "N" for no.	t CBSAs?	N	165. 00					
	Name		County	State	Zip Co		FTE/Campus	
	0		1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 fline 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	0166.00
							1. 00	
Health Information Technology (HI	T) incentive in the A	America	an Recovery an	nd Rei nves	tment A	ct	1.00	
167.00 s this provider a meaningful use							Y	167. 00
168.00 If this provider is a CAH (line 1) reasonable cost incurred for the	O5 is "Y") and is a m	neani ng	ıful user (lin			nter the		168. 00
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user	, does	this provide	r qualify	for a h	nardshi p		168. 01
169.00 If this provider is a meaningful transition factor. (see instructions)	user (line 167 is "Y") and	is not a CAH	(line 105	is "N")	, enter the	O. C	0169.00
						Begi nni ng	Endi ng	
	1.00							
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and en	nding d	late for the r	eporti ng				170. 00
						1. 00	2.00	
171.00 If line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3 umn 1. If column 1 is	B, Pt.	I, line 2, co	I. 6? Ent		N		0171.00

Ν

19.00

Ν

If line 16 or 17 is yes, were adjustments made to PS&R

Report data for corrections of other PS&R Report

information? If yes, see instructions.

Heal th	Financial Systems MARGARET MARY COI	MMUNITY HOSPITA	L	In Lie	u of Form CM:	S-2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1329 P	eri od:	Worksheet S			
				rom 01/01/2023 o 12/31/2023		repared:		
					5/29/2024 7			
		Descri	ption)	Y/N 1. 00	Y/N 3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R)	N N	N S. 00	20.00		
	Report data for Other? Describe the other adjustments:	11.40						
		Y/N 1.00	<u>Date</u> 2.00	Y/N 3. 00	Date 4.00			
21. 00	Was the cost report prepared only using the provider's	N N	2.00	N N	4.00	21.00		
	records? If yes, see instructions.							
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS I	HOSPI TALS)		1.00			
	Capital Related Cost							
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, so Have changes occurred in the Medicare depreciation expense		sals made duri	na the cost	N N	22. 00 23. 00		
23.00	reporting period? If yes, see instructions.	c due to apprais	sars made duri	ng the cost		23.00		
24. 00	Were new leases and/or amendments to existing leases enter	red into during	this cost rep	orting period?	N	24. 00		
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	a the cost reno	rting period?	If ves see	N	25. 00		
20.00	instructions.	g the cost repo	tring period.	11 yes, see		20.00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	the cost report	ng period? If	yes, see	N	26. 00		
27. 00	instructions. Has the provider's capitalization policy changed during th	ne cost reporti	na period? If	ves. submit	N	27. 00		
	сору.			, ,				
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit e	entered into du	sing the cost	roporti na	N	28. 00		
28.00	period? If yes, see instructions.	enterea into au	rng the cost	reporting	IN IN	28.00		
29. 00	Did the provider have a funded depreciation account and/or	•	ebt Service Re	serve Fund)	N	29. 00		
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		dobt2 Lf voc	500	N	30.00		
30.00	instructions.	turity writh new	debt? IT yes,	266	IN	30.00		
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see	N	31.00		
	instructions. Purchased Services							
32. 00		ervi ces furni sh	ed through con	tractual	N	32.00		
	arrangements with suppliers of services? If yes, see instr							
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 apno, see instructions.	oplied pertainii	ng to competit	ive bidding? If	N	33.00		
	Provi der-Based Physi ci ans							
34. 00	Were services furnished at the provider facility under an	arrangement wi	th provider-ba	sed physicians?	Y	34. 00		
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	vistina aareeme	nts with the n	rovi der_hased	Υ	35. 00		
33.00	physicians during the cost reporting period? If yes, see i	nstructions.	its with the p	TOVI GCI Dasca		33.00		
				Y/N	Date			
	Home Office Costs			1.00	2. 00			
36. 00	Were home office costs claimed on the cost report?			N		36.00		
37. 00	If line 36 is yes, has a home office cost statement been p	orepared by the	home office?	N		37. 00		
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	ffice different	from that of	N		38.00		
	the provider? If yes, enter in column 2 the fiscal year er	nd of the home	offi ce.					
39. 00	If line 36 is yes, did the provider render services to oth see instructions.	ner chain compo	nents? If yes,	N		39. 00		
40. 00		e home office?	If yes, see	N		40.00		
	i nstructi ons.							
		1.	00	2	00			
	Cost Report Preparer Contact Information	1.		2.				
41. 00	Enter the first name, last name and the title/position	e, last name and the title/position KYLE SMITH						
	held by the cost report preparer in columns 1, 2, and 3, respectively.							
42. 00	Enter the employer/company name of the cost report	BLUE & CO., LL	С			42.00		
	preparer.				DOG 0011			
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43.00		
	1. opo. c p. opor or the obtained it and 2, it oppositivory.	1		1		II		

Heal th	Financial Systems MARGARET MARY CO	DMML	JNI TY HOSPI TAL		In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der CCN: 15-1329		eriod: rom 01/01/2023	Worksheet Part II	S-2	
				To			Pre 7: 2	pared: 4 am
			3. 00					
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	DI	RECTOR					41.00
	held by the cost report preparer in columns 1, 2, and 3,							
	respectively.							
42.00	Enter the employer/company name of the cost report							42.00
	preparer.							
43.00	Enter the telephone number and email address of the cost							43.00
	report preparer in columns 1 and 2, respectively.							

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

Component Worksheet A No. of Beds Bed Days CAH/REH Hours Title V Title No.						o 12/31/2023	Date/Time Pre 5/29/2024 7:2	
Component								T CIII
Component Worksheet A No. of Beds Robel Days CAH/REH Hours Title V Line No. 1.00 2.00 3.00 4.00 5.00								
PART I - STATISTICAL DATA 1.00 2.00 3.00 4.00 5.00							Tri ps	
PART I - STATISTICAL DATA		Component		No. of Beds		CAH/REH Hours	Title V	
DART I - STATISTICAL DATA 1.00 Hospitolal Adul its & Pedis (col umis 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) 2.00 Moland other (see instructions) 2.00 3.00 4.00 Mol RF Subprovi der 4.00 0.5.00 4.00 4.00 Mol RF Subprovi der 4.00 0.5.00 4.00				2.22				
Nospital 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)		DADT I CTATICTICAL DATA	1.00	2.00	3.00	4.00	5.00	
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 IPF Subprovi der 4.00 HM0 IPF Subprovi der 4.00 HM0 IPF Subprovi der 5.00 Hospi tal Adult s Peds. Swing Bed SNF 6.00 Hospi tal Adult s Peds. Swing Bed SNF 7.00 Total Adult sand Peds. (exclude observation beds) (see instructions) 8.00 INTENSI VE CARE UNIT 9.00 CORMANY CARE UNIT 9.00 CORMANY CARE UNIT 10.00 SUBGRAVIA CARE UNIT 11.00 SUBGRAVIA CARE (SPECIFY) 12.00 Total (see instructions) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAR Wi sits 16.00 Subprovi DER - IRF 16.00 Subprovi DER - IRF 16.00 Subprovi DER - IRF 17.00 SUBGROVI DER - IRF 18.00 SUBPROVI DER - IRF 18.00 S	1 00		20.00	10	(570	74 ((4 00	0	1 00
Hospice days) (see instructions for col. 2	1.00		30.00	18	6,570	74, 664. 00	U	1.00
For the portion of LDP room available beds) 2.00 Mo and other (see instructions) 3.00 3.00 Mo and other (see instructions) 3.00 3.00 3.00 Mo IMP S Subprovi der 4.00 5.00 6.								
2.00 HM0 and other (see instructions) 3.00 HM0 IRF Subprovider 4.00 4.00 HM0 IRF Subprovider 6.00 HM0 IRF Subprovider 6.00 HM0 IRF Subprovider 6.00 HM0 IRF Subprovider 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 Hospital Adults and Peds. (exclude observation beds) (see instructions) 8.01 INTENSIVE CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 11.00 SUBROVIDER (SEPCIFY) 12.00 TOTAL (see instructions) 13.00 NORSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 Subprovider IPF 17.00 Total (see instructions) 16.00 Subprovider IPF 17.00 Total (see instructions) 17.00 Total (see instructions) 18.00 Total (see instructions) 18.00 Total (see instructions) 18.00 Total (see instructions) 19.00 Total (see instructions) 19.00 Total (see instructions) 10.00 Total (see instructions) 10.								
3.00 HM0 IPF Subprovi der 4.00 HM0 IPF Subprovi der 5.00 Hcspit tal Adult s & Peds. Swing Bed SNF 6.00 Hospit tal Adult s & Peds. Swing Bed NF 7.00 Tortal Adult s and Peds. (exclude observation beds) (see instructions) 8.00 INTENSI VE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 SURGI CAL INTENSI VE CARE UNI T 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 13.00 NURSERY 13.00 LAH vi sits 15.10 Ref hours and vi sits 16.00 SUBPROVI DER - I RF 18.00 SUBPROVI DER - I RF 19.00 SUBPROVI DER - I RF 19.00 SUBPROVI DER REM CALL LITY 10.00 ON BURSING FACILITY 10.00 ON BU	2 00							2 00
MAD I RF Subprovi der		,						
5.00 Hospi tal Adult s & Peds. Swing Bed SNF 0 5.00								
0.00 Hospital Adulta & Peds. Swing Bed NF Total Adulta and Peds. (exclude observation beds) (see instructions) 18		•					0	
beds) (see instructions)	6.00						0	6. 00
8.00 INTÉRISIVE CARE UNIT 31.00 7 2.555 5,688.00 0 8.00 10.00 CORONARY CARE UNIT 10.00 11.00 SURGI CAL INTERISIVE CARE UNIT 11.00 12.00 THER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 43.00 25 9,125 80,352.00 0 14.00 15.00 CAH visits 0 0 0 15.00 CAH visits 0 0 16.00 SUBPROVIDER - IPF 0 0 17.00 SUBPROVIDER - IRF 0 0 18.00 SUBPROVIDER 1 0 0 19.00 CAH CALLITY 0 0 0 19.00 CAH CALLITY 0 0 0 19.00 O O 0 0 19.00 CAH CALLITY 0 0 0	7.00	Total Adults and Peds. (exclude observation		18	6, 570	74, 664. 00	0	7. 00
9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00								
10. 00 BURN INTENSIVE CARE UNIT 10. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 11. 00 12. 00 0 0 0 0 0 12. 00 11. 00 12. 00 0 0 0 0 0 0 0 0 0	8.00	INTENSIVE CARE UNIT	31. 00	7	2, 555	5, 688. 00	0	8.00
11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 0THER SPECIAL CARE (SPECIFY) 43.00 12.00 0THER SPECIAL CARE (SPECIFY) 43.00 12.00 13.00 14.00 15.00 14.00 15.00	9.00	CORONARY CARE UNIT						9. 00
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 17.00 Total (see instructions) 18.00 NURSERY 18.00 CAH visits 18.00 CAH visits 18.00 CAH visits 18.00 SUBPROVI DER - IPF 18.00 SUBPROVI DER - IPF 18.00 SUBPROVI DER - IRF 18.00 SUBPROVI DER REM CARE 19.00 SKILLED NURSING FACILITY 19.00 AMBULATORY SURGI CAL CENTER (D. P.) 21.00 OTHER LONG TERM CARE 21.00 AMBULATORY SURGI CAL CENTER (D. P.) 24.10 HOSPI CE (non-distinct part) 25.00 CMC - CMHC 26.01 MEDI CAL ARTS CENTER 27.00 Total (sum of lines 14-26) 28.00 Observati on Bed Days 29.00 Ambulance Trips 29.00 Employee di scount days - IRF 29.00 Sugn Over delivery days (see instructions) 20.01 Total ancillary labor & delivery room outpatient days (see instructions) 21.01 CTH NON-COVERED ASSOCIATION (STRUCTIONS) 20.01 Total ancillary labor & delivery room outpatient days (see instructions) 25.02 CARCHORD (STRUCTIONS) 26.01 Total (sum or covered days) 27.00 LTCH non-covered days 28.00 LTCH non-covered days 29.00 ASSOCIATION (STRUCTIONS) 29.00 ASSOCIATION (STRUCTIONS) 20.00 LTCH non-covered days 20.01 Structions) 25.00 CARCHORD (STRUCTIONS) 25.00 CARCHORD (STRUCTIONS) 26.01 CARCHORD (STRUCTIONS) 27.00 CARCHORD (STRUCTIONS) 28.00 LTCH non-covered days 29.00 ASSOCIATION (STRUCTIONS) 29.00 ASSOCIATION (STRUCTIONS) 20.00 LTCH non-covered days 29.00 ASSOCIATION (STRUCTIONS) 20.00 LTCH non-covered days 29.00 ASSOCIATION (STRUCTIONS) 29.00 ASSOCIATION (STRUCTIONS) 20.00 LTCH non-covered days 29.00 ASSOCIATION (STRUCTIONS) 29.0		BURN INTENSIVE CARE UNIT						
13.00 NURSERY	11. 00	SURGICAL INTENSIVE CARE UNIT						
14. 00								
15.00 CAH visits			43. 00					
15. 10 REH hours and visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 19. 00 SYILLED NURSING FACILITY 19. 00 WINSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 00 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Tri ps 30. 00 Employee di scount days (see instruction) 31. 00 Employee di scount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days				25	9, 125	80, 352. 00		
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17. 00 SUBPROVI DER - IRF 17. 00 18. 00 SUBPROVI DER 18. 00 18. 00 SUBPROVI DER 19. 00 SKILLED NURSI NG FACILITY 19. 00 18. 00 19. 00 NURSI NG FACILITY 20. 00 NURSI NG FACILITY 20. 00 20. 00 21. 00 21. 00 22. 00 HOME HEALTH AGENCY 21. 00 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 23. 00 24. 00 HOSPI CE 116. 00 0 0 24. 00 24. 10 HOSPI CE 16. 00 24. 10 25. 00 24. 10 25. 00 24. 10 25. 00 24. 10 25. 00 26. 00 26. 00 26. 01 26. 00 26. 01 26. 02 26. 00 26. 01 26. 00 26. 01 26. 02 26. 00 26. 01 26. 01 26. 02 26. 00 26. 01 26. 02 26. 00 26. 01 26. 00 26. 01 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00 26. 00						0.00	0	
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19. 00 SKILLED NURSING FACILITY								
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21.00 OTHER LONG TERM CARE 21.00								
22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 116.00 0 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 88.00 26.01 MEDICAL ARTS CENTER 88.01 26.25 Total (sum of lines 14-26) 27.00 Observation Bed Days 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 101.00 22.00 23.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE			101 00				0	
24.00 HOSPICE (non-distinct part) 30.00			101.00				O	
24. 10 HOSPICE (non-distinct part) 30.00 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 88.00 26. 01 MEDICAL ARTS CENTER 88.01 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 27. 00 Total (sum of lines 14-26) 25 28. 00 Observation Bed Days 29.00 Ambulance Trips 29.00 30. 00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days			116 00	0	1			
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27.00 Total (sum of lines 14-26) 25 27.00 28.00 29.00 28.00 29.0	26. 01	MEDICAL ARTS CENTER	88. 01				0	26. 01
28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 29.00 30.00 30.00 30.00 31.00 32.01 33.00	27.00	Total (sum of lines 14-26)		25				27.00
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days 30.00 0 0 0 0 32.00 32.01 33.00	28.00	Observation Bed Days					0	28.00
31.00 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 31.00 0 0 0 0 32.00 32.01 LTCH non-covered days	29. 00							29.00
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH non-covered days	30.00	Employee discount days (see instruction)						30.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00		, ,						
outpatient days (see instructions) 33.00 LTCH non-covered days 33.00				0	0			
33.00 LTCH non-covered days 33.00	32. 01							32. 01
	00.05							00.00
33.01 LTCH site neutral days and discharges 33.01 Temporary Expansion COVID-19 PHE Acute Care 30.00 0 0 34.00			20.00	_				
34.00 Temporary Expansion COVID-19 PHE Acute Care 30.00 0 0 34.00	34.00	Tremporary expansion covid-19 PHE Acute Care	30.00	0	1	1	0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

34.00 Temporary Expansion COVID-19 PHE Acute Care

Provider CCN: 15-1329

0

34.00

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/29/2024 7:24 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Title XIX Component Total ALL Total Interns Employees On Pati ents & Residents Payrol I 6. 00 7.00 8.00 9.00 10.00 PART I - STATISTICAL DATA 1, 193 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 83 3, 111 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) 642 575 2.00 3.00 HMO IPF Subprovider HMO IRF Subprovider 3 00 0 4.00 0 C 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 325 0 325 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 277 6.00 Total Adults and Peds. (exclude observation 7.00 1, 518 83 3,713 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 65 237 8.00 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11 00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 672 13.00 1, 583 14.00 Total (see instructions) 89 4,622 0.00 495.26 14.00 15.00 CAH visits C 15.00 15. 10 REH hours and visits 0 0 15.10 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVI DER 18.00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 0.00 22.00 0 0 0 0.00 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 0.00 0 C 0 0.00 24.00 24.00 24.10 HOSPICE (non-distinct part) 0 24.10 CMHC - CMHC 25.00 25.00 RURAL HEALTH CLINIC 15. 43 26 00 1.552 3,726 11 706 0 00 26 00 MEDICAL ARTS CENTER 26.01 5, 786 2, 184 17, 262 0.00 24.33 26.01 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 535.02 27.00 Observation Bed Days 28 00 1, 923 2, 238 28 00 Ambul ance Trips 29.00 0 29.00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 32 00 0 Ω 0 32 00 32.01 Total ancillary labor & delivery room 0 32.01 outpatient days (see instructions) LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 0 33.01

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1329

				10	12/31/2023	5/29/2024 7: 2	
		Full Time Equivalents	-	Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	376	29	1, 222	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)			148	270		2. 00
3.00	HMO IPF Subprovider				0		3.00
4. 00	HMO IRF Subprovider				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
0 00	beds) (see instructions)						0.00
8. 00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10. 00 11. 00
12. 00	1						12.00
13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	376	29	1, 222	14.00
15. 00	CAH vi si ts	0.00	U	370	27	1, 222	15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	0.00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0. 00					26.00
26. 01	MEDICAL ARTS CENTER	0. 00					26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days			О			33. 00
33. 00	LTCH non-covered days LTCH site neutral days and discharges			0			33.00
	Temporary Expansion COVID-19 PHE Acute Care						34. 00
57.00	Transporting Expansion Covid-17 The Acute Care			ı l	l	ļ	37.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		MUNITY HOSPITA Provider C		Peri od:	eu of Form CN Worksheet S		'
			CCN: 15-8511	From 01/01/202 To 12/31/202	3	Prep	
				RHC I	Cos		r aiii
						Ì	
Clinic Address and Identification					. 00	\dashv	
.00 Street				112 N. BUCKEY	E ST.	П	1. 0
			ty	State	ZIP Code		
			00	2. 00	3. 00		
2.00 City, State, ZIP Code, County	(OSGOOD			N 47037	_	2.0
					1.00		
B. 00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for	urban		1.00	0	3.0
			Gra	nt Award	Date		
				1.00	2. 00		
Source of Federal Funds			1		T		
4.00 Community Health Center (Section 330(d), PHS 5.00 Migrant Health Center (Section 329(d), PHS A						1	4. 0 5. 0
5.00 Health Services for the Homeless (Section 34						l	6.0
7.00 Appal achi an Regional Commission	o(d), This Act)					l	7.0
3. 00 Look-Alikes							8.0
P. 00 OTHER (SPECIFY)							9.0
				1.00	0.00	\rightarrow	
0.00 Does this facility operate as other than a h	osnital based F	DUC or EDUC2 E	ntor "V" for	1. 00 N	2. 00		10. C
yes or "N" for no in column 1. If yes, indic						۷	10. 0
2. (Enter in subscripts of line 11 the type o							
	Sund	day	Λ.	Monday	Tuesday		
	from	to	from	to	from		
[F., 111] 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	1. 00	2. 00	3.00	4. 00	5. 00	_	
Facility hours of operations (1) 11.00 CLINIC			08: 00	16: 30	08: 00		11. 0
1.00 CLINIC			08.00	10. 30	08.00		11.0
				1. 00	2.00		
12.00 Have you received an approval for an excepti	on to the produ	uctivity stand	ard?	Y			12.0
10 00 1 - 1 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		100 04 chanta	r 9, section	ı N		ol	13.0
30.8? Enter "Y" for yes or "N" for no in col	umn 1. If yes,	enter in colu					
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	umn 1. If yes,	enter in colu		· · · · · · · · · · · · · · · · · · ·			
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	umn 1. If yes, List the names	enter in colu s of all provi	ders and				13. 0
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	umn 1. If yes, List the names ing multiple co	enter in colu s of all provi	ders and Cs (as defin	ned N			13. 0
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoling.	umn 1. If yes, List the names ing multiple co)? Enter "Y" f dated RHC group	enter in colum s of all providonsolidated RHF For yes or "N" bings and comp	ders and Cs (as defin for no. If lete a	ned N			13. 0
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated	umn 1. If yes, List the names ing multiple co)? Enter "Y" f dated RHC group RHC grouping.	enter in colu s of all providonsolidated RH for yes or "N" bings and comp Consolidated	ders and Cs (as defin for no. If lete a RHC groupin	ned N			13. 0
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered c	umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC	enter in colu s of all provi pnsolidated RH for yes or "N" bings and comp Consolidated Cs in the grou	ders and Cs (as defin for no. If lete a RHC groupin	ned N			13. 0
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated	umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC	enter in colu s of all provi pnsolidated RH for yes or "N" bings and comp Consolidated Cs in the grou	ders and Cs (as defin- for no. If lete a RHC groupin- ping or	ned N	CCN		13.0
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered c	umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC	enter in colu s of all provi pnsolidated RH for yes or "N" bings and comp Consolidated Cs in the grou	ders and Cs (as defin- for no. If lete a RHC groupin- ping or	ned N	CCN 2.00		13. 0
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered c	umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC Cs in the group	enter in colus of all provious	ders and Cs (as definfor no. If lete a RHC groupinping or Prov	ngs N ngs name 1.00	2.00	0	
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH	umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC Cs in the group	enter in colus of all provides of all providence	ders and Cs (as defin- for no. If lete a RHC groupin- ping or Prov	ngs N N ngs N N N N N N N N N N N N N N N N N N N	2.00 Total Visit	0	
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered c comprised exclusively of new consolidated RH 14.00 RHC/FQHC name, CCN	umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC Cs in the group	enter in colus of all provious	ders and Cs (as definfor no. If lete a RHC groupinping or Prov	ngs N ngs name 1.00	2.00	0	14.0
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH 14.00 RHC/FQHC name, CCN 15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	enter in colus of all provides of all providence	ders and Cs (as defin- for no. If lete a RHC groupin- ping or Prov	ngs N N ngs N N N N N N N N N N N N N N N N N N N	2.00 Total Visit	0	14. 0
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH 14.00 RHC/FOHC name, CCN 15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	enter in colus of all provides of all providence	ders and Cs (as defin- for no. If lete a RHC groupin- ping or Prov	ngs N N ngs N N N N N N N N N N N N N N N N N N N	2.00 Total Visit	0	14. 0
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH 14.00 RHC/FOHC name, CCN 15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	enter in colus of all provides of all providence	ders and Cs (as defin- for no. If lete a RHC groupin- ping or Prov	ngs N N ngs N N N N N N N N N N N N N N N N N N N	2.00 Total Visit	0	14. 0
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH 14.00 RHC/FOHC name, CCN 15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	enter in colus of all provides of all providence	ders and Cs (as defin- for no. If lete a RHC groupin- ping or Prov	ngs N N ngs N N N N N N N N N N N N N N N N N N N	2.00 Total Visit	0	
30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH 14.00 RHC/FQHC name, CCN 15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	umn 1. If yes, List the names ing multiple cc)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	enter in colus of all provides of all providence	ders and Cs (as defin- for no. If lete a RHC groupin- ping or Prov	ngs N N ngs N N N N N N N N N N N N N N N N N N N	2.00 Total Visit	0	14. 0

Health Financial Systems	MARGARET MARY CO	MMUNITY HOSPITA	AL	In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CCN: 15-1329	Peri od:	Worksheet S-8	3	
		Component	CCN: 15-8511	From 01/01/2023 To 12/31/2023		epared: 24 am	
				RHC I	Cost		
		Cou	unty				
		4.	00				
2.00 City, State, ZIP Code, County						2.00	
	Tuesday	Wedn	esday	Thursday			
	to	from	to	from	to		
	6. 00	7.00	8. 00	9. 00	10.00		
Facility hours of operations (1)							
11. 00 CLINI C	16: 30	08: 00	16: 30	08: 00	16: 30	11.00	
	Fr	i day	Sa	turday			
	from	to	from	to			
	11. 00	12. 00	13.00	14. 00			
Facility hours of operations (1)							
11. 00 CLINIC	07: 00	06: 00	08: 00	12: 00		11. 00	

Heal th	Financial Systems MAR	GARET MARY COM	MUNITY HOSPITA	.L	In Li∈	eu of Form CMS	S-2552
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1329	Peri od: From 01/01/2023	Worksheet S	-8
			Component	CCN: 15-8567	To 12/31/2023	Date/Time P	
					RHC II	5/29/2024 7 Cost	
	01: :: - Address				1.	00	
1. 00	Clinic Address and Identification Street				188 STATE ROUT	F 129	1.
1.00	Total coet		Ci	ty	State	ZIP Code	''
	Tax and a second			00	2. 00	3. 00	
2. 00	City, State, ZIP Code, County		BATESVI LLE			47006	2.
						1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for				0 3.
					nt Award	Date	
	Source of Federal Funds				1. 00	2.00	
4. 00	Community Health Center (Section 330(d), PHS	Act)					4.
5. 00	Migrant Health Center (Section 329(d), PHS A						5.
6. 00 7. 00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	O(d), PHS Act)					6. 7.
8. 00	Look-Alikes						8.
9. 00	OTHER (SPECIFY)						9.
					4.00	0.00	
10.00	Does this facility operate as other than a h	osnital-hased [RHC or FOHC2 F	nter "Y" for	1. 00 N	2.00	0 10.
10.00	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operation	ns in column			0 10.
	Trock 3. /	Sun	day	M	londay	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1. 00	2. 00	3. 00	4. 00	5.00	
11. 00	CLINIC			08: 00	16: 30	08: 00	11.
12.00	Hove you received an approval for an eventi	on to the produ	10+1111 +11 0+0md	o rad?	1.00	2. 00	12
	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub.' umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	Y		0 13.
13. 01	If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC	for yes or "N" bings and comp Consolidated Cs in the grou	for no. If lete a RHC grouping			0 13.
		.,,	.,		der name	CCN	
14.00	DUC/FOLIC name CON				1. 00	2. 00	1.1
14.00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visit	14.
		1. 00	2.00	3.00	4.00	5. 00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.

Health Financial Systems MA	MARGARET MARY COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-1			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1329	Peri od:	Worksheet S-8	3	
		Component	CCN: 15-8567	From 01/01/2023 To 12/31/2023		epared: 24 am	
				RHC II	Cost		
		Cou	unty				
		4.	00				
2.00 City, State, ZIP Code, County		RI PLEY				2.00	
	Tuesday	Wedn	esday	Thursday			
	to	from	to	from	to		
	6. 00	7. 00	8. 00	9. 00	10.00		
Facility hours of operations (1)							
11. 00 CLINIC	16: 30	08: 00	16: 30	08: 00	16: 30	11.00	
	Fri	day	Sa	turday			
	from	to	from	to			
	11. 00	12. 00	13. 00	14. 00			
Facility hours of operations (1)							
11. 00 CLINIC	07: 00	06: 00	08: 00	12: 00		11.00	

HOSPI ⁻	TAL-BASED HOSPICE IDENTIFICATION	I DATA		Provi der CC Hospi ce CCI	CN: 15-1329 N: 15-1551	Peri od: From 01/01/2023 To 12/31/2023		GH IV pared:
						Hospi ce I	5/29/2024 7: 2	4 am
		Unduplicated				поѕргсе г		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility			,	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING I	PERIODS BEGINN	ING BEFORE OCTO	DBER 1, 2015			
1. 00	Hospice Continuous Home Care							1.00
2. 00	Hospice Routine Home Care							2.0
3. 00	Hospice Inpatient Respite Care							3.0
4. 00	Hospice General Inpatient Care							4.0
5. 00	Total Hospice Days							5.0
	Part II - CENSUS DATA FOR COST	REPORTING PER	ODS BEGINNING	BEFORE OCTOBER	R 1, 2015			
5. 00	Number of patients receiving							6.0
	hospi ce care							
7. 00	Total number of unduplicated							7.0
	Continuous Care hours billable							
	to Medicare							
3. 00	Average Length of Stay (line 5 / line 6)							8.0
9. 00	Unduplicated census count							9.0
		-1 ! 1	*II		2 1 4			9.00
OIE:	Parts I and II, columns 1 and 2	arso include	the days repor		3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							cols. 1	
							through 3)	
				1. 00	2. 00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERIODS BEGI	NNING ON OR AFT	TER OCTOBER 1	· -		
10.00				0		0 0		10.0
11.00				9, 727	'	95 664	10, 486	
12.00				0		0 1	1	
	Hospice General Inpatient Care			0		0 0	0	
14.00	Total Hospice Days	AL DATA FOR CO.	OT DEDODTING S	9, 727		95 665	10, 487	j 14. 00
15 00	PART IV - CONTRACTED STATISTICA		SI REPURITNG P					1
15.00				0 0		0 0		
	Hospice General Inpatient Care			1 ()	I	()	()	l 16.0

	Financial Systems MARGARET MARY COMMUNI				u of Form CMS-2		
HOSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CCI		Period: From 01/01/2023 Fo 12/31/2023		pared:	
					1 00		
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1. 00		
	Uncompensated and Indigent Care Cost-to-Charge Ratio					1	
1.00	Cost to charge ratio (see instructions)		0. 286018	1.00			
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		7, 123, 558				
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			i d?		4.00	
5. 00 6. 00	If line 4 is no, then enter DSH and/or supplemental payments fr Medicaid charges	rom Medicald	a		0	5. 00 6. 00	
7. 00	Medicaid cost (line 1 times line 6)				33, 862, 721 9, 685, 348		
8. 00	Difference between net revenue and costs for Medicaid program ((see instru	rtions)		2, 561, 790	1	
0.00	Children's Health Insurance Program (CHIP) (see instructions for each line)						
9. 00	Net revenue from stand-alone CHIP		0	9.00			
	Stand-alone CHIP charges				0	10.00	
	Stand-alone CHIP cost (line 1 times line 10)				0	1	
12. 00	Difference between net revenue and costs for stand-alone CHIP (0	12.00	
12 00	Other state or local government indigent care program (see inst Net revenue from state or local indigent care program (Not incl				0	13.00	
14. 00	Charges for patients covered under state or local indigent care				0		
14.00	10)	program (i	iot Therauca	111 111103 0 01	O	14.00	
15.00	State or local indigent care program cost (line 1 times line 14	4)			0	15.00	
16.00	Difference between net revenue and costs for state or local inc				0	16.00	
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/local indig	ent care progra	ms (see		
17 00	instructions for each line)				0	17 00	
	Private grants, donations, or endowment income restricted to fu Government grants, appropriations or transfers for support of h				0	17. 00 18. 00	
19.00				(sum of lines	2, 561, 790		
17.00	8, 12 and 16)	mar gent v	sare programs	(Sam of Titles	2,001,770	17.00	
			Uni nsured	Insured	Total (col. 1		
			pati ents	pati ents	+ col. 2)		
			1. 00	2. 00	3. 00		
20.00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions)		250, 539	843, 530	1, 094, 069	20.00	
21. 00	Cost of patients approved for charity care and uninsured discou		250, 53° 71, 65°	·			
21.00	instructions)	ants (see	71,05	043, 530	715, 107	21.00	
22. 00	Payments received from patients for amounts previously written	off as	(o	0	22.00	
	chari ty care						

		patrents	patrents	+ (01. 2)	
		1.00	2. 00	3. 00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see				21.00
	instructions)				
22.00	Payments received from patients for amounts previously written off as				22. 00
	chari ty care				
23. 00	Cost of charity care (see instructions)				23.00
				1. 00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyon	nd a Length of	stay limit		24.00
	imposed on patients covered by Medicaid or other indigent care program?				
25. 00	If line 24 is yes, enter the charges for patient days beyond the indigen	t care program	's length of		25. 00
	stay limit				
	Charges for insured patients' liability (see instructions)				25. 01
	Bad debt amount (see instructions)				26. 00
	Medicare reimbursable bad debts (see instructions)				27. 00
	Medicare allowable bad debts (see instructions)				27. 01
	Non-Medicare bad debt amount (see instructions)				28. 00
	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	instructions)			29. 00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)				30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31.00

Heal th	Financial Systems MAR	GARET MARY COMM	MUNITY HOSPITA	L	In Lie	u of Form CMS-:	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C	CN: 15-1329 F	Peri od:	Worksheet A	
					From 01/01/2023 To 12/31/2023		
	Cook Cooks Doors at a	C-1	0+1	T-+-1 (1 1	D1: 6:+	5/29/2024 7: 2	4 am
	Cost Center Description	Sal ari es	Other	+ col . 2)	Reclassificat ions (See	Reclassified Trial Balance	
					A-6)	(col . 3 +-	
					·	col. 4)	
	CENEDAL CEDIULCE COCT CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT		2, 531, 625	2, 531, 625	-34, 748	2, 496, 877	1.00
1. 01	00101 NEW CAP REL COSTS-OFFSITE BLDG		824, 732			859, 480	1
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP		4, 457, 322		· ·	4, 232, 325	•
2. 01	00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	(,	224, 997	
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	235, 963	15, 003, 602			15, 239, 563	
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	7, 619, 337 0	14, 253, 286 1, 510, 680			21, 766, 306 1, 510, 570	
7. 00 7. 01	00700 OPERATION OF PLANT -OFFSITE	0	355, 409			355, 409	1
7. 02	00702 OPERATION OF PLANT - HOSPITAL & OFFS	552, 540	23, 729			576, 269	1
8.00	00800 LAUNDRY & LINEN SERVICE	87, 796	84, 178	171, 974	-13, 439	158, 535	8. 00
9. 00	00900 HOUSEKEEPI NG	978, 609	423, 220			1, 399, 163	1
10.00	01000 DI ETARY	598, 703	547, 009	1, 145, 712		165, 173	
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	740, 597	5, 953	746, 550	936, 157	936, 157 746, 550	
14. 00	01400 CENTRAL SERVICES & SUPPLY	740, 347	5, 7 55	740, 550		740, 550	14.00
15. 00	01500 PHARMACY	660, 565	3, 931, 218	4, 591, 783	-12, 618	4, 579, 165	
16.00	01600 MEDICAL RECORDS & LIBRARY	729, 217	35, 305			764, 522	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	0.044.400	0.170.110	1 404 506	550 500		
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 264, 123 358, 165	2, 172, 410				•
43. 00	04300 NURSERY	358, 165	42, 513 133, 244			389, 698 793, 085	
10.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	100,211	100,21	007,011	770,000	10.00
50.00	05000 OPERATING ROOM	1, 991, 521	4, 982, 532	6, 974, 053	-3, 594, 613	3, 379, 440	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 337, 181	268, 092			128, 935	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 545, 054	11, 413, 420			14, 688, 071	
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	1, 646, 009 1, 086, 218	2, 308, 515 123, 008			3, 989, 997 1, 184, 817	1
66. 00	06600 PHYSI CAL THERAPY	1, 095, 479	41, 715			1, 187, 584	1
67. 00	06700 OCCUPATI ONAL THERAPY	328, 568	10, 887			330, 912	•
68. 00	06800 SPEECH PATHOLOGY	103, 098	1, 619			104, 525	
69. 00	06900 ELECTROCARDI OLOGY	702, 167	196, 691			869, 878	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	39 0			3, 104, 365	
72. 00 73. 00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	1	, , , , , , , ,	2, 225, 055 70, 118	1
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			, , , , , , , , , , ,	707.10	70.00
88. 00	08800 RURAL HEALTH CLINIC	1, 341, 385	151, 836	1, 493, 221	0	1, 493, 221	88. 00
88. 01	08801 MEDICAL ARTS CENTER	2, 693, 436	142, 571			2, 836, 007	
90.00	09000 CLINIC	2, 512, 310	1, 082, 606			3, 371, 564	1
90. 01 90. 02	O9001 WOUND CLINC O9002 BEHAVI ORAL HEALTH	361, 697	337, 081	698, 778	-274, 120	424, 658 0	1
91. 00		2, 322, 309	2, 992, 143	5, 314, 452	-244, 412		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	, , , , , , , , , , , , , , , , , , , ,	,			.,,	92.00
	OTHER REIMBURSABLE COST CENTERS			1	-1		
101.00	10100 HOME HEALTH AGENCY	0	0		0	0	101.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE		0		0	0	113.00
	11600 HOSPI CE	764, 888	350, 205				
118.00		36, 656, 935	70, 738, 395				
	NONREI MBURSABLE COST CENTERS			,			
	19200 PHYSI CI ANS' PRI VATE OFFI CES	11, 459, 365	2, 749, 558			14, 223, 417	1
	19201 PEDI ATRI CS 19202 BROOKVI LLE	112, 259 2, 454, 048	7, 406 265, 956			119, 665 2, 720, 004	
192.02	19202 BROOKVILLE 19203 RADI OLOGY - OSGOOD	107, 065	12, 248			119, 313	
	19204 ENT	0	0				192.04
	07950 COMMUNITY RELATIONS	400, 059	726, 163			742, 821	
	07951 COMMUNITY BENEFITS	389, 119	154, 864	543, 983		543, 983	
	07952 OTHER NON-REIMBURSABLE	22 550	151 003	104 405	0		194.02
	07953 EMS 07954 BATESVILLE TOOL & DIE CLINIC	33, 550 230, 014	151, 083 23, 709			184, 633 253, 723	1
	07955 MMHCB RHC	230, 014	23, 709	253, 725			194.04
194.06	07956 FOUNDATI ON	122, 559	172, 243			294, 802	194. 06
	07957 FQHC	0	0	(-		194. 07
200.00	TOTAL (SUM OF LINES 118 through 199)	51, 964, 973	75, 001, 625	126, 966, 598	3 0	126, 966, 598	200. 00

 Health Financial
 Systems
 MARGARET MARY

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

Peri od: Worksheet A From 01/01/2023 Date/Time Prepared: 5/20/2024 7: 24 am

10 12/31/2	5/29/2024 7: 24 am
Cost Center Description Adjustments Net Expenses	
(See A-8) For	
Allocation	
6.00 7.00	
GENERAL SERVICE COST CENTERS	
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT -497, 136 1, 999, 741	1.00
1. 01 00101 NEW CAP REL COSTS-0FFSITE BLDG 0 859, 480	1. 01
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUI P	2.00
2. 01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 0 224, 997	2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL -6, 764, 591 15, 001, 715	5.00
7. 00 00700 0PERATI ON OF PLANT 0 1,510,570	7.00
7. 01 00701 0PERATION OF PLANT -OFFSITE 0 355, 409	7. 01
7. 02 00702 OPERATION OF PLANT - HOSPITAL & OFFS 0 576, 269	7. 02
8.00 00800 LAUNDRY & LINEN SERVICE 0 158,535	8.00
9. 00 00900 HOUSEKEEPI NG 0 1, 399, 163	9.00
10. 00 01000 DI ETARY 0 165, 173	10.00
11. 00 01100 CAFETERI A -294, 499 641, 658	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 0 746, 550	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 0	14.00
15. 00 01500 PHARMACY	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY -1, 365 763, 157	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	10. 00
30. 00 03000 ADULTS & PEDIATRICS -1, 795, 657 3, 200, 456	30.00
31. 00 03100 INTENSI VE CARE UNI T 0 389, 698	31.00
43. 00 04300 NURSERY	43.00
ANCI LLARY SERVI CE COST CENTERS	43.00
50. 00 05000 0PERATI NG ROOM -175, 500 3, 203, 940	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 128, 935	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C -1, 743, 529 12, 944, 542	54.00
60. 00 06000 LABORATORY	60.00
65. 00 06500 RESPI RATORY THERAPY	65.00
66. 00 06600 PHYSI CAL THERAPY	66.00
67. 00 06700 0CCUPATI ONAL THERAPY	67.00
68. 00 06800 SPEECH PATHOLOGY 0 104, 525	68.00
69. 00 06900 ELECTROCARDI OLOGY	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 3, 104, 365	71.00
71: 00 07100 MEDICAL SOFT ETES CHARGED TO PATIENTS 0 2, 225, 055	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 70, 118	73.00
OUTPATIENT SERVICE COST CENTERS	73.00
88. 00 08800 RURAL HEALTH CLI NI C 0 1, 493, 221	88.00
88. 01 08801 MEDI CAL ARTS CENTER 0 2, 836, 007	88.01
90. 00 09000 CLINIC -1, 972, 697 1, 398, 867	90.00
90. 01 09001 WOUND CLINC -59, 928 364, 730	90.00
90. 02 09002 BEHAVI ORAL HEALTH 0 0	90.02
91. 00 09100 EMERGENCY	91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) -1,359,024 3,511,010	92.00
OTHER REIMBURSABLE COST CENTERS	92.00
101. 00 10100 HOME HEALTH AGENCY 0 0	101.00
SPECIAL PURPOSE COST CENTERS	101.00
113. 00 11300 I NTEREST EXPENSE 0 0	113. 00
116. 00 11600 HOSPI CE 0 1, 115, 093	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) -15,141,827 92,622,410	118.00
NONREI MBURSABLE COST CENTERS	118.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 14, 223, 417	192.00
192. 01 19201 PEDI ATRI CS 0 119, 665	192.00
192. 02 19202 BROOKVI LLE 0 2, 720, 004	192.02
192. 03 19203 RADI OLOGY - OSGOOD 0 119, 313	192.03
192. 04 19204 ENT 0 0	192.03
192. 04 19204 ENT 0 0 194. 00 0 742, 821	194. 00
194. 01 07951 COMMUNI TY BENEFITS 0 543, 983	194.00
194. 01 07951 COMMONT IY BENEFITS 0 543, 983 194. 02 07952 OTHER NON-REI MBURSABLE 0 0	194.01
	194. 02
	194. 03
194. 04 07954 BATESVILLE TOOL & DIE CLINIC 0 253, 723 194. 05 07955 MMHCB RHC 0 0	194. 04
	194. 05
	1194 06
TOTAL DITTO TOTAL CONTROL OF THE CON	
194.07 07957 FQHC 0 0 200.00 TOTAL (SUM OF LINES 118 through 199) -15,181,529 111,785,069	194. 07 200. 00

Heal th Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-1329 Period: From 01/01/2023 To 12/31/2023 Page Prepared:

					10	5/29/2024 7:24 am
		Increases				 07 2 77 2 0 2 1 7 1 2 1 dill
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - CAFETERIA					
1. 00	CAFETERI A	<u>11.</u> 00	<u>489, 198</u>	446, 959		1.00
	O D DECLACE		489, 198	446, 959		
1. 00	B - OB RECLASS ADULTS & PEDIATRICS	30.00	610, 289	62, 824		1.00
2. 00	NURSERY	43. 00	598, 255	61, 586		2.00
2.00	0		1, 208, 544	124, 410		2.00
	C - COMMUNITY RELATIONS	1	., ===,	.=.,		
1.00	ADMINISTRATIVE & GENERAL	5. 00	140, 021	243, 380		1.00
	0		140, 021	243, 380		
	D - IMPLANTABLE SUPPLIES RECLA					
1. 00	I MPL. DEV. CHARGED TO	72. 00	0	2, 225, 055		1.00
0.00	PATI ENT	0.00				0.00
2.00		0.00	0	0		2.00
3. 00		0.00	0	0 2, 225, 055		3.00
	E - OFFSITE BUILDING DEPR RECI	ASS	<u> </u>	2, 225, 055		
1. 00	NEW CAP REL COSTS-MVBLE	2. 01	O	224, 997		1.00
	EQUIP OFFSIT					
	0		0	224, 997		
	F - CENTRAL SUPPLY RECLASS					
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	3, 104, 365		1.00
	PATI ENTS					
2.00		0.00	0	0		2.00
3. 00 4. 00		0. 00 0. 00	0	0		3. 00 4. 00
5. 00		0. 00	o	0		5.00
6. 00		0.00	Ö	0		6.00
7. 00		0. 00	o	O		7. 00
8. 00		0.00	O	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	О	0		10.00
11. 00		0. 00	0	0		11.00
12.00		0. 00	0	0		12.00
13. 00		0. 00	0	0		13.00
14.00		0.00	0	0		14.00
15. 00 16. 00		0. 00 0. 00	0	0		15. 00 16. 00
17. 00		0. 00	0	0		17.00
18. 00		0.00	o	Ö		18.00
19. 00		0.00	ő	0		19.00
20.00		0.00	O	0		20. 00
21.00		0.00	o	0		21.00
22.00		0.00	0	0		22.00
	0		0	3, 104, 365		
4 00	G - DEPRECIATION RECLASS	اده د		0. 7		4.55
1. 00	NEW CAP REL COSTS-OFFSITE	1. 01	0	34, 748		1.00
	BLDG	+		34, 748		
	O H - IT RECLASS		UU	34, /48		
1. 00	RADI OLOGY-DI AGNOSTI C	54.00	96, 588	0		1.00
2. 00	PHYSI CAL THERAPY	66. 00	60, 303	Ö		2.00
3. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	14, 494	Ö		3.00
4.00	WOUND CLINC	90. 01	32, 165	0		4.00
5.00	DRUGS CHARGED TO PATIENTS	73. 00	70, 118	0		5. 00
6.00	ADULTS & PEDIATRICS	30. 00	64, 081	0		6. 00
7. 00	OPERATING ROOM	50.00	64, 373	0		7.00
8. 00	LABORATORY	6000	84, 322	0		8.00
E00 00	TOTALS Grand Total: Increases		486, 444 2, 324, 207	6, 403, 914		F00 00
500.00	priand rotal: increases		2, 324, 207	0, 403, 914		500.00

0.00

0.00

0.00

0.00

0.00

RECLASSI FI CATI ONS Provider CCN: 15-1329 Peri od: Worksheet A-6 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 7: 24 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - CAFETERIA DI ETARY 1.00 10.00 489, 198 446, 959 0 1.00 446, 959 489, 198 B - OB RECLASS 1.00 DELIVERY ROOM & LABOR ROOM 52.00 1, 208, 544 124, 410 0 1.00 2.00 0.00 0 2.00 124, 410 1. 208. 544 C - COMMUNITY RELATIONS 1.00 COMMUNITY RELATIONS 194.00 140, 021 243, 380 0 1.00 140, 021 243, 380 D - IMPLANTABLE SUPPLIES RECLASS 2, 801 1.00 ADULTS & PEDIATRICS 30.00 0 1.00 2.00 OPERATING ROOM 50.00 o 2, 143, 821 0 2.00 3.00 WOUND CLINC 90.01 78, 433 0 3.00 0 ō 2, 225, 055 E - OFFSITE BUILDING DEPR RECLASS 1.00 NEW CAP REL COSTS-MVBLE 2.00 0 224, 997 9 1.00 EQUI P 224, 997 CENTRAL SUPPLY RECLASS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 1.00 0 3, 274 0 2.00 ADMINISTRATIVE & GENERAL 5.00 2.00 OPERATION OF PLANT 0 0 7.00 3.00 110 3.00 4.00 LAUNDRY & LINEN SERVICE 8.00 0 13, 439 4.00 5.00 HOUSEKEEPI NG 9.00 0 2,666 0 5.00 0 0 6.00 DI ETARY 10.00 44.382 6.00 7.00 PHARMACY 15.00 12, 618 7.00 8.00 ADULTS & PEDIATRICS 30.00 0 174, 813 0 8.00 INTENSIVE CARE UNIT 0 10, 980 9.00 31.00 0 9.00 0 OPERATING ROOM 50.00 10.00 1, 515, 165 10.00 DELIVERY ROOM & LABOR ROOM 11.00 52.00 0 143, 384 11.00 0 12.00 RADI OLOGY-DI AGNOSTI C 54.00 366, 991 12.00 0 13.00 LABORATORY 60.00 48, 849 13.00 0 0 RESPIRATORY THERAPY 65.00 24.409 14.00 14.00 o 15.00 PHYSICAL THERAPY 66.00 9, 913 15.00 OCCUPATIONAL THERAPY 67.00 0 8, 543 0 16.00 16.00 o 0 17.00 SPEECH PATHOLOGY 68.00 192 17.00 0 ELECTROCARDI OLOGY 0 18.00 69.00 28, 980 18.00 19.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 39 0 19.00 PATI ENTS 20.00 CLINIC 90.00 0 223, 352 0 20.00 WOUND CLINC 90.01 227, 852 0 21.00 21 00 0 22.00 **EMERGENCY** 91.00 244, 412 0 22.00 3, 104, 365 G - DEPRECIATION RECLASS 1.00 NEW CAP REL COSTS-BLDG & 1.00 0 34.748 1.00 0 34, 748 H - IT RECLASS ADMINISTRATIVE & GENERAL 1.00 486, 444 0 5.00 1.00 2.00 0.00 0 0 2.00 3.00 0.00 0 0 0 3.00

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486, 444

2, 324, 207

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4.00

5.00

6.00

7.00

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Λ 6, 403, 914

TOTALS

500.00 Grand Total: Decreases

4.00

5.00

6.00

7.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1329 Peri od: Worksheet A-7 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 7: 24 am Acqui si ti ons Begi nni ng Purchases Disposals and Donati on Total Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 5, 798, 684 1, 100, 773 1, 100, 773 1.00 Land 0 0 0 Land Improvements 2.00 278, 583 24, 409 24, 409 Ω 2.00 3.00 3.00 Buildings and Fixtures 81, 712, 152 2, 368, 269 2, 368, 269 0 0 4.00 Building Improvements 637, 141 637, 141 0 4.00 Fi xed Equi pment 7, 615, 900 201, 771 0 201, 771 0 5.00 5.00 0 6.00 Movable Equipment 68, 407, 153 1, 336, 350 1, 336, 350 0 6.00 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 163, 812, 472 5, 668, 713 0 5, 668, 713 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 163, 812, 472 5, 668, 713 5, 668, 713 10.00 10.00 O 0 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 6, 899, 457 0 1.00 2.00 0 2.00 Land Improvements 302, 992 84, 080, 421 3.00 Buildings and Fixtures 0 3.00 4.00 Building Improvements 637, 141 0 4.00 5.00 Fixed Equipment 7, 817, 671 0 5.00 0 6.00 Movable Equipment 69, 743, 503 6.00 HIT designated Assets 0 7.00 7.00

169, 481, 185

169, 481, 185

0

0

			Т	o 12/31/2023	Date/Time Pre 5/29/2024 7: 2	pared: 4 am
		SU	MMARY OF CAPIT	ΓAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see	instructions)	
				instructions)		
	9. 00	10. 00	11. 00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR		IN 2, LINES 1 a	and 2			
1.00 NEW CAP REL COSTS-BLDG & FLXT	1, 805, 592	0	726, 033	0	0	1. 00
1.01 NEW CAP REL COSTS-OFFSITE BLDG	824, 732	0	0	0	0	1. 01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	4, 457, 322	0	0	0	0	2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	0	2. 01
3.00 Total (sum of lines 1-2)	7, 087, 646	0	726, 033	0	0	3. 00
	SUMMARY O	- CAPITAL				
Coot Conton Dogorintian	O+hon	Total (1)				
Cost Center Description	Other	Total (1)				
	Capi tal -Rel at ed Costs (see					
	instructions)	7 till ough 14)				
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1. 00 NEW CAP REL COSTS-BLDG & FLXT	0	2, 531, 625				1. 00
1. 01 NEW CAP REL COSTS-OFFSITE BLDG	l ol	824, 732				1. 01
2. 00 NEW CAP REL COSTS-MVBLE EQUIP	l ol	4, 457, 322				2.00
2. 01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0				2. 01
3.00 Total (sum of lines 1-2)	l ol	7, 813, 679				3.00
	-1		1			

Heal th	Financial Systems MAR	GARET MARY COM	IMUNITY HOSPITA	ıL	In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS				Period: Worksheet A- From 01/01/2023 Part III To 12/31/2023 Date/Time Pr 5/29/2024 7:		pared:
		COME	PUTATION OF RAT	TI 0S	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	I nsurance	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	NEW CAP REL COSTS-BLDG & FIXT	65, 417, 862		65, 417, 86		0	1.00
1. 01	NEW CAP REL COSTS-OFFSITE BLDG	20, 287, 256	l .	20, 287, 25			1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	79, 482, 410	0	79, 482, 41		0	2.00
2. 01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	145 107 520	0	145 107 50	0.000000	0	2. 01
3. 00	Total (sum of lines 1-2)	165, 187, 528		165, 187, 52		F CAPI TAL	3.00
		ALLOCATION OF OTHER CAPITAL			SUMMART		
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			4 770 044		4 00
1. 00 1. 01	NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-OFFSITE BLDG	0	0		1, 770, 844	0	1. 00 1. 01
2. 00	NEW CAP REL COSTS-OFFSITE BLDG	0	0		859, 480 4, 223, 640	0	2.00
2. 00	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0		224, 997	· · · · · · · · · · · · · · · · · · ·	2.00
3. 00	Total (sum of lines 1-2)	0	0		7, 078, 961	0	3. 00
3. 00	Total (Sam of Times 1 2)	9	SL	JMMARY OF CAPI		, ,	3.00
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)	Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	

11. 00

228, 897

228, 897

0

0

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
NEW CAP REL COSTS-BLDG & FIXT
NEW CAP REL COSTS-OFFSITE BLDG

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

Total (sum of lines 1-2)

12.00

0 0 0

13.00

instructions) 14.00

15. 00

1, 999, 741 859, 480 4, 223, 640 224, 997 7, 307, 858

1.00

1.01

2. 00

3.00

1.00

1.01

2. 00 2. 01

3. 00

In Lieu of Form CMS-2552-10 Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL ADJUSTMENTS TO EXPENSES Provider CCN: 15-1329 Peri od: Worksheet A-8 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 7:24 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1. 00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1.00 1.00 REL COSTS-BLDG & FIXT (chapter FLXT ONEW CAP REL COSTS-OFFSITE 1.01 Investment income - NEW CAP 1.01 1.01 REL COSTS-OFFSITE BLDG BLDG (chapter 2) Investment income - NEW CAP 2.00 ONEW CAP REL COSTS-MVBLE 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter FOUL P Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.01 2.01 2.01 REL COSTS-MVBLE EQUIP OFFSIT EQUIP OFFSIT (chapter 2) 3 00 Investment income - other 0.00O 3.00 (chapter 2) 4.00 Trade, quantity, and time 0 0.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by suppliers (chapter 8) 6.00 6.00 0.00 7.00 Tel ephone services (pay 0.00 7.00 stations excluded) (chapter 21) 8.00 Tel evi si on and radio servi ce 0 0.000 8.00

Provi der CCN: 15-1329 Peri od: Worksheet A-8 From 01/01/2023 | Worksheet A-8 | Worksheet A-8 | To 12/31/2023 | Date/Time Prepared:

						5/29/2024 7: 24 am		
				Expense Classification on	0,2,,2021 ,12			
				To/From Which the Amount is				
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7		
	cost center bescription			Cost Center	LITIC #	Ref.		
		(2) 1. 00	2. 00	3.00	4. 00	5. 00		
27.00	Decree inting NEW CAR REL	1.00					27.00	
27. 00	Depreciation - NEW CAP REL		Ü	NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00	
	COSTS-MVBLE EQUIP			EQUI P	0.01		07.04	
27. 01	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2. 01	0	27. 01	
	COSTS-MVBLE EQUIP OFFSIT			EQUIP OFFSIT				
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00	
29. 00	Physicians' assistant		0		0. 00	0	1 = 7.00	
30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00	
	therapy costs in excess of							
	limitation (chapter 14)							
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99	
	instructions)							
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00	
	pathology costs in excess of							
	limitation (chapter 14)							
32. 00	CAH HIT Adjustment for	Α	-8 685	NEW CAP REL COSTS-MVBLE	2. 00	9	32.00	
02.00	Depreciation and Interest	, ,	0,000	EQUI P	2.00	ĺ	02.00	
33. 00	OTHER INCOME	В	-9 172	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33.00	
35. 00	OTHER OPERATING - OTHER OPER.	В		ADMINISTRATIVE & GENERAL	5. 00	0	35.00	
33.00	- MISC	ь .	-0, 170	ADMINISTRATIVE & GENERAL	3.00	O	33.00	
37. 00	OTHER OPERATING - OTHER OPER.	В	1 265	MEDICAL RECORDS & LIBRARY	16. 00	0	37.00	
37.00	- MEDI	ь	- 1, 303	WEDICAL RECORDS & LIBRARI	10.00	U	37.00	
20.00	OTHER OPERATING - OTHER OPER.	В	24 (15	DADLOLOCY DI ACNOSTI C	E4 00	0	38. 00	
38. 00	- PHYS	В	-34, 615	RADI OLOGY-DI AGNOSTI C	54. 00	U	38.00	
00.00			4 075	COCUPATIONAL TUEDADY	(7.00		00.00	
39. 00	OTHER OPERATING - OTHER OPER.	В	-1, 2/5	OCCUPATI ONAL THERAPY	67. 00	0	39. 00	
	- OCCU	_				_		
40. 00	OTHER OPERATING - OTHER OPER.	В	-20, 502	CLINIC	90. 00	0	40. 00	
	- OUTP							
43. 00	INTEREST OFFSET	A	-497, 136	NEW CAP REL COSTS-BLDG &	1. 00	11	43.00	
				FLXT				
44. 00	LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	1	
45.00	MEDICAL STAFF RETENTION COST	A		ADMINISTRATIVE & GENERAL	5. 00	0	45.00	
45.01	HAF	A	-6, 636, 161	ADMINISTRATIVE & GENERAL	5. 00	0	45. 01	
45.02	TELEPHONE & TV OFFSET	Α	-1, 819	ADMINISTRATIVE & GENERAL	5. 00	0	45. 02	
45.03	BOUTIQUE OFFSET	Α	-180	RADI OLOGY-DI AGNOSTI C	54.00	0	45. 03	
45.04	HOSPITALIST OFFSET	Α		ADULTS & PEDIATRICS	30.00	0	1	
45. 05	MEDICAL STAFF PLACEMENT FEE	A		ADMINISTRATIVE & GENERAL	5. 00	0		
45. 07	FOUNDATION GRANT EXPENSE TO	A		FOUNDATION	194. 06	0	45. 07	
75.07	HOSPI TAL		37, 102	0011071111011	174.00	0	'5.0'	
50. 00	TOTAL (sum of lines 1 thru 49)		-15, 181, 529				50.00	
50.00	(Transfer to Worksheet A,		-13, 101, 329				30.00	
	column 6, line 200.)							
(1) 5	corintian all chapter referen		1	. 040 D.L. 45 4			L	

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1329

						To 12/31/2023	Date/Time Pro 5/29/2024 7:2	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	Physician/Prov ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		ADMINISTRATIVE & GENERAL	66, 000		0 66, 000	I		1
2.00		ADULTS & PEDIATRICS	1, 813, 609			I		
3.00		NURSERY	118, 608			1	·	3. 00
4. 00		OPERATING ROOM	230, 500			I	0	4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	1, 766, 734			I	0	5. 00
6. 00		LABORATORY	68, 410		0 68, 410		0	6. 00
7. 00		ELECTROCARDI OLOGY	170, 161			•	0	7. 00
8. 00		CLINIC	1, 987, 195			0	0	8. 00
9. 00		WOUND CLINC	59, 928			0	0	9. 00
10.00	91.00	EMERGENCY	3, 103, 179				0	10.00
200.00			9, 384, 324				0	200.00
	Wkst. A Line #	1	Unadjusted RCE			Provi der	Physician Cost	
		I denti fi er	Li mi t		E Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	0.00	0.00	Education	12	14.00	
1 00	1.00	2. 00 ADMI NI STRATI VE & GENERAL	8. 00	9. 00	12.00	13.00	14.00	1. 00
1.00			0		0 0	1	-	1
2. 00 3. 00		ADULTS & PEDIATRICS NURSERY				1	-	
4. 00		OPERATING ROOM			0 0	1	-	4.00
4. 00 5. 00		RADI OLOGY-DI AGNOSTI C			0 0	1		
			0				0	
6. 00		LABORATORY	0				0	6.00
7.00		ELECTROCARDI OLOGY	0				0	,
8. 00		CLINIC	0		0 0		0	8.00
9. 00		WOUND CLINC	0		-		0	9.00
10.00	91.00	EMERGENCY	0		0 0	1	1	10.00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	9	Adjustment	0	200.00
	WKSt. A LINE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		rdentiffer	Share of col.	LIIIII	DI Sai i Owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMI NI STRATI VE & GENERAL	0.00		0 (1. 00
2. 00		ADULTS & PEDIATRICS	0		0	1	I .	2.00
3. 00		NURSERY	0		0			3.00
4. 00		OPERATING ROOM	0		o o			4.00
5. 00		RADI OLOGY-DI AGNOSTI C	1 0		0	,	•	5.00
6. 00		LABORATORY	0		o o		•	6.00
7. 00		ELECTROCARDI OLOGY			0	1	I .	7.00
8. 00	•	CLI NI C			0	1		8.00
9. 00		WOUND CLINC			0			9.00
10.00		EMERGENCY			0		•	10.00
200.00	71.00	EMEROENOT	0		-	7, 509, 759		200.00
_00.00	I .	l	1	ı	-1	., ., ., , , ,	I	, _ 50. 55

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1329

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/29/2024 7:24 am CAPITAL RELATED COSTS NEW MVBLE Cost Center Description Net Expenses NEW BLDG & NEW OFFSITE NEW MVBLE EQUIP OFFSIT for Cost FIXT BI DG **FOULP** Allocation (from Wkst A col. 7) 0 1.00 1. 01 2.00 2. 01 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1, 999, 741 1, 999, 741 1 00 00101 NEW CAP REL COSTS-OFFSITE BLDG 859, 480 859, 480 1.01 1.01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4, 223, 640 4, 223, 640 2.00 2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 224, 997 224, 997 2.01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 15, 230, 391 8, 555 0 18,069 0 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 15, 001, 715 286, 574 0 605, 272 0 5.00 00700 OPERATION OF PLANT 1, 510, 570 0 7.00 7 00 362 751 766, 158 0 00701 OPERATION OF PLANT -OFFSITE 0 7.01 355, 409 0 0 7.01 7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS 576, 269 0 0 7.02 00800 LAUNDRY & LINEN SERVICE 8.00 158, 535 22, 708 0 47, 962 0 8.00 00900 HOUSEKEEPI NG 0 9 00 1 399 163 9 00 31, 566 66, 671 0 01000 DI ETARY 10.00 165, 173 21, 230 0 44, 839 0 10.00 01100 CAFETERI A 641, 658 0 113, 192 0 11.00 11.00 53, 592 01300 NURSING ADMINISTRATION 746, 550 13.00 771 0 0 13.00 1.628 01400 CENTRAL SERVICES & SUPPLY 0 9, 566 20, 204 14 00 0 14 00 15.00 01500 PHARMACY 4, 579, 165 7,633 0 16, 121 0 15.00 01600 MEDICAL RECORDS & LIBRARY 763, 157 <u>73, 9</u>31 16.00 35,004 0 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 200, 456 186, 479 0 393, 862 0 30.00 03100 INTENSIVE CARE UNIT 389, 698 17, 552 0 37, 072 0 31.00 31.00 43.00 04300 NURSERY 674, 477 9, 313 0 19,670 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 203, 940 44, 367 0 93, 708 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 128, 935 0 0 52.00 16, 933 35, 764 52.00 05400 RADI OLOGY-DI AGNOSTI C 12, 944, 542 247, 350 0 522, 427 54.00 0 54.00 06000 LABORATORY 3, 989, 997 43, 976 0 92,881 60.00 0 60.00 65.00 06500 RESPIRATORY THERAPY 1, 184, 817 33, 626 0 71,022 0 65.00 06600 PHYSI CAL THERAPY 0 147, 168 66.00 1, 187, 584 69, 679 0 66.00 31, 200 67.00 06700 OCCUPATI ONAL THERAPY 329, 637 14, 772 0 0 67.00 06800 SPEECH PATHOLOGY 0 68 00 104, 525 13, 496 28, 505 0 68 00 53, 913 06900 ELECTROCARDI OLOGY 729, 717 0 0 69.00 69.00 25, 526 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 3, 104, 365 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 99, 820 2, 225, 055 0 72.00 72.00 47, 261 0 07300 DRUGS CHARGED TO PATIENTS 73.00 70, 118 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 1, 493, 221 48, 662 12, 739 88.00 08801 MEDICAL ARTS CENTER 88 01 2, 836, 007 147, 300 38, 561 88 01 \cap 90.00 09000 CLI NI C 1, 398, 867 177,078 0 374,005 0 90.00 90.01 09001 WOUND CLINC 364, 730 9,970 0 21,058 0 90.01 0 90.02 09002 BEHAVI ORAL HEALTH 90.02 0 09100 EMERGENCY 0 91.00 3, 511, 016 112, 972 238, 607 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 115, 093 31, 974 0 116.00 15, 139 0 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 92, 622, 410 1, 925, 439 195, 962 4, 066, 703 51, 300 118. 00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 131, 315 192. 00 14, 223, 417 18, 108 501, 621 38, 247 192. 01 19201 PEDI ATRI CS 28, 647 60 506 0 192.01 119 665 0 192. 02 19202 BROOKVI LLE 41, 594 192. 02 2, 720, 004 1, 339 158, 889 2,829 192. 03 19203 RADI OLOGY - OSGOOD 119, 313 3,008 788 192.03 0 0 192.04 192. 04 19204 ENT 0 0 C 3, 829 194. 00 07950 COMMUNITY RELATIONS 0 194, 00 742 821 0 8,087 194. 01 07951 COMMUNITY BENEFITS 0 0 194. 01 543, 983 17, 413 36, 779 194. 02 07952 OTHER NON-REIMBURSABLE 0 0 194.02 C 194. 03 07953 EMS 184, 633 0 0 0 0 194.03 194. 04 07954 BATESVILLE TOOL & DIE CLINIC 0 0 194 04 0 253, 723 0 194. 05 07955 MMHCB RHC C 0 0 0 194.05 194. 06 07956 FOUNDATI ON 0 0 194.06 255, 100 4,966 10, 489 194. 07 07957 FQHC C 0 0 194. 07 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 111, 785, 069 1, 999, 741 859, 480 4, 223, 640 224, 997 202. 00

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1329 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 7:24 am Cost Center Description **EMPLOYEE** Subtotal ADMINISTRATIV OPERATION OF OPERATION OF **BENEFITS** PLANT E & GENERAL **PLANT** DEPARTMENT -OFFSITE 5.00 7. 00 4A 4 00 7 01 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP REL COSTS-OFFSITE BLDG 1.01 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 2 00 2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 15, 257, 015 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 2, 145, 081 18, 038, 642 18, 038, 642 5.00 00700 OPERATION OF PLANT 7 00 2, 639, 479 507.889 3, 147, 368 0 7 00 7.01 00701 OPERATION OF PLANT -OFFSITE 355, 409 68, 388 423, 797 7.01 7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS 162, 967 739, 236 142, 244 0 7 02 00800 LAUNDRY & LINEN SERVICE 49, 086 25, 895 255, 100 53. 262 8.00 8.00 0 00900 HOUSEKEEPING 9 00 288.632 1, 786, 032 343, 668 74, 040 0 9 00 10.00 01000 DI ETARY 32, 298 263, 540 50, 710 49, 794 0 10.00 11.00 01100 CAFETERI A 144, 285 952, 727 183, 324 125, 701 0 11.00 1, 808 01300 NURSING ADMINISTRATION 218, 432 967, 381 186, 143 0 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 29, 770 5, 728 22, 437 0 14.00 01500 PHARMACY 194.828 4, 797, 747 17, 902 15.00 15 00 923, 182 0 01600 MEDICAL RECORDS & LIBRARY
INPATIENT ROUTINE SERVICE COST CENTERS 209, 193 82, 102 16.00 16.00 215, 076 1, 087, 168 0 30.00 03000 ADULTS & PEDIATRICS 4, 647, 479 894, 268 437, 391 30.00 866, 682 0 03100 INTENSIVE CARE UNIT 549, 960 31.00 105, 638 105, 823 41, 169 0 31.00 879, 910 43.00 04300 NURSERY 169, 312 176, 450 21,844 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 606, 367 3, 948, 382 759, 748 104, 065 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 37, 940 219, 572 42, 250 39, 717 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 1,074,070 54 00 14, 788, 389 2.845.582 580, 166 0 54 00 60.00 06000 LABORATORY 510, 346 4, 637, 200 892, 290 103, 146 0 60.00 06500 RESPIRATORY THERAPY 1, 609, 835 309, 764 65.00 320, 370 78, 871 0 65.00 66.00 06600 PHYSI CAL THERAPY 340, 887 1, 745, 318 335.834 66.00 163.433 0 06700 OCCUPATI ONAL THERAPY 96, 908 67.00 472, 517 90, 922 34,649 0 67.00 68.00 06800 SPEECH PATHOLOGY 30, 408 176, 934 34,046 31,655 0 68.00 06900 ELECTROCARDI OLOGY 69.00 207, 098 1,016,254 195, 548 59,872 0 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3 104 365 597.342 0 71 00 0 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 0 2, 372, 136 456, 446 110, 852 0 72.00 07300 DRUGS CHARGED TO PATIENTS 20, 681 90, 799 17, 472 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 1 950 251 375, 267 23 994 88 00 395 629 0 3, 816, 273 72,632 88.01 08801 MEDICAL ARTS CENTER 794, 405 734, 327 0 88.01 09000 CLI NI C 740, 983 2, 690, 933 517, 789 415, 339 90.00 90.00 90 01 09001 WOUND CLINC 511, 924 98, 504 23, 386 Ω 90.01 116, 166 09002 BEHAVI ORAL HEALTH 90.02 0 90.02 09100 EMERGENCY 684, 944 4, 547, 539 875, 037 264, 978 91.00 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 225 597 1, 387, 803 267.041 35, 508 01116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 10, 779, 063 87, 076, 004 13, 284, 167 2, 973, 087 96, 626 118. 00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 3, 384, 118 42, 474 247, 342 192. 00 18, 296, 826 3, 520, 632 192. 01 19201 PEDI ATRI CS 33, 110 241, 928 46 552 67, 193 0 192 01 192. 02 19202 BROOKVI LLE 723, 799 3, 648, 454 702, 036 3, 142 78, 346 192. 02 192. 03 19203 RADI OLOGY - OSGOOD 31, 578 154, 687 29, 765 0 1, 483 192. 03 0 192.04 192, 04 19204 FNT 0 0 194. 00 07950 COMMUNITY RELATIONS 76, 696 831, 433 159 984 8 981 0 194.00 194. 01 07951 COMMUNITY BENEFITS 40, 843 0 194. 01 114, 767 712, 942 137, 184 194. 02 07952 OTHER NON-REIMBURSABLE 0 194.02 0 194. 03 07953 FMS 0 194.03 9.895 194.528 37.431 0 194. 04 07954 BATESVILLE TOOL & DIE CLINIC 67,841 321, 564 61,875 0 0 194.04 194. 05 07955 MMHCB RHC 0 194.05

306, 703

111, 785, 069

36, 148

15, 257, 015

59,016

18, 038, 642

0

11.648

3, 147, 368

0

0 194.06

0 194, 07

0 201.00 423, 797 202. 00

200.00

194. 06 07956 FOUNDATI ON

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

194. 07 07957 FQHC

200.00

201.00

202.00

Period: Worksheet B
From 01/01/2023 Part I
To 1/21/2022 Part VI mo Propagation Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1329

				To	12/31/2023	Date/Time Pre	
	Cost Center Description	OPERATION OF PLANT - HOSPITAL &	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	5/29/2024 7: 2 CAFETERI A	4 am
		0FFS 7. 02	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 1. 01 2. 00 2. 01 4. 00 5. 00 7. 01 7. 02 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-OFFSITE BLDG 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 NEW CAP REL COSTS-MVBLE EQUIP 00FFSIT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - OFFSITE 00702 OPERATION OF PLANT - HOSPITAL & OFFS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	881, 480 9, 165 12, 740 8, 568 21, 629 311 3, 861 3, 080 14, 127	366, 613 71, 815 464 2, 072 0	2, 288, 295 34, 571	407, 647 0 0 0 0	1, 372, 724 21, 796 0 22, 454 48, 403	1.00 1.01 2.00 2.01 4.00 5.00 7.00 7.01 7.02 8.00 9.00 10.00 11.00 13.00 14.00 15.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	14, 127		37,001	<u> </u>	40, 403	10.00
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY ANCILLARY SERVICE COST CENTERS	75, 261 7, 084 3, 759	4, 523	28, 583	389, 151 18, 496 0	217, 096 15, 463 24, 633	30. 00 31. 00 43. 00
50. 00	05000 OPERATING ROOM	17, 906	51, 071	72, 249	0	181, 851	50.00
52. 00 54. 00 60. 00 65. 00 66. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY	6, 834 99, 828 17, 748 13, 571 28, 122	0 2, 087	402, 796 71, 611 54, 758	0 0 0 0	5, 264 149, 075 178, 355 29, 651 85, 949	52. 00 54. 00 60. 00 65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	5, 962			Ö	0	67. 00
68. 00 69. 00 71. 00 72. 00 73. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	5, 447 10, 302 0 19, 074	9, 557 0 0	21, 977 41, 568 0 76, 962 0	0 0 0 0 0	0 27, 224 0 0 85, 949	68. 00 69. 00 71. 00 72. 00 73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	381	l ol	O	0	88. 00
88. 01 90. 00 90. 01 90. 02 91. 00	08801 MEDI CAL ARTS CENTER 09000 CLI NI C 09001 WOUND CLI NC 09002 BEHAVI ORAL HEALTH 09100 EMERGENCY	71, 467 4, 024 0 45, 594	279 14, 542 3, 814 0	0	0 0 0 0 0	0 0 42, 975 0 101, 741	88. 01 90. 00 90. 01 90. 02 91. 00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONRE! MBURSABLE COST CENTERS	6, 110 511, 574		24, 652 1, 975, 758	0 407, 647	0 1, 237, 879	113. 00 116. 00 118. 00
192. 01	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 PEDI ATRI CS 19202 BROOKVI LLE	261, 566 11, 562 86, 201		46, 650	0 0		192. 00 192. 01 192. 02
192. 03 192. 04 194. 00	19203 RADI OLOGY - OSGOOD 19204 ENT 07950 COMMUNI TY RELATI ONS 07951 COMMUNI TY BENEFI TS	0 0 1, 545 7, 028	40 0 0		0 0	0	192. 03 192. 04 194. 00
194. 02 194. 03 194. 04 194. 05	07952 OTHER NON-REIMBURSABLE 07953 EMS 07954 BATESVILLE TOOL & DIE CLINIC 07955 MMHCB RHC 07956 FOUNDATION	0 0 0 0 2,004	0 0 0 0	0 0 0 0 0 8,087	0 0 0	0 1, 768 0 0	194. 02 194. 03 194. 04 194. 05 194. 06
	07957 FQHC Cross Foot Adjustments Negative Cost Centers	0 881, 480	0	0	0 0 407, 647	0	194. 07 200. 00 201. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-1329

			10	12/31/2023	Date/IIme Pre 5/29/2024 7:2	
Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	4 aiii
	13. 00	14. 00	15. 00	16. 00	24. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1.01 O0101 NEW CAP REL COSTS-OFFSITE BLDG						1. 01
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2. 01
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT						5. 00 7. 00
7. 01 00701 OPERATION OF PLANT -OFFSITE						7. 00
7. 02 00702 OPERATION OF PLANT - HOSPITAL & OFFS						7. 02
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13.00 O1300 NURSING ADMINISTRATION	1, 178, 694					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	77, 374				14.00
15. 00 01500 PHARMACY	50, 012	0	5, 826, 806	4 407 004		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	1, 497, 994		16. 00
30.00 O3000 ADULTS & PEDIATRICS	291, 777	ol	0	005 533	8, 314, 917	20.00
31. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	34, 432	0	0	985, 522 0	8, 314, 917	30. 00 31. 00
43. 00 04300 NURSERY	54, 906	o	0	0	1, 185, 700	43.00
ANCI LLARY SERVI CE COST CENTERS	01,700	<u> </u>	5	<u> </u>	1, 100, 700	10.00
50. 00 05000 OPERATING ROOM	0	0	0	110, 379	5, 245, 651	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	11, 805	0	0	O	355, 783	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	188, 883	0	0	201, 047	19, 310, 939	54.00
60. 00 06000 LABORATORY	205, 890	0	0	0	6, 106, 240	60.00
65. 00 06500 RESPIRATORY THERAPY	66, 041	0	0	0	2, 164, 578	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	2, 491, 878	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	632, 585 271, 791	67. 00 68. 00
69. 00 06900 SELECT FATHOLOGY	48, 316	0	0	11, 826	1, 420, 467	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	40, 510	77, 374	0	0	3, 779, 081	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	0	0	o	3, 035, 470	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	О	5, 826, 806	0	6, 021, 026	73.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	2, 349, 893	88.00
88. 01 08801 MEDI CAL ARTS CENTER	0	0	0	0	4, 623, 511	88. 01
90. 00 09000 CLI NI C	0	0	0	55, 189	4, 053, 619	90.00
90. 01 09001 WOUND CLINC 90. 02 09002 BEHAVI ORAL HEALTH	0	0	0	0	700, 863 0	90. 01 90. 02
91. 00 09100 EMERGENCY	226, 632	0	0	122, 205	6, 392, 177	90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	220, 032	Ĭ	J	122, 203	0, 372, 177	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE	_	_	_	_		113.00
116. 00 11600 HOSPI CE	0	0	0	0	1, 721, 114	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 178, 694	77, 374	5, 826, 806	1, 486, 168	80, 982, 816	118.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	O.	O	0	11, 826	22, 692, 614	192 00
192. 01 19201 PEDI ATRI CS	o o	0	0	0	418, 039	
192. 02 19202 BROOKVI LLE	o	o	0	o	4, 528, 349	
192. 03 19203 RADI OLOGY - OSGOOD	0	o	0	0	185, 975	
192. 04 19204 ENT	0	0	0	0		192. 04
194.00 07950 COMMUNITY RELATIONS	0	0	0	0	1, 024, 175	
194. 01 07951 COMMUNITY BENEFITS	0	0	0	0	943, 707	
194. 02 07952 OTHER NON-REI MBURSABLE	0	0	0	0		194. 02
194. 03 07953 EMS 194. 04 07954 BATESVILLE TOOL & DIE CLINIC		0	0		233, 727 383, 439	
194.05 07955 MMHCB RHC		0	0	0		194. 04
194. 06 07956 FOUNDATION		o O	0	ol	392, 228	
194. 07 07957 FQHC	l ol	Ö	Ö	ol	0	194. 07
200.00 Cross Foot Adjustments]					200.00
201.00 Negative Cost Centers	0	o	0	o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 178, 694	77, 374	5, 826, 806	1, 497, 994	111, 785, 069	202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL Worksheet B
Part I
Date/Time Prepared:
5/29/2024 7: 24 am COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1329 Peri od: From 01/01/2023 To 12/31/2023 Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 26. 00 25. 00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FLXT 00101 NEW CAP REL COSTS-OFFSLTE BLDG 1.00 1.00 1.01 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 2.01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00

4. 00 5. 00 7. 00 7. 01 7. 02 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT 00701 OPERATION OF PLANT - OFFSITE 00702 OPERATION OF PLANT - HOSPITAL & OFFS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS			5. 00 7. 00 7. 01 7. 02 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
30. 00	03000 ADULTS & PEDIATRICS	0	8, 314, 917	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	805, 533	31.00
43. 00		0	1, 185, 700	43.00
E0 00	ANCILLARY SERVICE COST CENTERS	٥	E 24E 4E1	FO 00
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	5, 245, 651 355, 783	50.00 52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	19, 310, 939	54.00
60. 00	06000 LABORATORY	0	6, 106, 240	60.00
65. 00	06500 RESPIRATORY THERAPY	Ö	2, 164, 578	65.00
66. 00	06600 PHYSI CAL THERAPY	Ö	2, 491, 878	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	o	632, 585	67.00
68.00	06800 SPEECH PATHOLOGY	O	271, 791	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	1, 420, 467	69. 00
71. 00	1 1	0	3, 779, 081	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	3, 035, 470	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	6, 021, 026	73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	2, 349, 893	88. 00
88. 01	08801 MEDI CAL ARTS CENTER	0	4, 623, 511	88. 01
90. 00	09000 CLINIC	0	4, 053, 619	90.00
90. 01		ő	700, 863	90.01
90. 02	09002 BEHAVI ORAL HEALTH	o	0	90.02
91.00		O	6, 392, 177	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		92. 00
	OTHER REIMBURSABLE COST CENTERS			
101. 0	0 10100 HOME HEALTH AGENCY	0	0	101.00
112 0	SPECIAL PURPOSE COST CENTERS			112 00
	0 11300 NTEREST EXPENSE 0 11600 HOSPI CE	0	1, 721, 114	113. 00 116. 00
118. 0		0	80, 982, 816	118.00
110.0	NONREI MBURSABLE COST CENTERS	<u> </u>	00, 702, 010	1110.00
192. 0	19200 PHYSICIANS' PRIVATE OFFICES	0	22, 692, 614	192. 00
192. 0	1 19201 PEDI ATRI CS	0	418, 039	192. 01
	2 19202 BROOKVI LLE	0	4, 528, 349	192. 02
	3 19203 RADI OLOGY - OSGOOD	0	185, 975	192. 03
	4 19204 ENT	0	0	192.04
	007950 COMMUNITY RELATIONS 107951 COMMUNITY BENEFITS	0	1, 024, 175	194. 00 194. 01
	2 07952 OTHER NON-REIMBURSABLE	0	943, 707	194.01
	3 07953 EMS	0	233, 727	194. 02
	4 07954 BATESVILLE TOOL & DIE CLINIC	ő	383, 439	194. 04
	07955 MMHCB RHC	o	0	194. 05
	07956 FOUNDATION	0	392, 228	194.06
	7 07957 FQHC	0	o	194. 07
200.0		0	o	200.00
201. 0		0	0	201. 00
202.0	TOTAL (sum lines 118 through 201)	0	111, 785, 069	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1329

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/29/2024 7:24 am CAPITAL RELATED COSTS NEW MVBLE Cost Center Description Di rectly NEW BLDG & NEW OFFSITE NEW MVBLE EQUIP OFFSIT Assigned New FIXT **FOULP** BI DG Capi tal Related Costs 1. 00 1. 01 2.00 2. 01 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 NEW CAP REL COSTS-OFFSITE BLDG 1.01 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 8, 555 18, 069 O 4.00 286, 574 5.00 00500 ADMINISTRATIVE & GENERAL 00000000 0 605, 272 0 5.00 7.00 00700 OPERATION OF PLANT 362, 751 0 766, 158 7.00 00701 OPERATION OF PLANT -OFFSITE 7 01 0 0 7.01 C 0 00702 OPERATION OF PLANT - HOSPITAL & OFFS 0 7.02 0 0 7.02 8.00 00800 LAUNDRY & LINEN SERVICE 22, 708 47, 962 0 8.00 00900 HOUSEKEEPI NG 0 0 9.00 9.00 31, 566 66, 671 01000 DI ETARY 0 10.00 10.00 21, 230 44,839 0 11.00 01100 CAFETERI A 53, 592 0 113, 192 0 11.00 01300 NURSING ADMINISTRATION 0 13.00 0 0 771 1,628 0 13.00 01400 CENTRAL SERVICES & SUPPLY 9.566 0 20, 204 14 00 0 14 00 01500 PHARMACY 0 15.00 7, 633 16, 121 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 73, 931 0 16.00 16.00 35.004 INPATIENT ROUTINE SERVICE COST CENTERS 0 0 30.00 30 00 03000 ADULTS & PEDIATRICS 186, 479 393 862 n 03100 INTENSIVE CARE UNIT 0 0 31.00 17, 552 37,072 0 31.00 04300 NURSERY 0 9, 313 0 0 43.00 43.00 19,670 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 44.367 O 93.708 0 50 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 16, 933 0 35, 764 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 247, 350 0 522, 427 0 54.00 54.00 06000 LABORATORY 0000000 0 92, 881 60.00 43.976 0 60.00 06500 RESPIRATORY THERAPY 0 71, 022 65.00 33.626 0 65.00 66.00 06600 PHYSI CAL THERAPY 69, 679 0 147, 168 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 14, 772 0 31, 200 0 67.00 06800 SPEECH PATHOLOGY 13, 496 0 68 00 28.505 68.00 0 69.00 06900 ELECTROCARDI OLOGY 25, 526 0 53, 913 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 47, 261 0 99, 820 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 C 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 48, 662 0 12, 739 88 00 08801 MEDICAL ARTS CENTER 0 88.01 147, 300 88.01 38, 561 0 0 09000 CLI NI C 177, 078 374,005 90.00 0 Λ 90 00 21, 058 90.01 09001 WOUND CLINC 0 9, 970 0 0 90.01 90. 02 09002 BEHAVI ORAL HEALTH 0 0 90.02 0 09100 EMERGENCY 0 238, 607 91.00 91.00 112, 972 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 15, 139 31, 974 0 116.00 195, 962 4, 066, 703 SUBTOTALS (SUM OF LINES 1 through 117) 0 51, 300 118. 00 118.00 1, 925, 439 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 18, 108 501, 621 38, 247 131, 315 192. 00 192. 01 19201 PEDI ATRI CS 0 28, 647 60, 506 0 192.01 0 192. 02 19202 BROOKVI LLE 1, 339 158, 889 2.829 41, 594 192. 02 192. 03 19203 RADI OLOGY - OSGOOD 788 192. 03 C 3,008 0 192. 04 19204 ENT 0 192.04 0 0 0 194. 00 07950 COMMUNITY RELATIONS 3.829 0 8.087 0 194, 00 194. 01 07951 COMMUNITY BENEFITS 0 194, 01 17, 413 0 36, 779 194. 02 07952 OTHER NON-REIMBURSABLE 0 194.02 194. 03 07953 EMS 0 194.03 0 0 0 0 0 194. 04 07954 BATESVILLE TOOL & DIE CLINIC O 0 0 194.04 C 0 194.05 194. 05 07955 MMHCB RHC 0 194. 06 07956 FOUNDATI ON 0 4, 966 0 10, 489 0 194.06 194. 07 07957 FQHC 0 0 194. 07 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 1, 999, 741 859, 480 224, 997 202. 00 202.00 4, 223, 640

0 194.02

0 194.03

0 194.04

0 194.05

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3, 395 202.00

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Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1329 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/29/2024 7:24 am Cost Center Description Subtotal **EMPLOYEE** ADMINISTRATIV OPERATION OF OPERATION OF PLANT **BENEFITS** E & GENERAL **PLANT** DEPARTMENT -OFFSITE 2A 5.00 7. 00 7 01 4 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP REL COSTS-OFFSITE BLDG 1.01 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 2 00 2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 26, 624 26, 624 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 891, 846 3,746 895, 592 5.00 00700 OPERATION OF PLANT 7 00 1, 128, 909 25, 215 1, 154, 124 7 00 7.01 00701 OPERATION OF PLANT -OFFSITE 3, 395 3, 395 7.01 7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS 0 285 7,062 0 7 02 00800 LAUNDRY & LINEN SERVICE 70,670 2.437 19.531 8.00 8.00 45 0 00900 HOUSEKEEPING 17, 062 9 00 98.237 504 27, 150 0 9 00 10.00 01000 DI ETARY 66,069 56 2,518 18, 259 0 10.00 11.00 01100 CAFETERI A 166, 784 252 9, 101 46, 094 0 11.00 13.00 01300 NURSING ADMINISTRATION 2, 399 9, 241 0 13.00 381 663 14.00 01400 CENTRAL SERVICES & SUPPLY 29, 770 284 8, 228 0 14.00 01500 PHARMACY 23, 754 45, 833 15.00 15 00 340 6,565 0 01600 MEDICAL RECORDS & LIBRARY
INPATIENT ROUTINE SERVICE COST CENTERS 30, 106 16.00 16.00 108, 935 10, 386 0 376 30.00 03000 ADULTS & PEDIATRICS 580, 341 44, 397 160, 389 30.00 1,513 0 03100 INTENSIVE CARE UNIT 31.00 54, 624 184 5, 254 15, 097 0 31.00 04300 NURSERY 28, 983 43.00 308 8,406 8,010 0 43.00 ANCILLARY SERVICE COST CENTERS 1, 059 50.00 05000 OPERATING ROOM 138, 075 37, 719 38, 160 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52, 697 2,098 14, 564 52.00 0 66 212, 744 05400 RADI OLOGY-DI AGNOSTI C 54 00 769, 777 1,875 141, 273 0 54 00 60.00 06000 LABORATORY 136, 857 891 44, 299 37,823 0 60.00 06500 RESPIRATORY THERAPY 15, 379 28, 922 65.00 104, 648 559 0 65.00 66.00 06600 PHYSI CAL THERAPY 595 16, 673 59. 930 0 66.00 216, 847 06700 OCCUPATI ONAL THERAPY 45.972 67.00 169 4,514 12, 705 0 67.00 68.00 06800 SPEECH PATHOLOGY 42,001 53 1,690 11, 608 0 68.00 06900 ELECTROCARDI OLOGY 69.00 79, 439 362 9,708 21, 955 0 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 29, 656 0 71 00 C 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 72.00 147, 081 C 22,661 40, 649 0 72.00 36 0 73.00 73.00 867 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 192 88 00 61 401 691 18 631 0 08801 MEDICAL ARTS CENTER 88.01 185, 861 1, 387 36, 457 0 582 88.01 551, 083 09000 CLI NI C 1, 294 25, 706 152, 303 90.00 90.00 0 90 01 09001 WOUND CLINC 31, 028 203 4, 890 8, 575 0 90.01 09002 BEHAVI ORAL HEALTH 90.02 0 0 90.02 1, 196 09100 EMERGENCY 351, 579 43, 443 97, 166 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101, 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 13, 258 116. 00 11600 HOSPI CE 47, 113 394 13.021 01116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 239, 404 18,820 659, 513 1, 090, 217 774 118.00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 689, 291 1, 981 192. 00 5. 895 174.822 15, 575 0 192.01 192. 01 19201 PEDI ATRI CS 89 153 58 2 311 24,639 192. 02 19202 BROOKVI LLE 204, 651 34, 854 1, 152 628 192.02 1, 264 192. 03 19203 RADI OLOGY - OSGOOD 3, 796 55 1, 478 0 12 192. 03 192. 04 19204 ENT 0 192.04 0 C Ω 0 194. 00 07950 COMMUNITY RELATIONS 7, 943 11, 916 134 3 293 0 194 00 194. 01 07951 COMMUNITY BENEFITS 54, 192 14, 977 0 194. 01 200 6,811

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194. 03 07953 FMS

194. 07 07957 FQHC

200.00

201.00

202.00

194. 05 07955 MMHCB RHC

194. 06 07956 FOUNDATI ON

194. 02 07952 OTHER NON-REIMBURSABLE

194. 04 07954 BATESVILLE TOOL & DIE CLINIC

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

Period: Worksheet B
From 01/01/2023 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1329

					To	12/31/2023	Date/Time Pre	
		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/29/2024 7: 2 CAFETERI A	4 am
			PLANT -	LINEN SERVICE				
			HOSPITAL & OFFS					
			7. 02	8. 00	9. 00	10. 00	11. 00	
		AL SERVICE COST CENTERS						
1. 00 1. 01	1	NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-OFFSITE BLDG						1.00 1.01
2. 00		NEW CAP REL COSTS-011311E BEDG						2.00
2. 01		NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2. 01
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT						5. 00 7. 00
7. 00		OPERATION OF PLANT -OFFSITE						7.00
7. 02		OPERATION OF PLANT - HOSPITAL & OFFS	7, 347					7. 02
8.00	1	LAUNDRY & LINEN SERVICE	76					8.00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	106 71	18, 170 117		89, 526		9. 00 10. 00
11. 00		CAFETERI A	180	ł .		07, 320	229, 084	
13.00	1	NURSI NG ADMI NI STRATI ON	3	C		0	3, 637	1
14.00		CENTRAL SERVICES & SUPPLY	32	C	.,	0	0	14.00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	26 118	l e		0	3, 747 8, 078	ı
10.00		IENT ROUTINE SERVICE COST CENTERS	110		4,010	<u> </u>	8,078	10.00
30.00		ADULTS & PEDIATRICS	627	18, 549	21, 396	85, 464	36, 232	30.00
31.00		INTENSIVE CARE UNIT	59			4, 062	2, 580	1
43. 00		NURSERY LARY SERVICE COST CENTERS	31	4, 091	1, 069	0	4, 111	43.00
50. 00		OPERATING ROOM	149	12, 922	5, 091	0	30, 348	50.00
52.00		DELIVERY ROOM & LABOR ROOM	57	700		0	878	52.00
54.00	1	RADI OLOGY-DI AGNOSTI C	832			0	24, 878	
60. 00 65. 00	1	LABORATORY RESPI RATORY THERAPY	148 113			0	29, 764 4, 948	1
66. 00	1	PHYSI CAL THERAPY	234			0	14, 343	1
67. 00		OCCUPATI ONAL THERAPY	50			0	0	1
68.00	1	SPEECH PATHOLOGY	45	438		0	0	
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	86 0	2, 418		0	4, 543 0	1
72.00		IMPL. DEV. CHARGED TO PATIENT	159			o	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	<u> </u>		0	14, 343	73. 00
00.00		TIENT SERVICE COST CENTERS	0	1 0/		ol.		00.00
88. 00 88. 01		RURAL HEALTH CLINIC MEDICAL ARTS CENTER	0	1		0	0	
90.00		CLI NI C	596			ő	0	1
90. 01		WOUND CLINC	34	965		0	7, 172	
90. 02	1	BEHAVI ORAL HEALTH	0 380	(105	1	0	14 070	90. 02 91. 00
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	380	6, 195	12, 962	U	16, 979	91.00
72.00		REI MBURSABLE COST CENTERS		L				,2.00
101.00		HOME HEALTH AGENCY	0	C	0	0	0	101. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE		Ι		T		113.00
		HOSPI CE	51	C	1, 737	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4, 263	90, 698		89, 526	206, 581	118. 00
100.00		MBURSABLE COST CENTERS	2 101	1 20	15 570	ol.	15 152	100.00
		PHYSI CI ANS' PRI VATE OFFI CES PEDI ATRI CS	2, 181 96	30		0		192. 00 192. 01
		BROOKVI LLE	718			o		192.02
	1	RADI OLOGY - OSGOOD	0			0	0	192. 03
192.04			0	C		0		192.04
		COMMUNITY RELATIONS COMMUNITY BENEFITS	13 59			0		194. 00 194. 01
		OTHER NON-REIMBURSABLE	0			o	· ·	194. 02
194. 03			0	(c	0	0		194. 03
	1	BATESVILLE TOOL & DIE CLINIC	0		0	0		194. 04
		MMHCB RHC FOUNDATION	17		0 570	0		194. 05 194. 06
194. 07			0		0	o		194. 07
200.00		Cross Foot Adjustments				ļ		200.00
201.00		Negative Cost Centers	0	02.750	-	00 534		201.00
202. 00	' I	TOTAL (sum lines 118 through 201)	7, 347	92, 759	161, 229	89, 526	229, 084	J2U2. UU

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-1329

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/29/2024 7:24 am

			10	12/31/2023	5/29/2024 7: 24	
Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
	13. 00	14. 00	15. 00	16.00	24. 00	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT 1. 01 O0101 NEW CAP REL COSTS-OFFSLTE BLDG						1. 00 1. 01
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2. 01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2. 00 2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT						5. 00 7. 00
7.01 00701 OPERATION OF PLANT -OFFSITE 7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS						7. 01 7. 02
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A						10. 00 11. 00
13.00 01300 NURSING ADMINISTRATION	16, 412					13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	0 696	39, 412 0	81, 837			14. 00 15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	162, 015		16. 00
30. 00 03000 ADULTS & PEDIATRICS	4, 062	0	0	106, 589	1, 059, 559	30.00
31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY	479 765	0	0 0	0 0	85, 497 55, 774	31. 00 43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	O	0	0	11, 938	275, 461	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	164	0	0	O	73, 167	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	2, 630 2, 867	0	0	21, 744 0	257, 695	54. 00 60. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	920	0	0	o o		65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	Ö	Ō	ō	66, 238	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0 673	0	0	0 1, 279		68. 00 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	39, 412 0	0	0	69, 068	71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	81, 837	0	97, 083	73. 00
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	O	0	ol	81, 011	88. 00
88. 01 08801 MEDICAL ARTS CENTER	0	0	0	0	224, 358	88. 01
90. 00 09000 CLI NI C 90. 01 09001 WOUND CLI NC	0	0	0	5, 969 0	760, 947 54, 011	90. 00 90. 01
90. 02 09002 BEHAVI ORAL HEALTH 91. 00 09100 EMERGENCY	0 3, 156	0	0	0 13, 217	0 546, 273	90. 02 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	3, 130			15, 217	340, 273	92. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 1	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE					1	113. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 16, 412	0 39, 412	0 81, 837	0 160, 736	75, 574 1 5, 878, 045 1	
NONREI MBURSABLE COST CENTERS						
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 PEDI ATRI CS	0	0	0 0	1, 279 0	921, 780 1 120, 237 1	
192. 02 19202 BROOKVI LLE 192. 03 19203 RADI OLOGY - OSGOOD	0	0	0	o	245, 442 1 5, 351 1	
192. 04 19204 ENT	0	0	0	o	0 1	192. 04
194. 00 07950 COMMUNITY RELATIONS 194. 01 07951 COMMUNITY BENEFITS	0	0	0	0	26, 408 1 81, 133 1	
194. 02 07952 OTHER NON-REIMBURSABLE	0	0	0	Ö	0 1	194. 02
194. 03 07953 EMS 194. 04 07954 BATESVILLE TOOL & DIE CLINIC	0 0	0	0	0	2, 170 1 3, 190 1	
194. 05 07955 MMHCB RHC 194. 06 07956 FOUNDATI ON	0	0	0	0		194. 05
194. 07 07957 FQHC		0	0	0	0 1	194. 07
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		O	n	n		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	16, 412	39, 412	81, 837	162, 015	7, 307, 858	

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1329 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/29/2024 7: 24 am Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP REL COSTS-OFFSITE BLDG 1.01 1 01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 7.01 00701 OPERATION OF PLANT -OFFSITE 7.01 00702 OPERATION OF PLANT - HOSPITAL & OFFS 7 02 7.02 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13.00 | 01300 | NURSI NG ADMI NI STRATI ON 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 059, 559 30.00 03100 INTENSIVE CARE UNIT 31.00 0 85, 497 31.00 43.00 04300 NURSERY 0 55, 774 43.00 ANCILLARY SERVICE COST CENTERS 275, 461 50.00 05000 OPERATING ROOM 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 73, 167 52.00 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 218, 091 54.00 06000 LABORATORY 60.00 00000000 257, 695 60.00 06500 RESPIRATORY THERAPY 65 00 159 875 65 00 06600 PHYSI CAL THERAPY 66.00 321, 615 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 66, 238 06800 SPEECH PATHOLOGY 68.00 57, 383 68.00 06900 ELECTROCARDI OLOGY 123, 392 69 00 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 69,068 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 215, 973 72.00 07300 DRUGS CHARGED TO PATIENTS 0 97, 083 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 81, 011 88.00 88.01 08801 MEDICAL ARTS CENTER 0 224, 358 88 01 0 09000 CLI NI C 90.00 760.947 90.00 09001 WOUND CLINC 90 01 54, 011 90.01 90.02 09002 BEHAVI ORAL HEALTH 0 90.02 09100 EMERGENCY 0 91.00 546, 273 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 75, 574 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 5, 878, 045 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 921, 780 192. 00 192. 01 19201 PEDI ATRI CS 0 120, 237 192.01 192. 02 19202 BROOKVI LLE 0000000000000 245, 442 192.02 192. 03 19203 RADI OLOGY - OSGOOD 192. 03 5, 351 192. 04 19204 ENT C 192.04 194.00 07950 COMMUNITY RELATIONS 194.00 26, 408 194. 01 07951 COMMUNITY BENEFITS 81, 133 194. 01 194. 02 07952 OTHER NON-REIMBURSABLE 194. 02 194. 03 07953 EMS 2, 170 194.03 194. 04 07954 BATESVILLE TOOL & DIE CLINIC 194. 04 3, 190 194. 05 07955 MMHCB RHC 194. 05 C 194.06 194. 06 07956 FOUNDATI ON 24, 102 194. 07 07957 FQHC 0 194.07 200.00 Cross Foot Adjustments 0 200.00

7, 307, 858

201 00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

201 00

202.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1329

COST Genter Description NEW BLDG A NEW DETECT NEW BURD SCRUPE SC				T	0 12/31/2023	Date/Time Pre 5/29/2024 7:2	
FIXT SOURCE COURT COUR			CAPITAL REL	ATED COSTS			
SERNERAL SERVICE COST CENTERS	Cost Center Description	FIXT (SQUARE	BLDG (SQUARE	EQUI P (SQUARE	EQUIP OFFSIT (SQUARE	BENEFITS DEPARTMENT (GROSS	
1.00	CENEDAL CEDIMOS COCT CENTEDO	1. 00	1. 01	2. 00	2. 01	4. 00	
0.0400 CAMPLOVER ENTERTIS DEPARTMENT	1. 00			· ·			1.00 1.01 2.00
7. 02 00702 (PERATION OF PLANT - HOSPITAL & OFFS 0 0 00 00 0 1.077 0 0 87. 794 0 9.00 09900 (MUSKEKEN NG 2, 498 0 2, 498 0 1.00 0.00 1.00 01 010 01 010 01 010 01 010 01 010 01 01	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	22, 678 28, 706	0	677 22, 678 28, 706	0	7, 272, 914 0	2. 01 4. 00 5. 00 7. 00 7. 01
13.00 01300 NURSING ADMINISTRATION 61 0 740, 597 1	7. 02 00702 OPERATION OF PLANT - HOSPITAL & OFFS 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY	1, 797 2, 498 1, 680	0 0	0 1, 797 2, 498 1, 680	0 0 0	552, 540 87, 796 978, 609 109, 505	7. 02 8. 00 9. 00 10. 00
INPATI ENT ROUTH NE SERVICE COST CENTERS 3,14,757 0 14,757 0 2,238,493 33 30 0 300 0 0 0 0	13. 00 01300 NURSI NG ADMINI STRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	61 757 604	0 0	61 757 604	0	740, 597 0 660, 565	13. 00 14. 00 15. 00
31.00 0.3100 INTENSI VE CARE UNIT 1.389 0 1.389 0 358, 165 3 3 3 3 3 3 3 5 3		2,770	0	2,770	O	729, 217	16.00
50.00	31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	1, 389	o	1, 389	0	358, 165	31.00
55.00 06500 RESPIRATORY THERAPY 2, 661 0 2, 661 0 1, 086, 218 61 60 06000 PHYSICAL THERAPY 5, 514 0 5, 514 0 5, 514 0 1, 155, 782 66 67 00 06700 0CCUPATI ONAL THERAPY 1, 169 0 1, 169 0 3, 28, 588 68 00 08000 SPECH PATHOLOGY 1, 068 0 103, 098 61 67 00 0 0 0 0 0 0 0 0	50. 00	1, 340 19, 574	0	1, 340 19, 574	=	128, 637 3, 641, 642	52. 00 54. 00
771.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 72.00 MPL. DEV. CHARGED TO PATIENT 3,740 0 3,740 0 0 0 70.118 72.00 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 70.118 72.00 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 70.118 72.00 73.	65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	2, 661 5, 514 1, 169 1, 068	0 0	2, 661 5, 514 1, 169 1, 068	0 0 0	1, 086, 218 1, 155, 782 328, 568 103, 098	65.00 66.00 67.00 68.00
88.01 08801 MEDICAL ARTS CENTER 0 15,571 0 15,571 2,693,434 88, 90.00 09000 CLINIC 14,013 0 14,013 0 2,512,310 99. 00 09000 CLINIC 789 0 789 0 393,862 99. 02 09002 BEHAVI ORAL HEALTH 0 0 0 0 0 0 0 0 0	71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 73. 00 07300 DRUGS CHARGED TO PATIENTS 0UTPATIENT SERVICE COST CENTERS	0 3, 740	0	0 3, 740	0 0	0	71. 00 72. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 99. 0THER REI MBURSABLE COST CENTERS 101. 00	88. 01 08801 MEDI CAL ARTS CENTER 90. 00 09000 CLI NI C 90. 01 09001 WOUND CLI NC	0 14, 013 789	15, 571 0 0	0 14, 013 789	15, 571	2, 693, 436 2, 512, 310 393, 862 0	88. 01 90. 00 90. 01 90. 02
113.00 11300 INTEREST EXPENSE 1, 198 0 1, 198 0 764, 888 116 118 116 100 NONREI MBURSABLE COST CENTERS 1, 433 53, 026 1, 433 53, 026 11, 473, 859 192 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 433 53, 026 1, 433 53, 026 11, 473, 859 192	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 940	0	8, 940	0	2, 322, 309	91.00 92.00
113.00 11300 INTEREST EXPENSE 1, 198 0 1, 198 0 764, 888 116, 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 152, 369 20, 715 152, 369 20, 715 36, 546, 499 118 118 118 118 119 118		0	0	0	0	0	101. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117		1				
194. 00 07950 COMMUNITY RELATIONS 303 0 303 0 260, 038 194 194 01 07951 COMMUNITY BENEFITS 1, 378 0 1, 378 0 389, 119 194 02 07952 OTHER NON-REI MBURSABLE 0 0 0 0 0 0 194 194 03 07953 EMS 0 0 0 0 0 0 0 33, 550 194 194 04 07954 BATESVILLE TOOL & DIE CLINIC 0 0 0 0 0 0 230, 014 194 05 07955 MMHCB RHC 0 0 0 0 0 0 0 194 194 06 07956 FOUNDATION 393 0 122, 559 194 194 07 07957 FOHC 0 0 0 0 0 0 0 0 194 194 07 07957 FOHC 0 0 0 0 0 0 0 0 194 194 07 07957 FOHC 0 0 0 0 0 0 0 0 194 194 07 07957 FOHC 0 0 0 0 0 0 0 0 0 194 195 195 195 195 195 195 195 195 195 195	192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 PEDI ATRI CS 192. 02 19202 BROOKVI LLE 192. 03 19203 RADI OLOGY - OSGOOD	2, 267 106 0	0 16, 796 318	2, 267 106 0	0 16, 796	112, 259 2, 454, 048 107, 065	192. 01 192. 02
194. 05 07955 MMHCB RHC 0 0 0 0 194 194. 06 07956 FOUNDATI ON 393 0 393 0 122, 559 194 194. 07 07957 FOHC 0 0 0 0 0 0 0 200. 00 Cross Foot Adjustments 200 0 0 0 0 0	194. 00 07950 COMMUNITY RELATIONS 194. 01 07951 COMMUNITY BENEFITS 194. 02 07952 OTHER NON-REIMBURSABLE 194. 03 07953 EMS	303 1, 378	0	303	0 0 0	260, 038 389, 119 0 33, 550	194. 00 194. 01 194. 02 194. 03
zor.oo _{l I} negative cost centers I I I I20)	194. 05 07955 MMHCB RHC 194. 06 07956 FOUNDATI ON 194. 07 07957 FQHC	0	o	0 0 393 0	0 0 0 0	0 122, 559	194. 05
202.00 Cost to be allocated (per Wkst. B, 1,999,741 859,480 4,223,640 224,997 15,257,015 203	202.00 Cost to be allocated (per Wkst. B,	1, 999, 741	859, 480	4, 223, 640	224, 997	15, 257, 015	
Part 1	1 1 1) 12. 636674	9. 459909	26. 689837	2. 476440	0. 294941	203. 00

Health Fina	ncial Systems MA	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023		
			CAPITAL REI	LATED COSTS			
	Cost Center Description	NEW BLDG &	NEW OFFSITE	NEW MVBLE	NEW MVBLE	EMPLOYEE	
		FI XT	BLDG	EQUI P	EQUIP OFFSIT	BENEFI TS	
		(SQUARE	(SQUARE	(SQUARE	(SQUARE	DEPARTMENT	
		FEET)	FEET)	FEET)	FEET)	(GROSS	
						SALARI ES)	
		1. 00	1. 01	2.00	2. 01	4. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)					26, 624	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part					0. 000515	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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1329 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 7:24 am Cost Center Description Reconciliatio ADMINISTRATIV OPERATION OF OPERATION OF OPERATION OF E & GENERAL PLANT **PLANT PLANT** n (ACCUM. (SQUARE -OFFSITE HOSPITAL & (SQUARE 0FFS COST) FEET) (SQUARE FEET) FEET) 5.00 7.00 7. 01 5A GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 NEW CAP REL COSTS-OFFSITE BLDG 1.01 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 -18, 038, 642 5.00 00500 ADMINISTRATIVE & GENERAL 93, 746, 427 5.00 7.00 00700 OPERATION OF PLANT 2, 639, 479 106, 188 7.00 00701 OPERATION OF PLANT -OFFSITE 355, 409 7.01 90, 855 7.01 0 \cap 00702 OPERATION OF PLANT - HOSPITAL & OFFS 7.02 0 739, 236 0 172, 838 7.02 8.00 00800 LAUNDRY & LINEN SERVICE 0 255, 100 1.797 1, 797 8.00 00900 HOUSEKEEPI NG 0 0 1, 786, 032 2, 498 0 2, 498 9.00 9.00 01000 DI ETARY 0 10.00 263, 540 1,680 1,680 10.00 11.00 01100 CAFETERI A 952, 727 4, 241 0 4, 241 11.00 13.00 01300 NURSING ADMINISTRATION o 0 0 967, 381 61 61 13.00 o 01400 CENTRAL SERVICES & SUPPLY 29, 770 757 14 00 757 14 00 15.00 01500 PHARMACY 4, 797, 747 604 0 604 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 087, 168 2,770 0 2,770 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 14, 757 14, 757 30 00 03000 ADULTS & PEDIATRICS 0 4, 647, 479 0 30.00 03100 INTENSIVE CARE UNIT 31.00 0 549, 960 1, 389 0 1, 389 31.00 04300 NURSERY 0 879, 910 0 43.00 737 737 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 3, 948, 382 3.511 3.511 50 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 219, 572 1, 340 0 1, 340 52.00 19, 574 05400 RADI OLOGY-DI AGNOSTI C 0 14, 788, 389 0 19, 574 54.00 54.00 0 06000 LABORATORY 0000000 3, 480 60.00 4.637.200 3.480 60.00 06500 RESPIRATORY THERAPY 1, 609, 835 65.00 2.661 2.661 65.00 66.00 06600 PHYSI CAL THERAPY 1, 745, 318 5, 514 0 5, 514 66.00 06700 OCCUPATI ONAL THERAPY o 67.00 472, 517 1, 169 1, 169 67.00 0 06800 SPEECH PATHOLOGY 1, 068 1,068 68.00 176, 934 68 00 0 69.00 06900 ELECTROCARDI OLOGY 1,016,254 2,020 2,020 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 3, 104, 365 0 71.00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 2, 372, 136 3, 740 ol 3,740 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 90, 799 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 1, 950, 251 0 5, 144 O 88 00 0 08801 MEDICAL ARTS CENTER 88.01 3, 816, 273 15, 571 88.01 0 0 09000 CLI NI C 90.00 2, 690, 933 14.013 0 14,013 90 00 90.01 09001 WOUND CLINC 0 511, 924 789 0 789 90.01 90. 02 09002 BEHAVI ORAL HEALTH 0 0 90.02 0 4, 547, 539 91.00 09100 EMERGENCY 0 91.00 8,940 0 8,940 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 198 116.00 1, 387, 803 1.198 -18, 038, 642 20, 715 SUBTOTALS (SUM OF LINES 1 through 117) 69, 037, 362 100, 308 100, 308 118. 00 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 18, 296, 826 1, 433 53, 026 51, 287 192. 00 192. 01 19201 PEDI ATRI CS 0 241, 928 2, 267 2, 267 192. 01 0 16, 796 192. 02 19202 BROOKVI LLE 3 648 454 106 16, 902 192. 02 192. 03 19203 RADI OLOGY - OSGOOD 154, 687 C 318 0 192.03 192. 04 19204 ENT 0 192.04 0000000 0 194. 00 07950 COMMUNITY RELATIONS 303 ol 303 194.00 831, 433 194. 01 07951 COMMUNITY BENEFITS 1, 378 194. 01 712, 942 1, 378 0 194. 02 07952 OTHER NON-REIMBURSABLE 0 0 0 194.02 194. 03 07953 EMS 194, 528 0 0 0 194.03 194. 04 07954 BATESVILLE TOOL & DIE CLINIC 0 321, 564 0 0 194.04 194. 05 07955 MMHCB RHC 0 0 0 194.05 194. 06 07956 FOUNDATI ON 306, 703 393 0 393 194.06 194. 07 07957 FQHC 0 0 0 194. 07 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 18, 038, 642 3, 147, 368 423, 797 881, 480 202. 00 202.00 Part I) 0. 192420 5. 100036 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 29. 639583 4.664542 204.00 Cost to be allocated (per Wkst. B, 895, 592 1, 154, 124 3, 395 7, 347 204. 00 Part II)

Health Financial Systems M	ARGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
Cost Center Description	Reconciliatio	ADMI NI STRATI V			OPERATION OF	
	n	E & GENERAL	PLANT	PLANT	PLANT -	
		(ACCUM.	(SQUARE	-0FFSITE	HOSPITAL &	
		COST)	FEET)	(SQUARE	0FFS	
				FEET)	(SQUARE	
					FEET)	
	5A	5. 00	7.00	7. 01	7. 02	
205.00 Unit cost multiplier (Wkst. B, Part		0. 009553	10. 86868	6 0. 037367	0. 042508	205. 00
206.00 NAHE adjustment amount to be allocate (per Wkst. B-2)	d					206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST A	Financial Systems MAF LLOCATION - STATISTICAL BASIS		Provi der CC		eriod: rom 01/01/2023 o 12/31/2023		pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	5/29/2024 7: 2 NURSI NG ADMI NI STRATI O N (HOURS OF SERVI CE)	4 am
		8. 00	9. 00	10.00	11. 00	13. 00	
	GENERAL SERVICE COST CENTERS						1
13. 00 14. 00 15. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-OFFSITE BLDG 00200 NEW CAP REL COSTS-MYBLE EQUIP 00201 NEW CAP REL COSTS-MYBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT 00701 OPERATION OF PLANT - HOSPITAL & OFFS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	324, 151 63, 497 410 1, 832 0 0 0	111, 201 1, 680 4, 241 61 757 604 2, 770	16, 706 0 0 0 0 0	33, 380 530 0 546 1, 177	267, 592 0 11, 354 0	14. 00 15. 00
30. 00	03000 ADULTS & PEDIATRICS	64, 813	14, 757	15, 948	5, 279	66, 240	
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	3, 999 14, 297	1, 389 737	758 0	376 599	7, 817 12, 465	
43.00	ANCI LLARY SERVI CE COST CENTERS	14, 277	737	O _I	377	12, 403	43.00
50.00	05000 OPERATING ROOM	45, 156	3, 511	0	4, 422	0	1
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	2, 446 48, 783	1, 340 19, 574	0	128 3, 625	2, 680 42, 881	1
60.00	06000 LABORATORY	0	3, 480	Ö	4, 337	46, 742	
65.00	06500 RESPIRATORY THERAPY	1, 845	2, 661	0	721	14, 993	1
66.00	06600 PHYSI CAL THERAPY	17, 467	5, 514	0	2, 090	0	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	3, 960 1, 531	1, 169 1, 068	0	0	0	1
	06900 ELECTROCARDI OLOGY	8, 450	2, 020	0	662	10, 969	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	3, 740 0	0	0 2, 090	0	
	OUTPATIENT SERVICE COST CENTERS	0	0	0	2, 090	0	73.00
	08800 RURAL HEALTH CLINIC	337	0	0	0	0	
	08801 MEDICAL ARTS CENTER 09000 CLINIC	247 12, 858	14 013	0	0	0	
	09001 WOUND CLINC	3, 372	14, 013 789	0	1, 045	0	
	09002 BEHAVI ORAL HEALTH	0	0	0	0	0	
	09100 EMERGENCY	21, 648	8, 940	0	2, 474	51, 451	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						ļ
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0	1, 198	0	0	0	113. 00 116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	316, 948	96, 013		30, 101	267, 592	
400.00	NONREI MBURSABLE COST CENTERS		40 744		0.000		
	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 PEDI ATRI CS	104	10, 741 2, 267	0	2, 208 101		192. 00 192. 01
	19202 BROOKVI LLE	7, 064	106	Ö	0		192. 02
192.03	19203 RADI OLOGY - OSGOOD	35	0	0	o		192. 03
	19204 ENT	0	0	0	0		192.04
	07950 COMMUNITY RELATIONS 07951 COMMUNITY BENEFITS	0	303 1, 378	0	389 422		194. 00 194. 01
	07952 OTHER NON-REIMBURSABLE	0	0	Ö	0		194. 02
	07953 EMS	0	0	0	43		194. 03
	07954 BATESVILLE TOOL & DIE CLINIC	0	0	0	0		194. 04
	07955 MMHCB RHC 07956 FOUNDATION	0	393	0	116		194. 05 194. 06
	07957 FQHC	o o	0	Ö	0		194. 07
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	2// /12	2 200 205	407 (47	1 272 724	1 170 404	201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	366, 613	2, 288, 295	407, 647	1, 372, 724	1, 178, 694	202.00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	1. 130995 92, 759	20. 578007 161, 229	24. 401233 89, 526	41. 124146 229, 084	4. 404818 16, 412	

Heal th Finar	ncial Systems MAF	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od: From 01/01/2023	Worksheet B-1	
					To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE	(SQUARE	(MEALS	(FTE' S)	ADMI NI STRATI O	
		(POUNDS OF	FEET)	SERVED)		N	
		LAUNDRY)				(HOURS OF	
		·				SERVICE)	
		8. 00	9. 00	10.00	11.00	13.00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 286160	1. 449888	5. 35891	3 6. 862912	0. 061332	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 MARGARET MARY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1329
Period:
From 01/01/2023
To 12/31/2023 Date/Time Prepared:
5/29/2024 7: 24 am

					10		e Prepared: 4 7:24 am
	Cost C	enter Description	CENTRAL	PHARMACY	MEDI CAL	,	
			SERVICES &	(100% T0	RECORDS &		
			SUPPLY (100% MED	DRUGS)	LI BRARY (TI ME		
			SUPPLI ES)		SPENT)		
			14. 00	15. 00	16.00		
		I CE COST CENTERS	T				
1.00	1 1	P REL COSTS-BLDG & FLXT					1.00
1. 01 2. 00		P REL COSTS-OFFSITE BLDG P REL COSTS-MVBLE EQUIP					1. 01 2. 00
2. 00		P REL COSTS-MVBLE EQUIP OFFSIT					2.00
4. 00		EE BENEFITS DEPARTMENT					4.00
5.00		STRATIVE & GENERAL					5.00
7.00	00700 OPERAT	ION OF PLANT					7. 00
7. 01		ION OF PLANT -OFFSITE					7. 01
7. 02	1	ION OF PLANT - HOSPITAL & OFFS					7.02
8. 00 9. 00	1	Y & LINEN SERVICE					8.00
10.00	00900 HOUSEK 01000 DI ETAR						9.00
11. 00	01100 CAFETE						11.00
13. 00	1	G ADMINISTRATION					13.00
		L SERVICES & SUPPLY	100				14.00
15.00	01500 PHARMA	CY	0	100			15. 00
16.00	· · · · · · · · · · · · · · · · · · ·	L RECORDS & LIBRARY	0	0	760		16. 00
20.25		UTINE SERVICE COST CENTERS	_				20.55
	1	& PEDIATRICS	0				30.00
	1 1	IVE CARE UNIT	0	0			31. 00 43. 00
43.00	ANCLLLARY SE	RVICE COST CENTERS	0	ı U	U		43.00
50.00	05000 OPERAT		0	0	56		50.00
	1	RY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADI OL	OGY-DI AGNOSTI C	0	0	102		54.00
	06000 LABORA		0	0	0		60.00
65.00	1 1	ATORY THERAPY	0	0	0		65. 00
66.00	06600 PHYSI C		0	0	0		66.00
67. 00 68. 00	06800 SPEECH	TI ONAL THERAPY	0	0	0		67. 00 68. 00
	06900 SFEECTR		0	0	6		69.00
	1 1	L SUPPLIES CHARGED TO PATIENTS	100	o	o		71.00
	1 1	DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00		CHARGED TO PATLENTS	0	100	0		73. 00
		ERVI CE COST CENTERS	1				
	1	HEALTH CLINIC	0	0	0		88.00
88. 01 90. 00	09000 CLI NI C	L ARTS CENTER	0	0	28		88. 01 90. 00
90.00	09001 WOUND	CLINC	0	0	0		90.01
	09002 BEHAVI		0	o	0		90. 02
	09100 EMERGE		0	0	62		91.00
92.00		ATION BEDS (NON-DISTINCT PART)					92. 00
		RSABLE COST CENTERS			- 1		
101.00		EALTH AGENCY	0	0	0		101.00
112 00	11300 I NTERE	OSE COST CENTERS					113.00
	11600 HOSPI C		0	0	0		116.00
118.00		ALS (SUM OF LINES 1 through 117)					118.00
		BLE COST CENTERS					
	1 1	IANS' PRIVATE OFFICES	0	· ·			192. 00
	19201 PEDI AT		0	0	-		192. 01
	19202 BROOKV		0	0	0		192.02
	19203 RADI OL 19204 ENT	JUI - USUUUJ	0	0	0		192. 03 192. 04
		ITY RELATIONS			0		192.04
	07951 COMMUN			ol	0		194. 01
		NON-REI MBURSABLE	0	o	0		194. 02
	07953 EMS		0	O	0		194. 03
		ILLE TOOL & DIE CLINIC	0	0	0		194. 04
	07955 MMHCB		0	0	0		194. 05
	07956 FOUNDA	I I UN	0		0		194. 06 194. 07
200.00	07957 FQHC	Foot Adjustments		ا	ا		200.00
200.00		ve Cost Centers					201.00
202.00	1 0	b be allocated (per Wkst. B,	77, 374	5, 826, 806	1, 497, 994		202.00
	Part I			., ===, ===	,,		
	1 1	ost multiplier (Wkst. B, Part I)	773 740000	58, 268. 060000	1, 971. 044737		203.00
203.00	1						
203. 00 204. 00	1	be allocated (per Wkst. B,	39, 412				204. 00

Heal th Finar	ncial Systems MA	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
		,			From 01/01/2023 To 12/31/2023		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL			
		SERVICES &	(100% T0	RECORDS &			
		SUPPLY	DRUGS)	LI BRARY			
		(100% MED		(TIME			
		SUPPLI ES)		SPENT)			
		14. 00	15. 00	16.00			
205. 00	Unit cost multiplier (Wkst. B, Part	394. 120000	818. 370000	213. 17763	32		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)						
		•					

	TON OF NATIO OF COSTS TO CHANGES		Trovider C		From 01/01/2023 To 12/31/2023	Part I Date/Time Pre 5/29/2024 7: 2	pared: 4 am
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description		Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	8, 314, 917		8, 314, 91		0	30.00
	3100 INTENSIVE CARE UNIT	805, 533		805, 53		0	
	4300 NURSERY	1, 185, 700		1, 185, 70	0	0	43.00
	NCILLARY SERVICE COST CENTERS	,					
	5000 OPERATING ROOM	5, 245, 651		5, 245, 65		0	50.00
	5200 DELIVERY ROOM & LABOR ROOM	355, 783		355, 78		0	52.00
	5400 RADI OLOGY-DI AGNOSTI C	19, 310, 939		19, 310, 93		0	54.00
	6000 LABORATORY	6, 106, 240		6, 106, 24	.0	0	60.00
	6500 RESPI RATORY THERAPY	2, 164, 578	0	2, 164, 57		0	65.00
	6600 PHYSI CAL THERAPY	2, 491, 878	0	2, 491, 87		0	66.00
	6700 OCCUPATI ONAL THERAPY	632, 585	0	632, 58		0	67.00
	6800 SPEECH PATHOLOGY	271, 791	0	271, 79	0	0	68. 00
	6900 ELECTROCARDI OLOGY	1, 420, 467		1, 420, 46		0	69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 779, 081		3, 779, 08		0	71.00
	7200 IMPL. DEV. CHARGED TO PATIENT	3, 035, 470		3, 035, 47	0	0	72.00
	7300 DRUGS CHARGED TO PATIENTS	6, 021, 026		6, 021, 02	6 0	0	73.00
	UTPATIENT SERVICE COST CENTERS						
	8800 RURAL HEALTH CLINIC	2, 349, 893		2, 349, 89		0	
	8801 MEDICAL ARTS CENTER	4, 623, 511		4, 623, 51	1 0	0	88. 01
	9000 CLI NI C	4, 053, 619		4, 053, 61		0	90.00
	9001 WOUND CLINC	700, 863		700, 86	3 0	0	90. 01
	9002 BEHAVI ORAL HEALTH	0			0 0	0	90. 02
	9100 EMERGENCY	6, 392, 177		6, 392, 17	7 0	0	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 250, 561		3, 250, 56	1	0	92.00
	THER REIMBURSABLE COST CENTERS						
101.00 10	0100 HOME HEALTH AGENCY	0			0	0	101.00
SF	PECIAL PURPOSE COST CENTERS						
	1300 I NTEREST EXPENSE						113.00
	1600 HOSPI CE	1, 721, 114		1, 721, 11			116. 00
200.00	Subtotal (see instructions)	84, 233, 377	0	84, 233, 37	7 0		200. 00
201.00	Less Observation Beds	3, 250, 561		3, 250, 56	1		201. 00
202.00	Total (see instructions)	80, 982, 816	0	80, 982, 81	6 0	0	202. 00

Heal th	Financial Systems MAR	RGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
СОМРИТ	TATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2023 To 12/31/2023		
				XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	7 0/0 770		7 0/0 77		I	
30.00	03000 ADULTS & PEDIATRICS	7, 063, 773		7, 063, 77			30.00
31.00	03100 NTENSIVE CARE UNIT	612, 274		612, 27			31.00
43.00	04300 NURSERY	2, 964, 445		2, 964, 44	5		43.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	2 000 122	10 072 505	20, 981, 70	8 0. 250011	0.000000	50.00
50.00	05200 DELIVERY ROOM & LABOR ROOM	2, 908, 123 284, 795	18, 073, 585 85, 271				
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 542, 371	108, 859, 308				
60.00	06000 LABORATORY	4, 499, 147	48, 388, 988				
65.00	06500 RESPIRATORY THERAPY	1, 550, 191	1, 767, 654				
66.00	06600 PHYSI CAL THERAPY	1, 550, 191	5, 280, 843				
67.00	06700 OCCUPATI ONAL THERAPY	144, 257	1, 092, 244				
68.00	06800 SPEECH PATHOLOGY	30, 796	447, 442			0.000000	
69.00	06900 ELECTROCARDI OLOGY	371, 688	7, 006, 128			0.000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 375, 261	4, 734, 370				
71.00	07200 IMPL. DEV. CHARGED TO PATIENT	336, 675	3, 403, 898				
	07300 DRUGS CHARGED TO PATIENTS	3, 751, 990	12, 246, 695				
73.00	OUTPATIENT SERVICE COST CENTERS	3, 731, 770	12, 240, 075	13, 440, 00	0.370343	0.000000	73.00
88. 00	08800 RURAL HEALTH CLINIC	O	2, 749, 457	2, 749, 45	7		88.00
88. 01	08801 MEDI CAL ARTS CENTER		4, 411, 276				88. 01
90.00	09000 CLINIC	1, 000	7, 833, 634			0. 000000	
90. 01	09001 WOUND CLINC	0	2, 297, 809				
90. 02	09002 BEHAVI ORAL HEALTH	l ol	0		0. 000000		
91.00	09100 EMERGENCY	1, 470, 690	17, 048, 162			0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	876, 534	4, 542, 742				
	OTHER REIMBURSABLE COST CENTERS	0.2722.	.,				
101.00	10100 HOME HEALTH AGENCY	O	0		0		101.00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	-		- 1		
113.00	11300 NTEREST EXPENSE						113.00
	11600 HOSPI CE	o	1, 910, 610	1, 910, 61	0		116.00
200.00		30, 958, 556	252, 180, 116				200.00
201.00							201.00
202.00	Total (see instructions)	30, 958, 556	252, 180, 116	283, 138, 67	2		202.00
		,					

			10 12/31/2023	Date/IIme Prepared: 5/29/2024 7:24 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88. 00
88. 01 08801 MEDI CAL ARTS CENTER				88. 01
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 WOUND CLINC	0. 000000			90. 01
90. 02 09002 BEHAVI ORAL HEALTH	0. 000000			90. 02
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113.00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1329	Peri od:	Worksheet C
		From 01/01/2023	

					Fo 12/31/2023		pared: 4 am
			Ti tl	e XIX	Hospi tal	Cost	
	·		·		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	8, 314, 917		8, 314, 91		8, 314, 917	
31.00	03100 INTENSIVE CARE UNIT	805, 533		805, 533	3 0	805, 533	31.00
43.00	04300 NURSERY	1, 185, 700		1, 185, 700	0	1, 185, 700	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 245, 651		5, 245, 65		-11	
52.00	05200 DELIVERY ROOM & LABOR ROOM	355, 783		355, 783	3 0	355, 783	
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 310, 939		19, 310, 939	9 0	19, 310, 939	54.00
60.00	06000 LABORATORY	6, 106, 240		6, 106, 240	0	6, 106, 240	
65.00	06500 RESPI RATORY THERAPY	2, 164, 578	0	2, 164, 578	3 0	2, 164, 578	
66.00	06600 PHYSI CAL THERAPY	2, 491, 878	0	2, 491, 878	3 0	2, 491, 878	
67.00	06700 OCCUPATI ONAL THERAPY	632, 585	0	632, 58	5 0	632, 585	67.00
68.00	06800 SPEECH PATHOLOGY	271, 791	0	271, 79°	1 0	271, 791	68. 00
	06900 ELECTROCARDI OLOGY	1, 420, 467		1, 420, 46	7 0	1, 420, 467	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 779, 081		3, 779, 08	1 0	3, 779, 081	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	3, 035, 470		3, 035, 470	0	3, 035, 470	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 021, 026		6, 021, 026	5 0	6, 021, 026	73.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	2, 349, 893		2, 349, 893	0	2, 349, 893	
88. 01	08801 MEDI CAL ARTS CENTER	4, 623, 511		4, 623, 51	1 0	4, 623, 511	88. 01
90.00	09000 CLI NI C	4, 053, 619		4, 053, 619	9 0	4, 053, 619	90.00
90. 01	09001 WOUND CLINC	700, 863		700, 863	3 0	700, 863	90. 01
	09002 BEHAVI ORAL HEALTH	0			0	0	90. 02
91.00	09100 EMERGENCY	6, 392, 177		6, 392, 17	7 0	6, 392, 177	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 250, 561		3, 250, 56°	1	3, 250, 561	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0		(0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 H0SPI CE	1, 721, 114		1, 721, 114	1	1, 721, 114	116.00
200.00	Subtotal (see instructions)	84, 233, 377	0	84, 233, 37	7 0	84, 233, 377	200.00
201.00	Less Observation Beds	3, 250, 561		3, 250, 56°	1	3, 250, 561	201.00
202.00	Total (see instructions)	80, 982, 816	0	80, 982, 816	0	80, 982, 816	202.00

Heal th	Financial Systems MAF	RGARET MARY COMM	IUNI TY HOSPI TA	L	In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provi der CO		Peri od:	Worksheet C	
					From 01/01/2023		
					To 12/31/2023		
				VI V		5/29/2024 7: 2	4 am
				e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
			7.00	0.00	0.00	Ratio	
	LABORT FAIT BOUTLAND OFFICE COOT OFFITEDS	6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				[
30.00	03000 ADULTS & PEDIATRICS	7, 063, 773		7, 063, 77			30.00
31.00	03100 INTENSIVE CARE UNIT	612, 274		612, 27			31.00
43.00	04300 NURSERY	2, 964, 445		2, 964, 44	5		43.00
	ANCILLARY SERVICE COST CENTERS				_		
50.00	05000 OPERATING ROOM	2, 908, 123	18, 073, 585			0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	284, 795	85, 271			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 542, 371	108, 859, 308			0. 000000	54.00
60.00	06000 LABORATORY	4, 499, 147	48, 388, 988	52, 888, 13	5 0. 115456	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	1, 550, 191	1, 767, 654	3, 317, 84	5 0. 652405	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	174, 546	5, 280, 843	5, 455, 38	0. 456774	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	144, 257	1, 092, 244	1, 236, 50	0. 511593	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	30, 796	447, 442	478, 23	8 0. 568317	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	371, 688	7, 006, 128	7, 377, 81	6 0. 192532	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 375, 261	4, 734, 370	6, 109, 63	0. 618545	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	336, 675	3, 403, 898	3, 740, 57	3 0.811499	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 751, 990	12, 246, 695			0. 000000	73.00
	OUTPATIENT SERVICE COST CENTERS				<u>'</u>		
88. 00	08800 RURAL HEALTH CLINIC	0	2, 749, 457	2, 749, 45	7 0. 854675	0.000000	88. 00
88. 01	08801 MEDI CAL ARTS CENTER	o	4, 411, 276			0.000000	
90.00	09000 CLI NI C	1, 000	7, 833, 634			0.000000	90.00
90. 01	09001 WOUND CLINC	0	2, 297, 809			0.000000	90. 01
90. 02	09002 BEHAVI ORAL HEALTH	0	, , , , , ,	, , ,	0. 000000	0.000000	
91. 00	09100 EMERGENCY	1, 470, 690	17, 048, 162	18, 518, 85		0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	876, 534	4, 542, 742	5, 419, 27		0. 000000	
72.00	OTHER REIMBURSABLE COST CENTERS	0.0,001	1,012,712	5/ 117/27	0.0770.0	0.00000	72.00
101 00	10100 HOME HEALTH AGENCY	0	0		0		101.00
101.00	SPECIAL PURPOSE COST CENTERS	J	<u> </u>		<u> </u>		101.00
113 00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	o	1, 910, 610	1, 910, 61	0		116.00
200.00		30, 958, 556	252, 180, 116				200.00
200.00		30, 730, 330	232, 100, 110	203, 130, 07	-		201.00
201.00		30, 958, 556	252, 180, 116	283, 138, 67	2		202.00
202.00	10tal (366 Histiactions)	30, 730, 330	232, 100, 110	203, 130, 07	-		1202.00

			10 12/31/2023	5/29/2024 7:24 am	
		Title XIX	Hospi tal	Cost	_
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				30.00	
31.00 03100 INTENSIVE CARE UNIT				31.00	0
43. 00 04300 NURSERY				43.00	0
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000			50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00	
60. 00 06000 LABORATORY	0. 000000			60.00	
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00	
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00	
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00	
88. 01 08801 MEDICAL ARTS CENTER	0. 000000			88. 01	
90. 00 09000 CLI NI C	0. 000000			90.00	
90. 01 09001 WOUND CLINC	0. 000000			90. 01	
90. 02 09002 BEHAVI ORAL HEALTH	0. 000000			90. 02	
91. 00 09100 EMERGENCY	0. 000000			91.00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00	0
OTHER REIMBURSABLE COST CENTERS				101.00	_
101. 00 10100 HOME HEALTH AGENCY				101.00	U
SPECIAL PURPOSE COST CENTERS				112.00	_
113. 00 11300 I NTEREST EXPENSE				113.00	
116. 00 11600 HOSPI CE				116.00	
200.00 Subtotal (see instructions)				200.00	
201.00 Less Observation Beds				201.00	
202.00 Total (see instructions)				202.00	U

In Lieu of Form CMS-2552-10 Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-1329 Peri od: Worksheet D From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/29/2024 7:24 am Title XVIII Hospi tal Cost Total Charges Ratio of Cost Capital Costs Cost Center Description Capi tal Inpati ent to Charges Related Cost (from Wkst. Program (column 3 x C, Part I, column 4) (from Wkst. (col. 1 ÷ Charges B, Part II, col. 8) col. 2) col. 26) 1. 00 2.00 3.00 4. 00 5. 00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 0.013129 330, 193 50 00 275, 461 20, 981, 708 4, 335 52.00 05200 DELIVERY ROOM & LABOR ROOM 73, 167 370,066 0.197713 52.00 05400 RADI OLOGY-DI AGNOSTI C 1, 218, 091 111, 401, 679 0.010934 394, 227 54.00 4, 310 54.00 06000 LABORATORY 52, 888, 135 257, 695 0.004872 882, 699 60.00 4, 301 60.00 24, 990 06500 RESPIRATORY THERAPY 0.048186 65.00 159, 875 3, 317, 845 518, 616 65.00 66.00 06600 PHYSI CAL THERAPY 321, 615 5, 455, 389 0.058954 77,673 4,579 66.00 67.00 06700 OCCUPATI ONAL THERAPY 66, 238 1, 236, 501 0.053569 59, 328 3, 178 67.00 57, 383 10, 978 06800 SPEECH PATHOLOGY 68.00 478, 238 0.119988 1, 317 68.00 69.00 06900 ELECTROCARDI OLOGY 123, 392 7, 377, 816 0.016725 132, 174 2, 211 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 69, 068 6, 109, 631 0.011305 338, 345 3, 825 71.00 5, 789 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 215, 973 3, 740, 573 0.057738 100, 265 72.00 07300 DRUGS CHARGED TO PATIENTS 97,083 15, 998, 685 0.006068 961, 401 5, 834 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 81, 011 2, 749, 457 0.029464 0 0 88.00 88.01 08801 MEDICAL ARTS CENTER 224, 358 4, 411, 276 0.050860 0 88.01 0 90. 00 09000 CLINIC 760, 947 7, 834, 634 0.097126 0 0 90.00 09001 WOUND CLINC 54, 011 2, 297, 809 0.023505 0 90.01 90.01 0 90. 02 09002 BEHAVI ORAL HEALTH 0.000000 90.02 0 0 0.029498 91. 00 | 09100 | EMERGENCY 546, 273 18, 518, 852 5, 663 167 91.00 92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) 414, 216 5, 419, 276 0.076434 12,570 961 92.00 Total (lines 50 through 199) 65, 797 200. 00 200.00 5, 015, 857 270, 587, 570 3, 824, 132

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time | Prepared: | From 01/01/2024 | Prepared: | THROUGH COSTS

					10 12/01/2020	5/29/2024 7: 2	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
	06000 LABORATORY	0	0		0	0	60.00
	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS			,			
	08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
	08801 MEDICAL ARTS CENTER	0	0		0	0	88. 01
	09000 CLI NI C	0	0		0	0	90.00
	09001 WOUND CLINC	0	0		0	0	90. 01
	09002 BEHAVI ORAL HEALTH	0	0		0	0	90. 02
	09100 EMERGENCY	0	0		0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	0		0 0	0	200. 00

Peri od: Worksheet D From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared: THROUGH COSTS

				o 12/31/2023	Date/lime Pre 5/29/2024 7:2	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1	1	1	00 004 700		
50. 00 05000 OPERATING ROOM	0	0	0	, ,	l	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		370, 066	l .	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		111, 401, 679	l	
60. 00 06000 LABORATORY	0	0		52, 888, 135	l	
65. 00 06500 RESPIRATORY THERAPY	0	0		3, 317, 845	l e	
66. 00 06600 PHYSI CAL THERAPY	0	0		5, 455, 389	l	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0		1, 236, 501		67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		478, 238	l e	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		7, 377, 816 6, 109, 631	l e	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		3, 740, 573	l e	
73. 00 07300 DRUGS CHARGED TO PATTENTS	0			15, 998, 685	l e	
OUTPATIENT SERVICE COST CENTERS				13, 770, 003	0.000000	73.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		2, 749, 457	0.000000	88. 00
88. 01 08801 MEDI CAL ARTS CENTER	0			4, 411, 276		
90. 00 09000 CLINIC	0	0		7, 834, 634		
90. 01 09001 WOUND CLINC	0	0		2, 297, 809	l e	
90. 02 09002 BEHAVI ORAL HEALTH	0	0		0	0. 000000	
91. 00 09100 EMERGENCY	0	l o	l d	18, 518, 852	•	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	l o		5, 419, 276	l e	
200.00 Total (lines 50 through 199)	0	O	O		•	200.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCI LLARY SERVI CE OTHER PASS Provi der CCN: 15-13	29 Period: Worksheet D

From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared: THROUGH COSTS 5/29/2024 7: 24 am Title XVIII Hospi tal Cost Cost Center Description Outpati ent I npati ent I npati ent Outpati ent Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) x col. 10) 11.00 9. 00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 330, 193 50.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 0 0 0 0 0 0 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 0.000000 394, 227 0 0 54.00 54.00 06000 LABORATORY 0.000000 882, 699 0 60.00 60.00 0 06500 RESPIRATORY THERAPY 0.000000 518, 616 65.00 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 0.000000 77,673 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 000000 59, 328 0 0 67.00 10, 978 68.00 06800 SPEECH PATHOLOGY 0.000000 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 132, 174 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 338, 345 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 0.000000 100, 265 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0.000000 961, 401 0 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0. 000000 0 0 0 88.00 88.00 0 08801 MEDICAL ARTS CENTER 0.000000 0 0 0 0 0 88.01 0 0 88.01 90.00 09000 CLI NI C 0.000000 0 0 90.00 90. 01 09001 WOUND CLINC 0.000000 0 0 90.01 90. 02 09002 BEHAVI ORAL HEALTH 0 0.000000 0 90.02 0 0 91. 00 09100 EMERGENCY 91.00 0.000000 5, 663 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 12,570 0 92.00 Total (lines 50 through 199) 0 0 200.00 200.00 3, 824, 132

In Lieu of Form CMS-2552-10 Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1329 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 Part V Date/Time Prepared: 5/29/2024 7:24 am Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 4. 00 5.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 751, 927 50.00 0. 250011 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.961404 0 0 0 0 0 0 0 0 0 52.00 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 38, 107, 000 0. 173345 0 54.00 60.00 06000 LABORATORY 0.115456 12, 610, 940 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.652405 534, 068 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.456774 1, 694, 979 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 511593 322, 039 0 67.00 06800 SPEECH PATHOLOGY 0. 568317 26, 756 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 192532 0 1, 903, 650 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 1, 143, 096 71.00 71.00 0.618545 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.811499 0 1, 054, 813 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 0.376345 4, 632, 020 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88. 01 08801 MEDICAL ARTS CENTER 88.01 09000 CLI NI C 90.00 0.517397 0 2, 333, 484 0 0 90.00 09001 WOUND CLINC 90.01 90 01 0.305014 0 913, 683 0 0 0 0 0 0 09002 BEHAVI ORAL HEALTH 90.02 0.000000 0 0 90.02 91.00 09100 EMERGENCY 0.345171 3, 794, 856 0 91.00 1, 217, 739 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.599815 0 0 Subtotal (see instructions) 200.00 0 74, 041, 050 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

74, 041, 050

0 202.00

Net Charges (line 200 - line 201)

202.00

Peri od: Worksheet D From 01/01/2023 Part V

					To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
			Title	XVIII	Hospi tal	Cost	
			sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
	ANOLILIARY CERVICE COCT CENTERS	6. 00	7. 00				
FO 00	ANCILLARY SERVICE COST CENTERS	020 022					
	05000 OPERATING ROOM	938, 023	ł	ł			50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
	05400 RADI OLOGY-DI AGNOSTI C	6, 605, 658					54. 00 60. 00
	06000 LABORATORY 06500 RESPI RATORY THERAPY	1, 456, 009					65.00
	06600 PHYSI CAL THERAPY	348, 429 774, 222					66.00
	06700 OCCUPATI ONAL THERAPY	164, 753					67.00
	06800 SPEECH PATHOLOGY	15, 206					68.00
	06900 ELECTROCARDI OLOGY	366, 514					69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	707, 056					71.00
	07200 IMPL. DEV. CHARGED TO PATTENTS	855, 980					72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 743, 238		1			73.00
73.00	OUTPATIENT SERVICE COST CENTERS	1, 743, 230	0				
88 00	08800 RURAL HEALTH CLINIC						88.00
	08801 MEDI CAL ARTS CENTER						88. 01
	09000 CLINIC	1, 207, 338	0				90.00
	09001 WOUND CLINC	278, 686					90. 01
	09002 BEHAVI ORAL HEALTH	0	l o				90. 02
	09100 EMERGENCY	1, 309, 874	l o				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	730, 418					92.00
200.00		17, 501, 404					200.00
201.00		0					201.00
	Only Charges						
202.00		17, 501, 404	0				202. 00

	MADOADET MADY COMMUNITY HOODITA			6.5	
Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCM	N: 15-1329	Peri od: From 01/01/2023	Worksheet D-1	
			To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS 1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days. 4.00 Semi-private room days (excluding swing-bed and observation bed days). If you have only private room days. 4.00 Semi-private room days (excluding swing-bed and observation bed days). If you have only private room days. 5.349 2.0 6.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) 11.00 Swing-bed SNF type inpat
PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS 1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.01 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.01 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 10.00 Swin
INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn) 1.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 3.111 3.01 3.02 3.03 4.00 Semi-private room days (excluding swing-bed and observation bed days) 3.111 3.01 3.01 3.01 3.01 3.01 3.01 3.
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 2.00 Inpatient days (including private room days excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to title XVIII only (in
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services app
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18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost
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19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 266.32 19.0 reporting period
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.0
reporting period
21.00 Total general inpatient routine service cost (see instructions) 8,314,917 21.0
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 0 22.0
5 x line 17)
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 0 23.0 x line 18)
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 73,771 24.0
7 x line 19)
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.0
x line 20)
26.00 Total swing-bed cost (see instructions) 545,814 26.0
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 7,769,103 27.0
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00
29. 00 Private room charges (excluding swing-bed charges) 0 29. 0 Private room charges (excluding swing-bed charges)
30.00 Semi-private room charges (excluding swing-bed charges)
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.0
32.00 Average private room per diem charge (line 29 ÷ line 3) 0.00 32.0
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 33.0
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 34.00
35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.0
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7,769,103) 37.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7,769,103 37.0 27 minus line 36)
PART II - HOSPITAL AND SUBPROVIDERS ONLY
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,452.44 38.0
39.00 Program general inpatient routine service cost (line 9 x line 38) 1,732,761 39.0
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 1,732,761 41.0

	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	277	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 193	9.00
	newborn days) (see instructions)	,	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	325	10.00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
.2.00	through December 31 of the cost reporting period	· ·	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
.0.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	· ·	
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	
16. 00	Nursery days (title V or XIX only)	0	
10.00	SWING BED ADJUSTMENT	0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
17.00	reporting period		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
10.00	reporting period		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	266. 32	19. 00
19.00	reporting period	200. 32	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
20.00	reporting period	0.00	20.00
21 00	Total general inpatient routine service cost (see instructions)	8, 314, 917	21. 00
21.00			
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	U	22. 00
22.00	5 x line 17)	0	23. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	U	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	73, 771	24. 00
24. 00		73, 771	24.00
25 00	7 x line 19)	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
27 00		E4E 014	2/ 00
26. 00	Total swing-bed cost (see instructions)	545, 814	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7, 769, 103	27. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00	Private room charges (excluding swing-bed charges)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	7, 769, 103	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 452. 44	38. 00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1, 732, 761	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 732, 761	41.00
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MCRI F32 - 22. 2. 178. 2

Cost Center Description		Financial Systems MAR	RGARET MARY COM			In Lie	u of Form CMS-2 Worksheet D-1	
Title Will Biograph Cost Cost Center Description Title Total Total Total Biograph Region					F		Date/Time Pre	pared:
Inpatient Inpa		Title XVIII Hospital						
1.00		Cost Center Description	I npati ent	Inpatient	Diem (col. 1	Program Days	(col. 3 x	
Interest vision Configuration Registed Indias 237 3.398.87 65 220,977 41.00						4. 00		
Milestive CARE UNIT	42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
44.00 SIRRO CAL INTERSIVE CARE UNIT						1		
45.00 SURGILA INTENSIVE CARE UNIT			805, 533	237	3, 398. 87	65	220, 927	•
46.00 SURGICAL INTERSIVE CARE UNIT 46.00								1
100 1885 SPECIAL CART (SPECIFY)								•
Cost Center Description 1.100 1.								•
1.00	47.00							47.00
Program inpatient cell ular Thorapy acquisition cost (Worksheet D-6, Part III, Iline 10, column 1)							1. 00	
49.00 No.	48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1, 350, 628	48. 00
PASS_THROUGH_COST_ADJUSTNERUTS						column 1)		•
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts II and III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II of 51.00 and IV) 52.01 Total Program accidable cost (sun of lines 56 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and of 52.00 medical education costs (Line 49 minus Line 52) 54.00 Program and ischarges 55.00 Target amount per discharge (confractor use only) 55.00 Permanent adjustment amount per discharge (confractor use only) 55.01 Permanent adjustment amount per discharge (confractor use only) 56.02 Adjustment amount per discharge (confractor use only) 57.00 Difference between adjusted inpatient operating cost and target amount (Line 56 minus Line 53) 58.00 Disconsidered costs (lessor of Line 53 - Line 54, or Line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 58.00 Expected costs (lessor of Line 53 - Line 54, or Line 54 is less than the lowest of Lines 55 plus 55.01 or Line 56, or Line 56, or time 56 or Line 54 is less than the lowest of Lines 55 plus 55.01 or Line 56, or Line 56, or time 56 or Line 54 is less than the lowest of Lines 55 plus 55.01 or Line 56, or time 56 or Line 54 is less than the lowest of Lines 55 plus 55.01 or Line 56, or time 56 or Line 54 is less than the lowest of Lines 55 plus 55.01 or Line 50 or Line	49. 00		41 through 48.(01)(see instru	ctions)		3, 304, 316	49. 00
1110 Sast sthrough costs applicable to Program Inpatient ancillary services (from West. D., sum of Parts II 0 51.00 and IIV) 52.00 Total Program inpatient operating costs (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost secteding capital related, non-physician anesthotist, and 53.00 Total Program inpatient operating cost secteding capital related, non-physician anesthotist, and 53.00 Total Program inpatient operating cost secteding capital related, non-physician anesthotist, and 53.00 Total Program inpatient operating cost and total program discharges 0.00 55.00 Target amount per discharge 0.00 55.00 Target amount per discharge (contractor use only) 0.00 55.01 50.02 Adjustment amount per discharge (contractor use only) 0.00 55.01 50.02 Adjustment amount per discharge (contractor use only) 0.00 55.01 50.02 Adjustment amount per discharge (contractor use only) 0.00 55.01 50.02 50.00	FO 00		-41441		WI+ D	-£ Dt- 1		
51.00 pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II and III and	50.00		attent routine	services (Tro	m wkst. D, Sum	or Parts I and	0	50.00
and IV) 52. 00 Total Program excludable cost (sum of lines 50 and 51) 53. 00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 53. 00 medical aducation costs. (line 46 mins line 52) 54. 00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 55. 00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 56. 00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 56. 00 Total Program inpatient costs (pine 52) 56. 00 Total Program inpatient operating cost and target emount (line 56 minus line 53) 57. 00 Total Program (see instructions) 58. 00 Bonus payment (see instructions) 59. 00 Total Program inpatient operating cost and target emount (line 56 minus line 53) 59. 00 Total excluding costs (sesser of line 51 line 54, or line 55 from the cost reporting period ending 1996, 60. 00 Expected costs (lesser of line 53 + line 54, or line 55 from the cost report, updated by the one market basket) 60. 00 Expected costs (lesser of line 53 + line 54, or line 55 from the cost report, updated by the one market basket) 61. 00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 50, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are loss than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter costs. (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter costs. (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter costs. (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter costs. (line 36 x 20) 63. 00 Allowable Inpatient cost plus incentive payment (see instructions) 64. 00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tilt XVIII only); for CAN, see instructions. (line 12 x line 64) 65. 00 Medicare swing-bed SNF inpatient routin	51. 00	,	atient ancilla	rv services (f	rom Wkst. D. s	um of Parts II	0	51.00
Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				, ,				
medical education costs (line 49 minus line 52)	52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
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55.02 Adjustment amount per discharge 0.00 55.02 55.02 Adjustment amount per discharge (contractor use only) 0.00 55.02 55.02 Adjustment amount (line 54 x sum of lines 55, 55.01, and 55.02) 0.00 55.02 56.00 Torget amount (line 54 x sum of lines 55, 55.01, and 55.02) 0.00 55.00 57.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 57.00 0.00		9						
55.02 Adjustment amount per discharge (contractor use only) 0.00 55.02 0.50.00 0.								•
56. 00 Target amount (line 54 x sum of lines 55, 55. 01, and 55. 02) 0 56. 00 0 57. 00 0 58. 00 0 59.			use onl v)					1
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61.00 Continuous improvement bonus payment (if line 53 * line 54 is less than the lowest of lines 55 plus 5.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Rel lef payment (see instructions) 63.00 Allowale Inpatient cost plus Incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only); for CAH, see instructions (title XVIII only); for CAH, see instructions (title XVIII only); for CAH, see instructions 67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost (line 97 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital-related costs (line 9 x line 76) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 88.00 Total Program inpatient	60.00		or title 55 ff	olii pi i oi yeai	cost report, u	buated by the	0.00	00.00
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CAH, see instructions 7. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Program capital -related costs (line 75 + line 2) 77.00 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost per diem limitation 10.00 10.01 10.01 10.02 10.03 10.04 10.04 10.05 10.05 10.05 10.06 10.07 10.07 10.07 10.07 10.07 10.08 10.09 10.09 10.00 1								
Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	66. 00		ne costs (line	64 plus line	65)(title XVII	l only); for	472, 043	66. 00
(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 9 x line 76) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost (see instructions) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions)	47.00	1	a casts through	n Docombor 21	of the cost re	oorting poriod	0	47.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 + line 2) 76.00 Program capital -related costs (line 9 x line 76) 77.00 Program capital -related costs (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Program inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 70 Total observation bed days (see instructions) 71 Total observation bed days (see instructions) 72 Total observation bed days (see instruct	67.00		e costs till ougi	i becember 31	or the cost re	boi triig perrou	U	67.00
First title V or XiX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 71.00 72.00 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 75.00 Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) Per diem capital-related costs (line 75 + line 2) 77.00 78.00 Roggegate charges to beneficiaries for excess costs (from provider records) Total Program routine service cost (line 74 minus line 77) Roggegate charges to beneficiaries for excess costs (from provider records) Total Program routine service cost per diem limitation 10.00	68. 00		e costs after [December 31 of	the cost repo	rting period	0	68.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71. 00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72. 00 Program routine service cost (line 9 x line 71) 73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74. 00 Total Program general inpatient routine service costs (line 72 + line 73) 75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 75. 00 76. 00 Program capital-related costs (line 75 + line 2) 77. 00 Program capital-related costs (line 9 x line 76) 1npatient routine service cost (line 74 minus line 77) 78. 00 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 80. 00 Inpatient routine service cost per diem limitation 81. 00 81. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 00 83. 00 Reasonable inpatient routine services (see instructions) 84. 00 87. 00 Program inpatient ancillary services (see instructions) 88. 00 Total Program inpatient operating costs (sum of lines 83 through 85) 87. 00 Total observation bed days (see instructions) 87. 00 Total observation bed days (see instructions)		(line 13 x line 20)			·			
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72.00 73.00 74.00 75.00 76.00 77.00 77.00 78.00 79.00 79.00 79.00 79.00 70.01 70.01 70.02 70.02 70.02 70.03 70.03 70.04 70.04 70.05 70.05 70.05 70.06 70.06 70.06 70.06 70.06 70.07 70.07 70.07 70.07 70.08								•
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75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 2, 238 87.00		,	•	m (line 14 x l	ine 35)			•
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76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 81.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 2, 238	75. 00		routine service	e costs (from	Worksheet B, P	art II, column		75. 00
77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions)	7/ 00		2)					7/ 00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 2, 238 87.00		•	,					
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85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 85.00 86.00 86.00 87.00		, ,						
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 2, 238 87.00				nns)				
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 2,238 87.00								ł
87.00 Total observation bed days (see instructions) 2,238 87.00	55. 55			3ag 30)				00.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,452.44 88.00		Total observation bed days (see instructions)					1
	88. 00	Adjusted general inpatient routine cost per	diem (line 27 –	÷ line 2)			1, 452. 44	88.00

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu				u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			3, 250, 561	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 059, 559	8, 314, 917	0. 12742	9 3, 250, 561	414, 216	90.00
91.00 Nursing Program cost	0	8, 314, 917	0.00000	0 3, 250, 561	0	91.00
92.00 Allied health cost	0	8, 314, 917	0.00000	0 3, 250, 561	0	92.00
93.00 All other Medical Education	0	8, 314, 917	0. 00000	3, 250, 561	0	93.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lie	In Lieu of Form CMS-2					
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1329	Peri od: From 01/01/2023	Worksheet D-1					
		To 12/31/2023						
	Title XIX	Hospi tal	Cost					
Cost Center Description								
			1. 00					
PART I - ALL PROVIDER COMPONENTS								
I NPATI ENT DAYS	I NPATI ENT DAYS							
1.00 Inpatient days (including private room	Inpatient days (including private room days and swing-bed days, excluding newborn)							
2.00 Inpatient days (including private room	0 Inpatient days (including private room days, excluding swing-bed and newborn days)							
3.00 Private room days (excluding swing-bed	Private room days (excluding swing-bed and observation bed days). If you have only private room days, 0 3.							

	Cost Center Description	COST	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5, 951	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	5, 349 0	2. 00 3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)	3, 111	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	277	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	83	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
16.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	15. 00 16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
18. 00	reporting period		
	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18. 00 19. 00
19. 00	Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period		
20. 00	Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	8, 314, 917 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00	Total swing-bed cost (see instructions)	476, 268	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	7, 838, 649	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29. 00 30. 00	Pri vate room charges (excluding swing-bed charges) Semi-pri vate room charges (excluding swing-bed charges)	0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7, 838, 649	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 465. 44	
	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)	121, 632 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 + line 40)	121, 632	

	Financial Systems MAR	GARET MARY COM	MUNITY HOSPITA Provider C		In Lie	u of Form CMS-2 Worksheet D-1	
COMPO	ATTON OF THEATTENT OFERATING COST		Provider C	F	rom 01/01/2023 o 12/31/2023	Date/Time Pre	pared:
			Title XIX Hospital			5/29/2024 7: 2 Cost	4 4 111
	Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	1, 185, 700	672				42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	805, 533	237	3, 398. 87	6	20, 393	
44.00	CORONARY CARE UNIT						44.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
	<u>'</u>					1. 00	
48.00	Program inpatient ancillary service cost (Wk					101, 533	•
48. 01	Program inpatient cellular therapy acquisiti				column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	Di)(see instru	ctions)		243, 558	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst D sum	of Parts I and	0	50.00
30.00		attent routine	services (110	iii wkst. D, suiii	or raits rain		30.00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancilla	ry services (f	rom Wkst. D, s	um of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	etist, and	0	53.00
	medical education costs (line 49 minus line	52)					
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	54.00
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
55. 01	Permanent adjustment amount per discharge					0.00	•
55. 02	Adjustment amount per discharge (contractor	use onl v)				0.00	1
56.00	Target amount (line 54 x sum of lines 55, 55)			0	56.00
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	ine 53)	0	57.00
58. 00	Bonus payment (see instructions)					0	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	0.00	59. 00				
60.00	Expected costs (lesser of line 53 ÷ line 54,	0. 00	60.00				
61. 00	market basket) Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line						61.00
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	60), or 1 % of	r the target a	mount (line 56), otherwise		
62. 00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ucti ons)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	ner 31 of the	cost renorting	neriad (See	0	65. 00
03.00	instructions)(title XVIII only)	ts arter become	oci oi tiic	cost reporting	perrou (see		03.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVII	only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost repo	rting period	0	68. 00
/ O = =	(line 13 x line 20)		Z1 1		-	_	46.5-
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service c						71.00
72.00	Program routine service cost (line 9 x line	•					72.00
73.00	Medically necessary private room cost applic						73.00
74.00	Total Program general inpatient routine serv	•		•	art II column		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)		e costs (ITOIII	worksneet B, P	art II, Corumn		75. 00
76.00	Per diem capital -related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		orovi der recor	ds)			79.00
80. 00	Total Program routine service costs for comp				us line 79)		80.00
81. 00	Inpatient routine service cost per diem limi			•	,		81.00
82.00	Inpatient routine service cost limitation (•				82.00
83.00	Reasonable inpatient routine service costs (ns)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		one)				84. 00 85. 00
86.00	Total Program inpatient operating costs (sum						86.00
55. 55	PART IV - COMPUTATION OF OBSERVATION BED PASS		549 55)				00.00
87. 00	Total observation bed days (see instructions)				2, 238	1
88. 00	Adjusted general inpatient routine cost per	diem (line 27 –	÷ line 2)			1, 465. 44	88.00

ealth Financial Systems MARGARET MARY COMMUNITY HOSPITAL In Lieu				u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Ti tl e	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			3, 279, 655	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	1, 059, 559	8, 314, 917	0. 12742	9 3, 279, 655	417, 923	90.00
91.00 Nursing Program cost	0	8, 314, 917	0.00000	0 3, 279, 655	0	91.00
92.00 Allied health cost	0	8, 314, 917	0.00000	0 3, 279, 655	0	92.00
93.00 All other Medical Education	l ol	8, 314, 917	0. 00000	0 3, 279, 655	0	93.00

	Financial Systems MARGARET MARY COMMUN				u of Form CMS-2	
I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
				From 01/01/2023 To 12/31/2023		narod:
				10 12/31/2023	5/29/2024 7: 2	
		Title	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x	
					col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			2, 048, 369		30.00
31.00	03100 INTENSIVE CARE UNIT			170, 112		31.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 25001	1 330, 193	82, 552	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 96140	4 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 17334	5 394, 227	68, 337	54.00
60.00	06000 LABORATORY		0. 11545	6 882, 699	101, 913	60.00
65.00	06500 RESPI RATORY THERAPY		0. 65240	5 518, 616	338, 348	65.00
66.00	06600 PHYSI CAL THERAPY		0. 45677	4 77, 673	35, 479	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 51159	3 59, 328	30, 352	67.00
68.00	06800 SPEECH PATHOLOGY		0. 56831	7 10, 978	6, 239	68.00
69.00	06900 ELECTROCARDI OLOGY		0. 19253	2 132, 174	25, 448	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 61854	5 338, 345	209, 282	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT		0. 81149	9 100, 265	81, 365	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 37634	5 961, 401	361, 818	73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC		0.00000	0	0	88. 00
88. 01	08801 MEDI CAL ARTS CENTER		0. 00000	0	0	88. 01
90.00	09000 CLI NI C		0. 51739		0	90.00
90. 01	09001 WOUND CLINC		0. 30501	4 0	0	90. 01
90. 02	09002 BEHAVI ORAL HEALTH		0. 00000		0	90. 02
01 00	00100 EMEDGENCY		0 04545	1	1 055	01 00

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91. 00 09100 EMERGENCY

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92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

Health Financial Systems		<u>MARY COMMUNITY HOSPITAL</u>		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST A	PORTI ONMENT	Provi der CC		Peri od:	Worksheet D-3	
		Component C		From 01/01/2023 Fo 12/31/2023		pared: 4 am
		Title	XVIII	wing Beds - SNF	Cost	
Cost Center Description	1		Ratio of Cost	I npati ent	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE CO	ST CENTERS					
30.00 03000 ADULTS & PEDIATRICS						30.00
31.00 03100 INTENSIVE CARE UNIT						31.00
43. 00 04300 NURSERY						43.00
ANCILLARY SERVICE COST CENTE	RS			_		
50.00 05000 OPERATING ROOM			0. 25001	1 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR	MOOS		0. 96140		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 17334	18, 833	3, 265	54.00
60. 00 06000 LABORATORY			0. 11545	5 77, 446	8, 942	60.00
65. 00 06500 RESPI RATORY THERAPY			0. 65240	70, 346	45, 894	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 45677	47, 249	21, 582	66.00
67. 00 06700 OCCUPATI ONAL THERAPY			0. 51159	43, 435	22, 221	67.00
68.00 06800 SPEECH PATHOLOGY			0. 56831	7 2, 300	1, 307	68.00
69. 00 06900 ELECTROCARDI OLOGY			0. 19253	6, 989	1, 346	69.00
71.00 07100 MEDICAL SUPPLIES CHARG	ED TO PATIENTS		0. 61854	5 23, 436	14, 496	71.00
72.00 07200 IMPL. DEV. CHARGED TO I	PATI ENT		0. 81149	9 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIE	√TS		0. 37634	5 154, 922	58, 304	73.00
OUTPATIENT SERVICE COST CENT	ERS					
88.00 08800 RURAL HEALTH CLINIC			0. 00000	O	0	88. 00
88.01 08801 MEDICAL ARTS CENTER			0.00000	O	0	88. 01
90. 00 09000 CLI NI C			0. 51739	7 0	0	90.00
90. 01 09001 WOUND CLINC			0. 30501	4 0	0	90. 01
90. 02 09002 BEHAVI ORAL HEALTH			0.00000	0	0	90. 02
01 00 00100 EMEDGENCY			0 24517	1	ا م	01 00

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91. 00 | 09100 | EMERGENCY | 92. 00 | 09200 | OBSERVATION | BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

200.00

201.00 202.00

Health Financial Systems MARGARET MARY COMM	UNITY HOSPITA	.L	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		eri od:	Worksheet D-3	
			rom 01/01/2023		
			o 12/31/2023	Date/Time Prep 5/29/2024 7: 24	
	Ti +I	e XIX	Hospi tal	Cost	4 4 1111
Cost Center Description	11 (1	Ratio of Cost		I npati ent	
oost center bescription		To Charges	Program	Program Costs	
		10 onar ges	Charges	(col. 1 x	
			orial gcs	col. 2)	
		1.00	2, 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			109, 366		30.00
31. 00 03100 NTENSI VE CARE UNI T			18, 199	l .	31.00
43. 00 04300 NURSERY			210, 391		43.00
ANCILLARY SERVICE COST CENTERS		•			
50. 00 05000 OPERATING ROOM		0. 250011	14, 340	3, 585	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 961404	50, 503	48, 554	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 173345	31, 460	5, 453	54.00
60. 00 06000 LABORATORY		0. 115456	109, 544	12, 648	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 652405	28, 674	18, 707	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 456774	1, 173	536	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 511593	864	442	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 568317	838	476	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 192532	5, 247	1, 010	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 618545	0	o	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 811499	1, 573	1, 276	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 376345	0	o	73.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0. 854675	0	0	88. 00
88. 01 08801 MEDICAL ARTS CENTER		1. 048112	2	0	88. 01
90. 00 09000 CLI NI C		0. 517397	0	0	90.00
90. 01 09001 WOUND CLINC		0. 305014	0	0	90. 01
OO OO OOOOO PEUNU ODAL UEN TU		0 000000	ما ا		00 00

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90. 02 09002 BEHAVI ORAL HEALTH

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

91. 00 09100 EMERGENCY

200.00

201.00

202.00

	<u> </u>	MARY COMMUNITY HOSPITA			u of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		eri od:	Worksheet D-3	
		Component (rom 01/01/2023 o 12/31/2023		pared:
					5/29/2024 7: 2	
		Ti tl		ving Beds - SNF		
	Cost Center Description		Ratio of Cost	Professional Control	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			4 00	0.00	col . 2)	
	LAIDATH FAIT DOUTLAIF CEDIALOF COCT CENTEDS		1. 00	2. 00	3. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					20.00
	03000 ADULTS & PEDI ATRI CS					30.00
	03100 NTENSI VE CARE UNIT 04300 NURSERY					31.00
43. 00	ANCILLARY SERVICE COST CENTERS					43. 00
50. 00	05000 OPERATING ROOM		0. 250011	14, 340	2 505	50.00
	05200 DELIVERY ROOM & LABOR ROOM		0. 961404	·		
	05400 RADI OLOGY-DI AGNOSTI C		0. 173345			
	06000 LABORATORY		0. 175345			
65. 00	06500 RESPIRATORY THERAPY		0. 652405			65.00
66. 00	06600 PHYSI CAL THERAPY		0. 456774			
	06700 OCCUPATI ONAL THERAPY		0. 511593			
	06800 SPEECH PATHOLOGY		0. 568317			
	06900 ELECTROCARDI OLOGY		0. 192532			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 618545		0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT		0. 811499		-	
	07300 DRUGS CHARGED TO PATIENTS		0. 376345	,		73.00
	OUTPATIENT SERVICE COST CENTERS			-		
88. 00	08800 RURAL HEALTH CLINIC		0. 854675	0	0	88. 00
88. 01	08801 MEDICAL ARTS CENTER		1. 048112		0	88. 01
90.00	09000 CLI NI C		0. 517397	0	0	90.00
90. 01	09001 WOUND CLINC		0. 305014	0	0	90. 01
00 00	COCCO DELLA MICRA TH		0 000000			00 00

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90. 02 09002 BEHAVI ORAL HEALTH

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

91. 00 09100 EMERGENCY

200.00

201.00 202.00

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1329	Peri od: From 01/01/2023 To 12/31/2023 Worksheet E Part B Date/Time Prepared:

	Title Will Head to	5/29/2024 7: 24	4 am
	Title XVIII Hospital	Cost	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	17, 501, 404	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3. 00 4. 00
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)		4.00
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5. 00
6. 00	Line 2 times line 5	0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7. 00
8.00	Transitional corridor payment (see instructions)	0	8. 00
9. 00	Ancillary service other pass through costs including REH direct graduate medical education costs 1	from 0	9. 00
10 00	Wkst. D, Pt. IV, col. 13, line 200	0	10. 00
10.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)	17, 501, 404	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES	17, 301, 404	11.00
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
	Aggregate amount actually collected from patients liable for payment for services on a charge basi		
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebas had such payment been made in accordance with 42 CFR §413.13(e)	sis 0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17. 00
	Total customary charges (see instructions)	0.000000	18. 00
	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	o	19.00
	instructions)		
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
	instructions)	47 /7/ /40	
	Lesser of cost or charges (see instructions)	17, 676, 418	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)	0 0	22. 00 23. 00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		24.00
21.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		21.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	165, 287	25.00
	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	12, 318, 030	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	5, 193, 101	27. 00
00 00	instructions)		00.00
	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
	REH facility payment amount (see instructions) ESRD direct medical education costs (from Wkst. E-4, line 36)	0	28. 50 29. 00
	Subtotal (sum of lines 27, 28, 28.50 and 29)	5, 193, 101	
	Primary payer payments	1, 048	
	Subtotal (line 30 minus line 31)	5, 192, 053	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
	Allowable bad debts (see instructions)	652, 469	
	Adjusted reimbursable bad debts (see instructions)	424, 105 543, 089	
	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)	5, 616, 158	
	MSP-LCC reconciliation amount from PS&R	3,010,130	38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		39.00
	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	39. 75
	Demonstration payment adjustment amount before sequestration	0	
	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
	Subtotal (see instructions) Sequestration adjustment (see instructions)	5, 616, 158	
	Demonstration adjustment (see instructions)	112, 323	40.01
	Sequestration adjustment-PARHM pass-throughs		40. 02
	Interim payments	6, 629, 607	41.00
	Interim payments-PARHM		41.01
	Tentative settlement (for contractors use only)	0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)		42. 01
	Balance due provider/program (see instructions)	-1, 125, 772	
43. 01			
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44. 00
	8115 2		
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
90. 00	TO BE COMPLETED BY CONTRACTOR	0	90.00
		0	90. 00 91. 00
91. 00 92. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	0 0.00	91.00

Health Financial Systems	MARGARET MARY COMMUN	IITY HOSPITAL	In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1329	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	pared:
				5/29/2024 7: 2	<u>.4 am</u>
		Title XVIII	Hospi tal	Cost	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1329 Peri od: Worksheet E-1 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 7:24 am Title XVIII Hospi tal Cost Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 4. 00 1.00 2.00 3.00 1.00 Total interim payments paid to provider 3, 064, 401 6, 629, 607 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 09/28/2023 186, 000 3.01 3.02 0 3.02 0 3 03 0 0 3 03 3.04 0 0 3.04 0 3.05 3.05 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 0 3.51 3.51 0 0 3.52 3.52 3 53 0 0 3 53 3.54 0 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 186,000 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3, 250, 401 6, 629, 607 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 0 5.02 0 5.02 5.03 0 5.03

Health Financial Systems MARGARET ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					5/29/2024 7: 2	4 am
				wing Beds - SNF		
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		631, 237	1	0	1.00
2.00	Interim payments payable on individual bills, either		()	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER				0	2 01
3. 01	ADJUSTIMENTS TO PROVIDER					3. 01 3. 02
3. 02						3. 02
3. 04						3. 04
3. 05						3. 05
3. 03	Provider to Program			<u>'</u>	0	3.03
3. 50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51	ADSOSTMENTS TO TROOK III				o o	3. 51
3. 52					l ol	3. 52
3. 53					l ol	3. 53
3. 54					l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		631, 237	'	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
E 01	Program to Provider TENTATIVE TO PROVIDER				0	5. 01
5. 01 5. 02	TENTATIVE TO PROVIDER		(5. 01
5. 02						5. 02
5.05	Provider to Program			/	U	5.05
5. 50	TENTATI VE TO PROGRAM)	0	5. 50
5. 51	TENTITY E TO TROOK IIII				Ö	5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				l ol	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		8, 096		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		()	0	6. 02
7. 00	Total Medicare program liability (see instructions)		639, 333		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor)	1. 00	2. 00	0.00
8. 00	Name of Contractor			I		8. 00

Heal th	Financial Systems MARGARET MARY COMMU	INITY HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUI	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1329 Period: From 01/01/2023			Worksheet E-	1
To 12/31/2023 Date/Ti me Prepa 5/29/2024 7: 24					
	Title XVIII Hospital				
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	Medicare days (see instructions)				2. 00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				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				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of a 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 (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	
	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32. 00

Health Financial Systems	MARGARET MARY COMMUN	NITY HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1329		Worksheet E-2
			From 01/01/2023	
		Component CCN: 15-Z329	To 12/31/2023	Date/Time Prepared:
		,		5/29/2024 7:24 am
•				_

		Component CCN: 15-Z329	To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
	COMPUTATION OF MET COOT OF COMPETE OFFI		1. 00	2. 00	
1. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		476, 763	0	1.00
2. 00	Inpatient routine services - swing bed-swr (see instructions)		470, 703	U	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A and sum of Wkst D	182, 159	0	1
0.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi		·	ŭ	0.00
	instructions)	3 · · · · p · · · · · · · · · · · · · ·			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teach	ing program (see		0.00	4.00
	instructions)			_	
5.00	Program days		325	0	1
6. 00 7. 00	Interns and residents not in approved teaching program (see i Utilization review - physician compensation - SNF optional me	•	0	0	6. 00 7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	triod offi y	658, 922	0	1
9. 00	Primary payer payments (see instructions)		030, 722	0	1
10.00	Subtotal (line 8 minus line 9)		658, 922	0	
11. 00	Deductibles billed to program patients (exclude amounts applied	cable to physician	0	0	1
	professional services)	, J			
12.00	Subtotal (line 10 minus line 11)		658, 922	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	6, 800	0	13.00
	for physician professional services)			_	
14.00	80% of Part B costs (line 12 x 80%)		/50 400	0	
	Subtotal (see instructions)		652, 122	0	
16. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	e)	U	U	16. 00 16. 50
16. 55	Rural community hospital demonstration project (§410A Demonst	•	0		16. 55
10. 55	adjustment (see instructions)	ration) payment			10.33
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
	Allowable bad debts (see instructions)		398	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		259	0	17.01
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	398	0	18.00
	Total (see instructions)		652, 381	0	
	Sequestration adjustment (see instructions)		13, 048	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03 19. 25	Sequestration adjustment-PARHM pass-throughs		0	0	19. 03 19. 25
	Sequestration for non-claims based amounts (see instructions) Interim payments		631, 237	0	20.00
	Interim payments Interim payments-PARHM		031, 237	O	20.00
	Tentative settlement (for contractor use only)		0	0	
	Tentative settlement-PARHM (for contractor use only)			ŭ	21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.0)	2, 19.25, 20, and 21)	8, 096	0	22.00
22. 01	Balance due provider/program-PARHM (see instructions)				22. 01
23.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2				
200 00	Rural Community Hospital Demonstration Project (§410A Demonstr				200 00
200.00	Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	riod under the 21st			200.00
	Cost Reimbursement				1
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))	,			
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst. D-3, col. 3, lir	ne		202.00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)	C'			204.00
	Computation of Demonstration Target Amount Limitation (N/A in period)	first year of the curre	ent 5-year demons	tration	
205 00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 t	imes line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs	•			1
207.00	Program reimbursement under the §410A Demonstration (see inst				207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	2, col. 1, sum of lines	1		208.00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209.00
210. 00	Reserved for future use				210.00
215 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line.	200 plus lino 210) (ccc			215. 00
Z 13. UU	instructions)	207 prus rine 210) (See			2 13.00
	1.1101.1101.0110)		ı l		1

Health Financial Systems	MARGARET MARY COMMU	JNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1329	Peri od: From 01/01/2023	Worksheet E-2
		Component CCN: 15-Z329		

		Component CCN: 15-Z329	To 12/31/2023	Date/Time Pr 5/29/2024 7:	
		Title XIX	Swing Beds - SNF		24 am
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	+ A	00 (07		2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par		92, 687		3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swiinstructions)	ng-bed pass-through, see			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teach	ing program (see	0.00		4.00
00	instructions)	g program (ooo	0.00		
5.00	Program days		0		5.00
6.00	Interns and residents not in approved teaching program (see i	nstructions)	O		6.00
7.00	Utilization review - physician compensation - SNF optional me	thod only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		92, 687		8.00
9.00	Primary payer payments (see instructions)		0		9.00
10.00	Subtotal (line 8 minus line 9)		92, 687		10.00
11.00	Deductibles billed to program patients (exclude amounts appli	cable to physician	0		11.00
	professi onal servi ces)				
	Subtotal (line 10 minus line 11)		92, 687		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	0		13.00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)		0		14.00
	Subtotal (see instructions)		92, 687		15. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16.00
	Pioneer ACO demonstration payment adjustment (see instruction	,			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonst	ration) payment			16. 55
4, 00	adjustment (see instructions)				1, 00
16. 99	Demonstration payment adjustment amount before sequestration		0		16. 99
	Allowable bad debts (see instructions)		0		17.00
	Adjusted reimbursable bad debts (see instructions)		0		17. 01
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0		18.00
	Total (see instructions)		92, 687		19.00
	Sequestration adjustment (see instructions)		0		19. 01
	Demonstration payment adjustment amount after sequestration)		U		19. 02
	Sequestration adjustment-PARHM pass-throughs				19. 03
	Sequestration for non-claims based amounts (see instructions)		0		19. 25
	Interim payments		٥		20.00
	Interim payments-PARHM		0		20. 01
21.00	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)		U		21.00
	Balance due provider/program (line 19 minus lines 19.01, 19.0	2 10 25 20 and 21)	92, 687		22.00
22. 00	Balance due provider/program-PARHM (see instructions)	2, 14.25, 20, and 21)	72,007		22. 00
	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	0		23.00
23.00	chapter 1, §115.2	nce with cms rub. 13-2,			23.00
	Rural Community Hospital Demonstration Project (§410A Demonst	ration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration pe				200.00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201.00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, lin	e		202.00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons	trati on	
	peri od)				
	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t				<u> </u> 206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbur				
	Program reimbursement under the §410A Demonstration (see inst	,	_		207.00
208. 00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	2, col. 1, sum of lines	1		208. 00
200 22	and 3)	-+:>			200 00
	Adjustment to Medicare swing-bed SNF PPS payments (see instru	CLIONS)			209.00
210.00	Reserved for future use				210. 00
215 00	Comparision of PPS versus Cost Reimbursement	200 plus line 210) (-			215 00
∠15.00	Total adjustment to Medicare swing-bed SNF PPS payment (line instructions)	207 prus rine 210) (see			215. 00
	That dot ona)		1		1

Health Financial Systems	MARGARET MARY COMMUN	NITY HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1329	From 01/01/2023	Worksheet E-3 Part V Date/Time Prepared: 5/29/2024 7:24 am
		Title XVIII	Hospi tal	Cost

				5/29/2024 7: 2	4 am
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1. 00	Inpatient services			3, 304, 316	
2.00				0	2.00
3. 00				0	3.00
3. 01				0	3. 01
4. 00	Subtotal (sum of lines 1 through 3.01)			3, 304, 316	
5.00	Primary payer payments			0	5.00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 337, 359	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
7 00	Reasonable charges			0	7 00
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8. 00 9. 00
9. 00 10. 00	Organ acquisition charges, net of revenue Total reasonable charges			0	10.00
10.00	Customary charges			U	10.00
11. 00	Aggregate amount actually collected from patients liable for	nayment for services on	a chargo basis	0	11. 00
12.00	Amounts that would have been realized from patients liable for		9		12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e	1 3	on a charge basis	·	12.00
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	·)		0.000000	13.00
14. 00	Total customary charges (see instructions)			0.000000	14.00
15. 00	Excess of customary charges over reasonable cost (complete or	lvifline 14 exceeds Li	ne 6) (see	0	15.00
.0.00	instructions)	ye exceeds	0) (000	· ·	
16.00	Excess of reasonable cost over customary charges (complete or	lv if line 6 exceeds lir	ne 14) (see	0	16. 00
	instructions)	,	, (
17.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			3, 337, 359	
20.00	Deductibles (exclude professional component)			450, 980	
21. 00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			2, 886, 379	
23. 00	Coinsurance			5, 600	
24. 00	Subtotal (line 22 minus line 23)			2, 880, 779	
25. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		22, 236	
26. 00	Adjusted reimbursable bad debts (see instructions)			14, 453	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		9, 380	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			2, 895, 232	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	
30.00			2, 895, 232		
30. 01 30. 02	Sequestration adjustment (see instructions)			57, 905 0	30. 01 30. 02
30. 02				U	30. 02
31. 00	Interim payments			3, 250, 401	
31. 00	Interim payments-PARHM			3, 230, 401	31.00
32. 00	Tentative settlement (for contractor use only)			0	
32. 00	Tentative settlement-PARHM (for contractor use only)			O	32. 00
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.0)2. 31. and 32)		-413, 074	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m		and 32,01)	, 071	33. 01
34. 00	Protested amounts (nonallowable cost report items) in accorda			0	
	§115. 2		']	
	•		'	'	

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1329	Period: Worksheet E-3 From 01/01/2023 Part VII To 12/31/2023 Date/Time Prepared: 5/29/2024 7:24 am

		7	To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
		Title XIX	Hospi tal	Cost	T UIII
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		243, 558		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		243, 558	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		243, 558	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routine service charges		337, 956		8. 00
9. 00	Ancillary service charges		269, 843	0	9. 00
10. 00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0	_	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		607, 799	0	12.00
40.00	CUSTOMARY CHARGES				40.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14. 00	basis	nayment for sorvices on	o	0	14. 00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42		٩	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	CFR 9413. 13(e)	0. 000000	0. 000000	15. 00
	Total customary charges (see instructions)		607, 799	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	364, 241	0	17. 00
17.00	line 4) (see instructions)	TT TTTE TO EXCECUS	001, 211	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	ol	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		o	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instru	ıcti ons)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16	o)	243, 558	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c	completed for PPS provid	ers.		
22. 00	Other than outlier payments		0	0	22.00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25.00
26. 00	Routine and Ancillary service other pass through costs		0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29. 00	Titles V or XIX (sum of lines 21 and 27)		243, 558	0	29. 00
30. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	30. 00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		243, 558	0	31.00
	Deductibles		243, 556	0	32.00
33. 00	Coinsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review	0	O	35. 00	
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	243, 558	0	36.00	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37. 00	
	Subtotal (line 36 ± line 37)	243, 558	0	38. 00	
	Direct graduate medical education payments (from Wkst. E-4)	o		39.00	
	Total amount payable to the provider (sum of lines 38 and 39)	243, 558	0	40.00	
41.00	Interim payments		298, 514	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-54, 956	0	42.00	
43.00	' '	ce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

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

Provider CCN: 15-1329

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 7: 24 am

——————————————————————————————————————					5/29/2024 7: 2	4 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	6, 536, 847	0	0	0	1.00
2. 00	Temporary investments	0	o o	0	0	2.00
3. 00	Notes receivable	0	o	0	0	3.00
4.00	Accounts recei vable	45, 807, 596	0	0	0	4.00
5.00	Other recei vable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-28, 896, 041	0	0	0	6.00
7.00	Inventory	1, 360, 638	0	0	0	7. 00
8.00	Prepai d expenses	1, 674, 420		0	0	8. 00
9. 00	Other current assets	606, 899		0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	27, 090, 359	0	0	0	11. 00
10.00	FI XED ASSETS	/ 000 457		0	0	12.00
12.00	Land	6, 899, 457		0	0	12.00
13. 00 14. 00	Land improvements Accumulated depreciation	302, 992 -267, 857		0	0	13. 00 14. 00
15. 00	Buildings	84, 080, 421		0	0	15.00
16. 00	Accumulated depreciation	-56, 786, 234		0	0	16.00
17. 00	Leasehold improvements	637, 141		0	0	17.00
18. 00	Accumulated depreciation	-357, 485		0	Ö	18.00
19. 00	Fi xed equipment	7, 817, 671		0	0	19.00
20.00	Accumulated depreciation	-5, 594, 489		0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22. 00
23.00	Major movable equipment	69, 743, 503	0	0	0	23. 00
24.00	Accumulated depreciation	-56, 346, 932	0	0	0	24.00
25. 00	Mi nor equi pment depreciable	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	50 400 400	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	50, 128, 188	8 0	0	0	30.00
31. 00	OTHER ASSETS Investments		0	0	0	31.00
32. 00	Deposits on Leases			0	0	32.00
33. 00	Due from owners/officers			0	0	33.00
34. 00	Other assets	101, 386, 557	1	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	101, 386, 557		0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	178, 605, 104	. 0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1, 787, 657	0	0	0	37.00
38. 00	Salaries, wages, and fees payable	0	0	0	0	38. 00
39. 00	Payroll taxes payable	7, 536, 764		0	0	39. 00
40. 00	Notes and Loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0)			42.00
43.00	Due to other funds Other current liabilities	2 022 004	0	0	0	43.00
44.00		3, 022, 994 12, 347, 415		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	12, 347, 413	0	0	0	45.00
46. 00	Mortgage payable		0	0	0	46. 00
47. 00	Notes payable			0	0	47.00
48. 00	Unsecured Loans		o o	0	0	48.00
49. 00	Other long term liabilities	12, 990, 368		0	Ö	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12, 990, 368		0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25, 337, 783		0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	153, 267, 321				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0	_	56.00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
E0 00	replacement, and expansion	152 247 221		0	_	E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	153, 267, 321 178, 605, 104		0	0	59. 00 60. 00
00.00	[59]	170,000,104		U		00.00
	1977	I	1		l	I

MARGARET MARY COMMUNITY HOSPITAL Health Financial Systems In Lieu of Form CMS-2552-10 STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-1329 Peri od: Worksheet G-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 7:24 am General Fund Special Purpose Fund Endowment Fund 1. 00 2.00 3.00 4.00 5.00 1.00 Fund balances at beginning of period 138, 512, 947 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 14, 754, 374 2.00 3.00 Total (sum of line 1 and line 2) 153, 267, 321 ol 3.00 4.00 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 0 5.00 0 5.00 6.00 0 6.00 7. 00 0 0 0 0 7.00 8.00 0 8.00

153, 267, 321

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17. 00		0		Ŏ			17. 00
18.00	Total deductions (sum of lines 12 17)	U	0	U		- 1	18. 00
	Total deductions (sum of lines 12-17)		1E2 247 221				
19. 00	Fund balance at end of period per balance		153, 267, 321		١		19. 00
	sheet (line 11 minus line 18)	Endowment	DI ont	Fund			
			Prant	Fund			
		Fund			1		
		4 00	7.00	8. 00			
1 00	Fund halanasa at haginning of pariod	6. 00	7. 00	8.00			1. 00
1.00	Fund balances at beginning of period	U		U			
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	U	_	U			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7. 00			0				7.00
8. 00			0				8.00
9. 00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10. 00
11. 00	Subtotal (line 3 plus line 10)	0		0			11. 00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13. 00
14.00			0			•	14. 00
15. 00			0				15. 00
16.00			0			•	16. 00
17.00			0				17. 00
18.00	Total deductions (sum of lines 12-17)	0		0			18. 00
19.00	Fund balance at end of period per balance	0		0			19. 00
	sheet (line 11 minus line 18)						

9.00

10.00

11.00

12.00

13.00

14.00

15.00

16.00

Total additions (sum of line 4-9)

Deductions (debit adjustments) (specify)

Subtotal (line 3 plus line 10)

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

			To	12/31/2023	Date/Time Pre 5/29/2024 7:2	
	Cost Center Description	In	pati ent	Outpati ent	Total	T GIII
	oost contor boson per on		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES			2.00	0, 00	
	General Inpatient Routine Services					
1.00	Hospi tal		6, 519, 025		6, 519, 025	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		687, 325		687, 325	5.00
6.00	Swing bed - NF		585, 812		585, 812	6.00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		7, 792, 162		7, 792, 162	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT		700, 918		700, 918	11.00
12.00	CORONARY CARE UNIT					12.00
13. 00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL INTENSIVE CARE UNIT					14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15.00
16. 00	Total intensive care type inpatient hospital services (sum of	lines	700, 918		700, 918	16. 00
17 00	11-15)		0 400 000		0 402 000	17 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		8, 493, 080	204 401 521	8, 493, 080	17.00
18.00	Ancillary services		9, 308, 860	204, 481, 521	223, 790, 381	18.00
19. 00 20. 00	Outpatient services RURAL HEALTH CLINIC		1, 545, 774	40, 242, 175	41, 787, 949	19. 00 20. 00
20. 00	MEDICAL ARTS CENTER		0	2, 749, 457 4, 411, 276	2, 749, 457 4, 411, 276	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	4, 411, 276	4, 411, 270	21.00
22. 00	HOME HEALTH AGENCY		U	0	0	22.00
23. 00	AMBULANCE SERVICES			٩	U	23. 00
24. 00	CMHC					24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26. 00	HOSPI CE		0	1, 910, 610	1, 910, 610	26. 00
27. 00	OTHER PRO FEES		557, 036	32, 520, 114	33, 077, 150	27. 00
27. 01	PRO FEES		2, 283, 390	17, 668, 498	19, 951, 888	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	•	32, 188, 140	303, 983, 651	336, 171, 791	28. 00
	G-3, line 1)		,,		,	
	PART II - OPERATING EXPENSES			•		
29.00	Operating expenses (per Wkst. A, column 3, line 200)			126, 966, 598		29. 00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35. 00			0			35.00
36. 00	Total additions (sum of lines 30-35)			0		36.00
37. 00	DEDUCT (SPECIFY)		0			37.00
38. 00			0			38.00
39.00			0			39.00
40.00			0			40.00
41.00	Total deductions (our of lines 27 41)		0			41.00
42. 00 43. 00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfor		126 044 500		42. 00 43. 00
43.00	to Wkst. G-3, line 4)) (Li alisi el		126, 966, 598		43.00
	10 WK31. 0-3, 11110 4)	I	1	l		

		MMUNITY HOSPITAL		u of Form CMS-2	2552-10	
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1329	Peri od:	Worksheet G-3		
			From 01/01/2023 To 12/31/2023			
				5/29/2024 7: 2	4 alli	
				1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 28)	,	336, 171, 791	1.00	
2.00	Less contractual allowances and discounts on patients' ac			208, 260, 817	2.00	
3. 00	Net patient revenues (line 1 minus line 2)			127, 910, 974	ı	
4.00	Less total operating expenses (from Wkst. G-2, Part II, I	ine 43)		126, 966, 598	ł	
5. 00	Net income from service to patients (line 3 minus line 4)	,		944, 376	ł	
	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 communica	0	8.00			
9.00						
10.00	Purchase di scounts			0	10.00	
11.00	Rebates and refunds of expenses			0	11.00	
12.00	Parking Lot receipts			0	12.00	
13.00	Revenue from Laundry and Linen service			0	13.00	
14.00	Revenue from meals sold to employees and guests			0	14.00	
15.00	Revenue from rental of living quarters			0	15.00	
16.00	Revenue from sale of medical and surgical supplies to oth	er than patients		0	16.00	
17.00	Revenue from sale of drugs to other than patients	·		0	17.00	
18.00	Revenue from sale of medical records and abstracts			0	18. 00	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00	
21.00	Rental of vending machines			0	21.00	
22.00	Rental of hospital space			0	22. 00	
23.00	Governmental appropriations			0	23. 00	
24.00	OTHER OPERATING INCOME			1, 860, 453	24.00	
24. 01	CONTRI BUTI ONS			189, 758	24. 01	
24. 02	UNREALIZED GAIN, DERIVATIVE		11, 719, 597	24. 02		
24. 03	UNREALIZED GAIN, INVESTMENTS			35, 624	24. 03	
24.04						
24 50	COVID 10 DUE Formalism				1 24 50	

0 28.00 14,754,374 29.00

13, 809, 998 14, 754, 374

24.04 24. 50 25. 00

26.00

27.00

24. 50 COVI D-19 PHE Funding

27. 00 OTHER EXPENSES (SPECIFY)

25. 00 Total other income (sum of lines 6-24)
26. 00 Total (line 5 plus line 25)

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

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68.00

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

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

NONREI MBURSABLE COST CENTERS

HOSPICE/PALLIATIVE MEDICINE FELLOWS*

BEREAVEMENT PROGRAM *

PALLIATIVE CARE PROGRAM*

OTHER PHYSICIAN SERVICES*

TELEHEALTH/TELEMONI TORI NG*

71.00 OTHER NONREIMBURSABLE (SPECIFY)*

NURSING FACILITY ROOM & BOARD*

VOLUNTEER PROGRAM *

RESIDENTIAL CARE*

FUNDRAI SI NG*

ADVERTI SI NG*

THRIFT STORE*

60.00

61.00

62.00

63.00

64.00

65.00

66.00

67 00

68.00

69 00

70.00

100.00 TOTAL

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 7:24 am Hospi ce CCN: 15-1551

					Hospi ce I	3/29/2024 /	24 (1111
		ADJUSTMENTS	TOTAL (col. 5				
			± col. 6)				
		6. 00	7. 00				
	GENERAL SERVICE COST CENTERS						
1. 00	CAP REL COSTS-BLDG & FIXT*	0		1			1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0					2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT*	0		1			3.00
4. 00	ADMI NI STRATI VE & GENERAL*	0		1			4.00
5. 00	PLANT OPERATION & MAINTENANCE*	0					5.00
6.00	LAUNDRY & LINEN SERVICE*	0					6.00
7.00	HOUSEKEEPI NG*	0	1				7.00
8.00	DI ETARY*	0	1				8.00
9.00	NURSI NG ADMI NI STRATI ON*	0		1			9.00
10. 00 11. 00	ROUTINE MEDICAL SUPPLIES* MEDICAL RECORDS*	0	-				10. 00 11. 00
12. 00	STAFF TRANSPORTATION*		1				12.00
13. 00	VOLUNTEER SERVICE COORDINATION*	0					13.00
14. 00	PHARMACY*	0	ł .				14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0		1			15.00
16. 00	OTHER GENERAL SERVICE*	0		1			16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS		L				17.00
25. 00	I NPATI ENT CARE-CONTRACTED**	0	0				25. 00
26. 00	PHYSI CI AN SERVI CES**	0					26.00
27. 00	NURSE PRACTITIONER**	0	· ·				27. 00
28. 00	REGI STERED NURSE**	0					28. 00
29. 00	LPN/LVN**	0					29.00
30. 00	PHYSI CAL THERAPY**	0	0	,			30.00
31. 00	OCCUPATIONAL THERAPY**	0	0				31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0				32.00
33.00	MEDICAL SOCIAL SERVICES**	0	63, 819				33.00
34.00	SPI RI TUAL COUNSELI NG**	0	31, 432				34.00
35.00	DI ETARY COUNSELI NG**	0	0				35.00
36.00	COUNSELING - OTHER**	0	0				36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	91, 949	1			37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0				38. 00
39. 00	PATI ENT TRANSPORTATI ON**	0	ł .)			39. 00
40.00	I MAGING SERVICES**	0					40.00
41. 00	LABS & DI AGNOSTI CS**	0					41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	-	1			42.00
42. 50	DRUGS CHARGED TO PATIENTS**	0	-	1			42.50
43.00	OUTPATIENT SERVICES**	0	-	1			43.00
44.00	PALLIATIVE RADIATION THERAPY**	0		1			44.00
45. 00	PALLI ATI VE CHEMOTHERAPY**	0					45.00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	1			46. 00
(0.00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM *		0	I			40.00
60. 00 61. 00	VOLUNTEER PROGRAM *	0		1			60.00
62.00	FUNDRALSING*	0		1			61. 00 62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*			1			63.00
64. 00	PALLIATIVE CARE PROGRAM*	0		1			64.00
65. 00	OTHER PHYSICIAN SERVICES*	0	-	1			65.00
66. 00	RESI DENTI AL CARE*	0	1	1			66.00
67. 00	ADVERTI SI NG*	0	1	•			67.00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	1				68.00
69. 00	THRIFT STORE*		0	1			69.00
70. 00	NURSING FACILITY ROOM & BOARD*	0	1				70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	0					71.00
100.00		0					100.00
							-

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

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OUTPATIENT SERVICES

PALLIATIVE CHEMOTHERAPY

PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

43.00

44.00

45.00

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED			25.00
26.00	PHYSI CI AN SERVI CES	0	18, 000	26.00
27.00	NURSE PRACTITIONER	0	6, 356	27.00
28.00	REGI STERED NURSE	0	405, 431	28. 00
29.00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	63, 813	33.00
34.00	SPIRITUAL COUNSELING	0	31, 429	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	91, 940	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	616, 969	100.00

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

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

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58

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45.00

58 100.00

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

		ADJUSTMENTS	TOTAL (col. 5	
		/ 00	± col . 6)	
	DUDENT DATIENT CARE CERVILOE COCT CENTERS	6. 00	7. 00	
05.00	DIRECT PATIENT CARE SERVICE COST CENTERS			05.00
25. 00	I NPATI ENT CARE-CONTRACTED	0	0	25.00
26. 00	PHYSI CI AN SERVI CES	0	0	26.00
27. 00	NURSE PRACTITIONER	0	1	27.00
28. 00	REGI STERED NURSE	0	39	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31. 00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	6	33.00
34.00	SPI RI TUAL COUNSELI NG	0	3	34.00
35. 00	DI ETARY COUNSELI NG	0	0	35. 00
36. 00	COUNSELING - OTHER	0	0	36.00
37. 00	HOSPICE ALDE & HOMEMAKER SERVICES	0	9	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATI ENT TRANSPORTATI ON	0	0	39. 00
40. 00	I MAGI NG SERVI CES	0	0	40.00
41. 00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	58	100.00

58

45.00

100. 00 TOTAL

PALLIATIVE CHEMOTHERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

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

Heal th	Financial Systems MARGARET MARY COI	MMUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der C		Period: From 01/01/2023	Worksheet 0-5	
EXPENS	SES FOR ALLOCATION	Hospi ce CCI	Hospi ce CCN: 15-1551		Date/Time Prepared: 5/29/2024 7:24 am	
				Hospi ce I		
	Descriptions		HOSPI CE	GENERAL	TOTAL	
			DI RECT	SERVI CE	EXPENSES (sum	
				EXPENSES FROM	of cols. 1 +	
			instructions)	WKST B PART I	2)	
				(see		
				instructions)		
	I		1. 00	2. 00	3. 00	
4 00	GENERAL SERVICE COST CENTERS			15.400	45.400	
1.00	CAP REL COSTS-BLDG & FIXT			15, 139		1.00
2. 00	CAP REL COSTS-MVBLE EQUIP			31, 974		2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT		(3.00
4. 00	ADMI NI STRATI VE & GENERAL		359, 31		626, 357	4.00
5. 00	PLANT OPERATION & MAINTENANCE		(,	1	5.00
6. 00	LAUNDRY & LINEN SERVICE		(0	0	6. 00
7. 00	HOUSEKEEPI NG		(24, 652		7.00
8. 00	DIETARY			0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON			0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES		(_	0	10.00
11.00	MEDI CAL RECORDS			-	0	11.00
12.00	STAFF TRANSPORTATION		48, 23		48, 234	12.00
13.00	VOLUNTEER SERVICE COORDINATION		00.51	٦	0	13.00
14.00	PHARMACY DIVISION ADMINISTRATIVE SERVICES		90, 51			1
15.00	PHYSI CI AN ADMINI STRATI VE SERVI CES			-	0	15.00
16.00	OTHER GENERAL SERVICE		(-	· ·	16.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES LEVEL OF CARE			0	0	17. 00
50.00	HOSPICE CONTINUOUS HOME CARE				0	50.00
51. 00	HOSPI CE ROUTI NE HOME CARE		616, 96		616, 969	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE		510, 70		58	
53. 00	HOSPICE GENERAL INPATIENT CARE				0	1
55. 50	NONREI MBURSABLE COST CENTERS		· · · · · · · · · · · · · · · · · · ·	~1		30.00
60.00	BEREAVEMENT PROGRAM				0	60.00
55.50				-1	ı	1 30.00

61.00

62.00

63.00

66.00

67.00

68. 00 69. 00

0 70.00

71.00

0 64.00

0 65.00

0

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0

0 99.00

1, 721, 114 100. 00

606, 021

1, 115, 093

61.00 VOLUNTEER PROGRAM

64. 00 PALLIATIVE CARE PROGRAM

65.00 OTHER PHYSICIAN SERVICES

68. 00 TELEHEALTH/TELEMONI TORI NG
69. 00 THRI FT STORE

70.00 NURSING FACILITY ROOM & BOARD

71.00 OTHER NONREIMBURSABLE (SPECIFY)

RESIDENTIAL CARE

99. 00 NEGATI VE COST CENTER 100. 00 TOTAL

HOSPICE/PALLIATIVE MEDICINE FELLOWS

62. 00 FUNDRAI SI NG

67. 00 ADVERTISING

63.00

66.00

COST A	ILLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provi der C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet 0-6 Part I Date/Time Pre	
			nospi ce cc	N. 13-1331	10 12/31/2023	5/29/2024 7: 2	4 am
					Hospi ce I		
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBLI	EMPLOYEE	SUBTOTAL	
		EXPENSES	& FIX	EQUI P	BENEFITS		
		_			DEPARTMENT		
	CENEDAL SEDVICE COST CENTEDS	0	1.00	2. 00	3. 00	3A	
1. 00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT	15, 139	15, 139	ı			1.00
2. 00	CAP REL COSTS-BLDG & FIXI	31, 974	10, 139	31, 97	4		2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	225, 597	0	1	0 225, 597		3.00
	1		0	1	0 225, 597	(2) 257	1
4.00	ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE	626, 357	15, 139	1	9	626, 357 88, 731	4. 00 5. 00
5.00	1	41, 618	15, 139	1			1
6. 00	LAUNDRY & LINEN SERVICE	24 (52	0		0	0	
7.00	HOUSEKEEPI NG	24, 652	0	1	0	24, 652	7.00
8. 00	DI ETARY	0	0	1	0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0	1	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0	0	10.00
11.00	MEDI CAL RECORDS	0	0		0	0	11.00
12. 00	STAFF TRANSPORTATION	48, 234	0		0	48, 234	12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0	•	0 0	0	13. 00
14.00	PHARMACY	90, 516	0		0 0	90, 516	1
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	15. 00
16. 00	OTHER GENERAL SERVICE	0	0	1	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0		0	0	17. 00
	LEVEL OF CARE			1	_	_	
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	616, 969	_		225, 575	842, 544	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	58	0	l .	0 22	80	
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0		0 0	0	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	1	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0	0	61.00
62.00	FUNDRAI SI NG	0	0		0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	1	0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES	0	0	1	0	0	65.00
66. 00	RESI DENTI AL CARE	0	0	1	0	0	66.00
67. 00	ADVERTI SI NG	0	0	1	0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	1	0	0	68. 00
69. 00	THRI FT STORE	0	0	1	0 0	0	69.00
70. 00	NURSING FACILITY ROOM & BOARD	0	_			0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	1	0	0	71.00
	NEGATI VE COST CENTER	0	0		0	4 704	99.00
100.00	TOTAL	1, 721, 114	15, 139	31, 97	4 225, 597	1, 721, 114	100.00

In Lieu of Form CMS-2552-10 Health Financial Systems COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-1329 Peri od: Worksheet 0-6 From 01/01/2023 Part I Hospi ce CCN: 12/31/2023 Date/Time Prepared: 15-1551 5/29/2024 7:24 am Hospi ce I ADMI NI STRATI V LAUNDRY & HOUSEKEEPI NG DI ETARY Descriptions PLANT E & GENERAL OPERATION & LINEN SERVICE MAI NTENANCE 4. 00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 626, 357 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 50, 767 139, 498 5.00 LAUNDRY & LINEN SERVICE 0 6.00 6.00 7.00 HOUSEKEEPI NG 14, 104 38, 756 7.00 8.00 DI ETARY 0 0 8.00 NURSING ADMINISTRATION 9.00 9.00 0 0 0 ROUTINE MEDICAL SUPPLIES 10.00 0 0 0 10.00 11.00 MEDICAL RECORDS 0 0 11.00 12.00 STAFF TRANSPORTATION 27, 597 0 12.00 13.00 VOLUNTEER SERVICE COORDINATION 13.00 C 0 38, 756 14.00 PHARMACY 51, 788 139, 498 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 15.00 OTHER GENERAL SERVICE 16.00 16.00 0 0 C PATIENT/RESIDENTIAL CARE SERVICES 17.00 0 C 0 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 50.00 HOSPICE ROUTINE HOME CARE 482,055 51.00 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 46 C 0 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 0 0 0 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 0 60.00 VOLUNTEER PROGRAM 0 0 61.00 0 61.00 FUNDRAI SI NG 62.00 62.00 0000000 0 0 0 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 PALLIATIVE CARE PROGRAM 0 64.00 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00

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626, 357

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139, 498

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38, 756

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66.00

67 00

68.00

69.00

70.00

0 100.00

RESIDENTIAL CARE

TELEHEALTH/TELEMONI TORI NG

NURSING FACILITY ROOM & BOARD

OTHER NONREIMBURSABLE (SPECIFY)

ADVERTI SI NG

THRIFT STORE

99.00 NEGATIVE COST CENTER

66.00

67 00

68.00

69.00

70.00

71 00

100.00 TOTAL

Hear th	Financiai Systems MA	RGARET WARY COM	MUNITY HUSPITA	\L	in Lie	U OF FORM CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provi der C	CN: 15-1329	Peri od:	Worksheet 0-6	
					From 01/01/2023		
			Hospi ce CC	N: 15-1551	To 12/31/2023		pared:
						5/29/2024 7: 2	4 am
					Hospi ce I		
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI O	MEDI CAL	RECORDS	TRANSPORTATI 0	SERVI CE	
		N	SUPPLI ES		N	COORDI NATI ON	
		9. 00	10. 00	11. 00	12.00	13.00	
	GENERAL SERVICE COST CENTERS			•	<u>.</u>		
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL						4.00
	1						
5.00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION	0					9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDI CAL RECORDS	0			0		11.00
12. 00	STAFF TRANSPORTATION	0			75, 831		12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	0			70,001	0	13.00
14. 00	PHARMACY				0	· -	1
	· · · · · · · · · · · · · · · · · · ·	0			0	0	14.00
15. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0			0	0	15. 00
16. 00	OTHER GENERAL SERVICE	0			0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						1
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0)	0 75, 823	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	o	0)	0 8	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0 0	0	1
	NONREI MBURSABLE COST CENTERS		-				1
60. 00	BEREAVEMENT PROGRAM	0		I	0	0	60.00
61. 00	VOLUNTEER PROGRAM				0	0	61.00
62. 00	FUNDRAI SI NG				0	0	
		0			0	1	62.00
63. 00	HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS	0			0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0			0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66. 00	RESI DENTI AL CARE	0			0	0	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
69.00	THRI FT STORE	o			0	0	69.00
70. 00	NURSING FACILITY ROOM & BOARD			[70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)			1	0	0	1
99.00	NEGATI VE COST CENTER		0		0 0	0	99.00
	TOTAL		0		0 75, 831	_	100.00
100.00	TOTAL	١	Ü	4	U 13, 831	J	1100.00

	Heal th	Financial Systems MAR	GARET MARY COM	MUNITY HOSPITA	۱L	In Lie	u of Form CMS-	2552-10
	COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVI CE COSTS	Provi der C	CN: 15-1329	Peri od:	Worksheet 0-6	6
						From 01/01/2023		
				Hospi ce CC	N: 15-1551	To 12/31/2023		epared:
							5/29/2024 7:2	24 am
						Hospi ce I		
1		Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERA		TOTAL	
		Descriptions	PHARWACT				TOTAL	
				ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
				E SERVICES		CARE SERVICES		
			14. 00	15. 00	16.00	17. 00	18. 00	
		GENERAL SERVICE COST CENTERS						
	1.00	CAP REL COSTS-BLDG & FIXT						1.00
	2.00	CAP REL COSTS-MVBLE EQUIP						2.00
	3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
								1
	4. 00	ADMI NI STRATI VE & GENERAL						4.00
	5.00	PLANT OPERATION & MAINTENANCE						5.00
	6.00	LAUNDRY & LINEN SERVICE						6. 00
	7.00	HOUSEKEEPI NG						7. 00
	8.00	DI ETARY						8.00
	9. 00	NURSI NG ADMI NI STRATI ON						9. 00
	10.00							10.00
		ROUTINE MEDICAL SUPPLIES						1
	11. 00	MEDI CAL RECORDS						11.00
	12.00	STAFF TRANSPORTATION						12. 00
	13.00	VOLUNTEER SERVICE COORDINATION						13.00
	14.00	PHARMACY	320, 558					14.00
	15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
	16. 00	OTHER GENERAL SERVICE	o O	0	1	0		16.00
			٩			-		1
	17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
		LEVEL OF CARE						
	50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	C	50.00
	51.00	HOSPICE ROUTINE HOME CARE	320, 527	0		0	1, 720, 949	51.00
	52.00	HOSPICE INPATIENT RESPITE CARE	31	0		0 0	165	
	53.00	HOSPICE GENERAL INPATIENT CARE	ol	Ö	l .	0 0	0	1
	33.00	NONREI MBURSABLE COST CENTERS	<u>U</u>		1	0 0		33.00
			ما		T			10.00
		BEREAVEMENT PROGRAM	0			0	C	
	61. 00	VOLUNTEER PROGRAM	0			0	[C	
	62.00	FUNDRAI SI NG	0			0	C	62.00
	63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	l c	63.00
	64.00	PALLIATIVE CARE PROGRAM	ol			0	l c	64.00
	65. 00	OTHER PHYSICIAN SERVICES	o o			0	ĺ	1
			o o			0	· ·	1
	66. 00	RESI DENTI AL CARE	٥	0	1	0	C	
	67.00	ADVERTI SI NG	이			U	C	
	68. 00	TELEHEALTH/TELEMONI TORI NG	0		1	0	[C	68.00
	69.00	THRIFT STORE	O		[0	C	69.00
	70.00	NURSING FACILITY ROOM & BOARD			1		l c	70.00
	71. 00	OTHER NONREIMBURSABLE (SPECIFY)	o	0	d .	0	ĺ	
	99.00	NEGATI VE COST CENTER	o	0		0 0		
	100.00		-		l .			
	100.00	TUTAL	320, 558	U	1	U _I U	1, 721, 114	+[100.00

Health Financial Systems	MARGARET MARY COM	IMUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STATISTICAL BASIS	SERVI CE COSTS	Provi der CO		Peri od: From 01/01/2023	Worksheet 0-6	
STATISTICAL BASIS		Hospi ce CCN			Date/Time Pre 5/29/2024 7:2	
				Hospi ce I		
Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI O	ADMI NI STRATI V	
	& FIX	EQUI P	BENEFITS	N	E & GENERAL	
	(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	

				Hospi ce I		
Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI O	ADMI NI STRATI V	
	& FIX	EQUI P	BENEFITS	N	E & GENERAL	
	(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
	,	VALUE)	(GROSS		COSTS)	
		,	SALARI ES)		,	
	1. 00	2. 00	3.00	4A	4. 00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FLXT	15, 139	1				1.00
2.00 CAP REL COSTS-MVBLE EQUIP		31, 974				2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT	0	0	225, 597			3.00
4. 00 ADMINISTRATIVE & GENERAL	0	0	0	-626, 357	1, 094, 757	4.00
5.00 PLANT OPERATION & MAINTENANCE	15, 139	31, 974	C	0	88, 731	5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	C	0	0	6.00
7. 00 HOUSEKEEPI NG	0	0	0	0	24, 652	7. 00
8. 00 DI ETARY	0	0	0	0	0	8. 00
9. 00 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	9. 00
10.00 ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11. 00 MEDI CAL RECORDS	0	0	0	0	0	11.00
12.00 STAFF TRANSPORTATION	0	0	0	0	48, 234	12.00
13.00 VOLUNTEER SERVICE COORDINATION	0	0	l c	0	0	13.00
14. 00 PHARMACY	0	0		0	90, 516	14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0	0	15.00
16. 00 OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17. 00 PATI ENT/RESI DENTI AL CARE SERVI CES	0	0	_	0	Ō	17. 00
LEVEL OF CARE		_				
50. 00 HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00 HOSPICE ROUTINE HOME CARE			225, 575	0	842, 544	
52.00 HOSPICE INPATIENT RESPITE CARE	0	0	22		80	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	0	0	0		0	
NONREI MBURSABLE COST CENTERS						
60. 00 BEREAVEMENT PROGRAM	0	0	C	0	0	60.00
61.00 VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62. 00 FUNDRAI SI NG	0	0	0	0	0	62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00 PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00 OTHER PHYSICIAN SERVICES	0	0		0	0	65.00
66. 00 RESIDENTI AL CARE	0	0	0	0	0	66.00
67. 00 ADVERTI SI NG	0	0	0	0	0	67.00
68. 00 TELEHEALTH/TELEMONI TORI NG	0	0	l c	0	0	68. 00
69. 00 THRI FT STORE	0	o		0	0	69. 00
70.00 NURSING FACILITY ROOM & BOARD				0		70. 00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0	0	l c	0	0	
99. 00 NEGATIVE COST CENTER						99.00
100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 15, 139	31, 974	225, 597		626, 357	
101.00 UNIT COST MULTIPLIER	1. 000000				0. 572142	
	1	1		ı		

Health Financial Systems MARGARET MARY COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15- STATISTICAL BASIS Hospice CCN: 15	From 01/01/2023 Part II

3171113	THE BIOLO		Hospi ce CC	N: 15-1551 T	0 12/31/2023	Date/Time Pre 5/29/2024 7:2	
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMINISTRATIO	
		MAI NTENANCE	(IN-FACILITY		DAYS)	N	
		(SQUARE FEET)	DAYS)		·	(DI RECT NURS.	
						HRS.)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
<u> </u>	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	76, 993					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPI NG	0		45, 750			7.00
8.00	DI ETARY	0		0	0		8.00
9. 00	NURSI NG ADMI NI STRATI ON	0		1 0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11. 00	MEDI CAL RECORDS	0		0		0	
12. 00	STAFF TRANSPORTATION	0		0		0	1
13. 00	VOLUNTEER SERVICE COORDINATION	0		0		0	1
14. 00	PHARMACY	76, 993		45, 750		0	1
	PHYSICIAN ADMINISTRATIVE SERVICES	,0,7,0		0		l ő	
16. 00	OTHER GENERAL SERVICE	0				0	1
	PATIENT/RESIDENTIAL CARE SERVICES	0	l	0		l	17.00
17.00	LEVEL OF CARE						17.00
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51. 00	HOSPICE ROUTINE HOME CARE					0	
	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	-	1
	HOSPICE GENERAL INPATIENT CARE	0	ĺ		0		
00.00	NONREI MBURSABLE COST CENTERS			<u> </u>	0		00.00
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61. 00	VOLUNTEER PROGRAM	0		l ő		Ö	
62.00	FUNDRAI SI NG	0		0		0	1
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	
64. 00	PALLIATIVE CARE PROGRAM	0		0		0	
65. 00	OTHER PHYSICIAN SERVICES	0		1 0		o o	
66. 00	RESI DENTI AL CARE	0	0	١	0	· ·	1
67. 00	ADVERTI SI NG	0	Ĭ	1 0	Ö	o o	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0		١		o o	1
69. 00	THRIFT STORE	0		١		ĺ	69.00
70.00	NURSING FACILITY ROOM & BOARD					l	70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	n	0	1
	NEGATI VE COST CENTER		١		O	l	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I	139, 498	٥	38, 756	n	0	100.00
	UNIT COST MULTIPLIER	1. 811827	l .		0. 000000		
101.00	ONLI OOSI WOLITILILK	1.011027	0.00000	0.04/120	0.000000	0.000000	1101.00

	51 years of Garden	ACADET MADY COM	MINI TV. HOCDI TA			. S. F OHG . (2550 40
COST A	Financial Systems MAF NLLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE STICAL BASIS	RGARET MARY COMM RERVICE COSTS	Provider C Hospice CC	CN: 15-1329	Period: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet 0-6 Part II Date/Time Pre 5/29/2024 7:2	pared:
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATI (SERVI CE	(CHARGES)	
		SUPPLI ES	(PATI ENT	N	COORDI NATI ON		
		(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS)			SERVICE)		
		10. 00	11. 00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP					1	2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT					1	3.00
4.00	ADMINISTRATIVE & GENERAL					1	4.00
5. 00	PLANT OPERATION & MAINTENANCE					1	5.00
6. 00	LAUNDRY & LINEN SERVICE					1	6.00
7. 00	HOUSEKEEPI NG					1	7. 00
8. 00	DI ETARY					1	8.00
9. 00	NURSING ADMINISTRATION					1	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	٥				1	10.00
11. 00	MEDI CAL RECORDS		0			1	11.00
12. 00	STAFF TRANSPORTATION		O	89, 51	5	1	12.00
13. 00	VOLUNTEER SERVICE COORDINATION				ol ol	1	13.00
14. 00	PHARMACY					167, 983	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			•		107, 703	15. 00
16. 00	OTHER GENERAL SERVICES					0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				\P	,	17.00
17.00	LEVEL OF CARE						17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		ol ol	0	50.00
51. 00	HOSPICE CONTINUOUS HOME CARE	0	0			167, 967	51.00
52.00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	0					
52.00		0	0		9 0 0 0	16 0	52. 00 53. 00
53.00	HOSPICE GENERAL INPATIENT CARE	l U	0		<u>U</u>	U	53.00
40.00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM				ol ol	0	40.00
60.00					ຶ່ງ ທ		00.00
61.00	VOLUNTEER PROGRAM				0 0	0	61.00
62.00	FUNDRAL SI NG				0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM				0 0	0	64.00

0.000000

0.000000

65.00

68.00

69. 00 70. 00

71.00

99.00

0 66.00

0 67.00

0

320, 558 100. 00 1. 908276 101. 00

0.000000

75, 831

0.847132

65. 00 OTHER PHYSICIAN SERVICES 66. 00 RESIDENTIAL CARE

68. 00 | TELEHEALTH/TELEMONI TORI NG

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD
71. 00 OTHER NONE BURSABLE (SPECIFY)

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

ADVERTI SI NG

67.00

Health Financial Systems	MARGARET MARY COMMUN	NITY HOSPITAL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOS	PICE GENERAL SERVICE COSTS	Provider CCN: 15-1329	Peri od:	Worksheet 0-6
STATI STI CAL BASI S			From 01/01/2023	Part II

Hospi ce CCN: 15-1551 To 12/31/2023 Date/Time Prepared: 5/29/2024 7:24 am Hospi ce I Cost Center Descriptions PHYSI CI AN OTHER GENERAL PATI ENT/ ADMI NI STRATI V SERVI CE RESI DENTI AL E SERVICES (SPECI FY CARE SERVICES (PATIENT BASIS) (IN-FACILITY DAYS) DAYS) 15. 00 16. 00 17.00 GENERAL SERVICE COST CENTERS 1 00 CAP REL COSTS-BLDG & FIXT 1 00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 PLANT OPERATION & MAINTENANCE 5.00 5.00 6.00 LAUNDRY & LINEN SERVICE 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 8.00 DIFTARY NURSING ADMINISTRATION 9.00 9.00 10.00 ROUTINE MEDICAL SUPPLIES 10.00 MEDICAL RECORDS 11.00 11.00 STAFF TRANSPORTATION 12.00 12.00 13.00 VOLUNTEER SERVICE COORDINATION 13.00 14.00 **PHARMACY** 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 0 15.00 OTHER GENERAL SERVICE 16.00 C 16.00 17.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 0 50.00 0 51.00 HOSPICE ROUTINE HOME CARE 0 51.00 HOSPICE INPATIENT RESPITE CARE 0 52.00 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 53.00 NONREIMBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 60.00 VOLUNTEER PROGRAM 0 61.00 61.00 FUNDRAI SI NG 62 00 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 64.00 PALLIATIVE CARE PROGRAM 64.00 OTHER PHYSICIAN SERVICES 65.00 65.00 66.00 RESIDENTIAL CARE 0 0 66.00 0 67.00 ADVERTI SI NG 67.00 68.00 TELEHEALTH/TELEMONI TORI NG 68.00 69.00 THRIFT STORE 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 71.00 99. 00 NEGATI VE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 100.00 101.00 UNIT COST MULTIPLIER 0.000000 0.000000 0.000000 101.00

Health Financial Systems	MARGARET MARY COMMUN	NITY HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE	SHARED SERVICE COSTS BY	Provi der CCN: 15-1329	From 01/01/2023	
		Hospi ce CCN: 15-1551	To 12/31/2023	Date/Time Prepared: 5/29/2024 7:24 am
			Hospi ce I	

Cost Center Descriptions			Hospi ce CC	N: 15-1551 T	o 12/31/2023	Date/Time Pre 5/29/2024 7:2	pared:
Cost Center Descriptions	-				Hospi ce I	0/2//2021 7:2	T GIII
Part I , Col . Charge Ratio				Charges by L	OC (from Provi	der Records)	
Part I , Col . Charge Ratio							
Part I , Col . Charge Ratio							
Part I , Col . Charge Ratio							
ANCILLARY SERVICE COST CENTERS	Cost Center Descriptions			HCHC	HRHC	HI RC	
ANCILLARY SERVICE COST CENTERS			Charge Ratio				
ANCILLARY SERVICE COST CENTERS							
1.00		0	1.00	2.00	3. 00	4. 00	
2.00 OCCUPATIONAL THERAPY 67.00 0.511593 0 0 0 2.00				_	1	1 -	
3.00 SPECH PATHOLOGY					_	_	
A. 00 DRUGS CHARGED TO PATIENTS 73.00 0.376345 0 0 0 4.00				•	-		
5.00 DURABLE MEDI CAL EQUI P-RENTED 96.00 0.115456 0 0 0 0 6.00						1	
Cost Center Descriptions Cost Center Descrip				0	0	0	
7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS 71. 00 0. 618545 0 0 0 7. 00 8. 00 OTHER OUTPATIENT SERVICE COST CENTER 93. 00 9. 00 10. 00 OTHER ANCILLARY SERVICE COST CENTERS 76. 00 10. 00 11. 00 OTHER ANCILLARY SERVICE COST CENTERS 76. 00 10. 00 11. 00 OTHER ANCILLARY SERVICE COST CENTERS 76. 00 10. 00 11. 00 OTHER ANCILLARY SERVICE COST CENTERS 76. 00 10. 00 11. 00 OTHER ANCILLARY SERVICE COST CENTERS 76. 00 10. 00 11. 00 OTHER ANCILLARY SERVICE COST CENTERS			1				
8.00 OTHER OUTPATIENT SERVICE COST CENTER 93.00 9.00 10.00 OTHER ANCILLARY SERVICE COST CENTERS 11.00 Totals (sum of lines 1-11)					0		
9.00 10.00 OTHER ANCI LLARY SERVICE COST CENTERS 11.00 OTHER ANCI LLARY SERVICE COST CENTERS 11.00 OTHER ANCI LLARY SERVICE COST CENTERS 11.00 OTHER ANCI LLARY SERVICE COST CENTERS Charges by LOC (from Provider Records) HGIP HCHC (col. 1 HRHC (col. 1 HRHC (col. 1 H KC (col. 1 x col. 4) x col. 4) x col. 5) 5.00 6.00 7.00 8.00 9.00 ANCI LLARY SERVICE COST CENTERS 1.00 PHYSI CAL THERAPY 2.00 OCCUPATI ONAL THERAPY 3.00 SPEECH PATHOLOGY 4.00 DRUGS CHARGED TO PATIENTS 5.00 0 DRUGS CHARGED TO PATIENTS 5.00 0 O O O O O O O O O O O O O O O O O				0	0	0	
10.00 OTHER ANCILLARY SERVICE COST CENTERS T6.00							
11.00 Totals (sum of lines 1-11) Charges by LOC (from Provi der Records) LOC (from Provi der Records) HGIP HCHC (col. 1 K col. 2) K col. 3) K col. 4) K col. 5 K col. 5 K col. 20 K col. 3 K col. 4 K col. 5 K col							
Charges by LOC (from Provi der Records)		76.00)				
Cost Center Descriptions	11.00 Totals (sum of lines 1-11)						11.00
Provider Records HGI P HCHC (col. 1 HRHC (col. 1 HGI P (col. 1 x col. 2) x col. 3) x col. 4) x col. 5)				Shared Service	e Costs by LOC		
Records HGI P							
Cost Center Descriptions							
X COÎ . 2) X COÎ . 3) X COÎ . 4) X COÎ . 5)							
ANCI LLARY SERVICE COST CENTERS 5.00 6.00 7.00 8.00 9.00	Cost Center Descriptions	HGI P	,		`	,	
ANCI LLARY SERVI CE COST CENTERS 1.00 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0							
1. 00 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		5. 00	6. 00	7. 00	8. 00	9. 00	
2. 00 OCCUPATIONAL THERAPY 3. 00 SPEECH PATHOLOGY 4. 00 DRUGS CHARGED TO PATIENTS 5. 00 DURABLE MEDICAL EQUIP-RENTED 6. 00 LABORATORY 7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS 8. 00 OTHER OUTPATIENT SERVICE COST CENTER 9. 00 RADIOLOGY-THERAPEUTIC 10. 00 OTHER ANCILLARY SERVICE COST CENTERS 9 O OTHER ANCILLARY SERVICE COST CENTERS 10 O OTHER ANCILLARY SERVICE COST CENTERS			.1	_	T _	1 -	
3. 00 SPEECH PATHOLOGY 0 0 0 0 0 0 0 3. 00 4. 00 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 4. 00 5. 00 DURABLE MEDICAL EQUIP-RENTED 5. 00 0 0 0 0 0 0 0 0 6. 00 7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
4. 00 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 4. 00 5. 00 5. 00 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 0 0 6. 00 6. 00 7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	1	_		1
5. 00 DURABLE MEDI CAL EQUI P-RENTED			ή	1		_	
6. 00 LABORATORY 0 0 0 0 0 0 0 6. 00 7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 7. 00 8. 00 OTHER OUTPATIENT SERVICE COST CENTER 9. 00 10. 00 OTHER ANCILLARY SERVICE COST CENTERS 10. 00			0) 0	0	0	
7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 7. 00 8. 00 OTHER OUTPATIENT SERVICE COST CENTER 8. 00 9. 00 RADIOLOGY-THERAPEUTIC 9. 00 OTHER ANCILLARY SERVICE COST CENTERS 10. 00							
8. 00 OTHER OUTPATIENT SERVICE COST CENTER 9. 00 RADI OLOGY-THERAPEUTI C 10. 00 OTHER ANCI LLARY SERVICE COST CENTERS 8. 00 9. 00 10. 00			-	1			1
9. 00 RADI OLOGY-THERAPEUTI C 10. 00 OTHER ANCI LLARY SERVI CE COST CENTERS 9. 00 10. 00		(0	0	0	0	
10.00 OTHER ANCILLARY SERVICE COST CENTERS 10.00							1
11.00 Totals (sum of lines 1-11) 0 0 0 0 11.00							
	11.00 Totals (sum of lines 1-11)		0) 0	0	0	11.00

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

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-1329 | Period: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/29/2024 7: 24 am

Hospice Hosp						5/29/2024 7: 2	4 am
HOSPICE CONTINUOUS HOME CARE 1.00 2.00 3.00					Hospi ce I		
1.00 2.00 3.00				TITLE XVIII	TITLE XIX	TOTAL	
HOSPICE CONTINUOUS HOME CARE				MEDI CARE	MEDI CAI D		
Total cost (Wkst. 0-6, Part I, col. 18, Iine 50 plus Wkst. 0-7, col. 6, Iine 11)				1. 00	2. 00	3. 00	
Inine 11		HOSPICE CONTINUOUS HOME CARE					
2.00	1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	7, col. 6,			0	1.00
3.00		line 11)					
4.00 Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
5.00 Program cost (line 3 times line 4)	3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3.00
HOSPICE ROUTINE HOME CARE Co. Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7,	4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, lin	e 10)		0		4. 00
6.00 Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11) 7.00 Total unduplicated days (Wkst. S-9, col. 4, line 11) 8.00 Total average cost per diem (line 6 divided by line 7) 9.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 9.727 95 95 9.00 10.00 Program cost (line 8 times line 9) HOSPICE INPATIENT RESPITE CARE 11.00 Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11) 12.00 Total average cost per diem (line 11 divided by line 12) 13.00 Total average cost per diem (line 11 divided by line 12) 14.00 Unduplicated days (Wkst. S-9, col. 4, line 12) 15.00 Program cost (line 13 times line 14) 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 18.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 19.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 19.00 Unduplicated program days (Wkst. S-9, col. 4, line 13) 19.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 19.00 Total average cost per diem (line 16 divided by line 17) 19.00 Total average cost per diem (line 16 divided by line 17) 19.00 Total average cost per diem (line 16 divided by line 17) 19.00 Program cost (line 18 times line 19) 19.00 Program cost (line 18 times line 19) 19.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 20.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 21.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14)	5.00				0 0		5.00
Iine 11)							
Total unduplicated days (Wkst. S-9, col. 4, line 11)	6.00		7, col. 7,			1, 720, 949	6.00
Total average cost per diem (line 6 divided by line 7) 164. 12 8.00 9.00 10.		line 11)					
9.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 9,727 95 1,596,395 15,591 10.00 HOSPICE INPATIENT RESPITE CARE 11.00 Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 1 12.00 165.00 13.00 14.00 15.00 16.00 16.00 16.00 16.00 16.00 17.00 17.00 17.00 18.00 19.00 19.00 19.00 19.00 19.00 19.00 10.00 19.00 10.00 1	7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				10, 486	7. 00
10.00 Program cost (line 8 times line 9) 1,596,395 15,591 10.00 HOSPICE INPATIENT RESPITE CARE	8.00	Total average cost per diem (line 6 divided by line 7)				164. 12	8. 00
HOSPICE INPATIENT RESPITE CARE 11.00 Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 1 12.00 13.00 Total average cost per diem (line 11 divided by line 12) 165.00 13.00 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 0 0 0 14.00 15.00 Program cost (line 13 times line 14) 0 0 0 15.00 HOSPICE GENERAL INPATIENT CARE 0 0 16.00 16.00 17.00 17.00 18.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 0 0 17.00 18.00 17.00 18.00 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	9, 72	95		9. 00
11.00 Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11) 12.00 13.00 14.00 15.00 15.00 15.00 16.00 15.00 16.				1, 596, 39	15, 591		10.00
I ine 11) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 1 12.00 13.00 Total average cost per diem (line 11 divided by line 12) 165.00 13.00 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 0 0 0 14.00 15.00 15.00 16.00							
12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 13.00 Total average cost per diem (line 11 divided by line 12) 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 15.00 Program cost (line 13 times line 14) 16.00 HOSPICE GENERAL INPATIENT CARE 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 17.00 Total average cost per diem (line 16 divided by line 17) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Program cost (line 18 times line 19) 10.00 Program cost (line 18 times line 19) 10.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 11.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 11.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 11.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 11.00 Total unduplicated days (Wkst. S-9, col. 4, line 14)	11. 00		7, col. 8,			165	11. 00
13.00 Total average cost per diem (line 11 divided by line 12) 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 15.00 Program cost (line 13 times line 14) HOSPICE GENERAL INPATIENT CARE 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 18.00 Total average cost per diem (line 16 divided by line 17) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Program cost (line 18 times line 19) 10.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 21.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.487 22.00		line 11)					
14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 0 0 0 14.00 15.00 Program cost (line 13 times line 14) 0 0 0 15.00 HOSPICE GENERAL INPATIENT CARE 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 0 0 16.00 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 0 17.00 18.00 Total average cost per diem (line 16 divided by line 17) 0.00 18.00 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 0 0 19.00 20.00 Program cost (line 18 times line 19) 0 0 20.00 TOTAL HOSPICE CARE 21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 1,721,114 21.00 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10,487 22.00	12.00					1	
15.00 Program cost (line 13 times line 14) 0 0 0 15.00 HOSPICE GENERAL INPATIENT CARE 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 0 17.00 18.00 Total average cost per diem (line 16 divided by line 17) 0.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 0 0 19.00 Program cost (line 18 times line 19) 0 0 19.00 10.00 Total unduplicated program cost (sum of line 1 + line 6 + line 11 + line 16) 1,721,114 21.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10,487 22.00	13.00					165. 00	13.00
HOSPICE GENERAL INPATIENT CARE	14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)		0		14.00
16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 0 17.00 18.00 Total average cost per diem (line 16 divided by line 17) 0.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 0 0 19.00 Program cost (line 18 times line 19) 0 0 0 20.00 TOTAL HOSPICE CARE 21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 1,721,114 21.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10,487 22.00	15.00				0 0		15. 00
I ine 11)							
17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 0 17.00 18.00 17.00 18.00 19.00 1	16.00		7, col. 9,			0	16. 00
18.00 Total average cost per diem (line 16 divided by line 17) 0.00 18.00 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 0 0 0 19.00 20.00 Program cost (line 18 times line 19) 0 0 20.00 TOTAL HOSPICE CARE 21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 1,721,114 21.00 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10,487 22.00							
19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 0 0 0 19.00 20.00 Program cost (line 18 times line 19) 0 0 20.00 TOTAL HOSPICE CARE 21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 1,721,114 21.00 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10,487 22.00	17.00						
20.00 Program cost (line 18 times line 19) 0 0 20.00 TOTAL HOSPICE CARE 21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 1,721,114 21.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10,487 22.00	18.00					0. 00	
TOTAL HOSPICE CARE 21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10, 487 22.00			ne 13)		0		
21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 1,721,114 21.00 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10,487 22.00	20.00				0 0		20.00
22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10,487 22.00		TOTAL HOSPICE CARE					
		,					
23.00 Average cost per diem (line 21 divided by line 22) 164.12 23.00							
	23.00	Average cost per diem (line 21 divided by line 22)				164. 12	23.00

		RGARET MARY COM			In Lie	u of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component		From 01/01/2023 To 12/31/2023	Date/Time Pre	nared:
			Component	CCN. 13-0311	10 12/31/2023	5/29/2024 7: 2	
					RHC I	Cost	
	·	Compensation	Other Costs	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	FACILITY HEALTH CARE STAFF COSTS	100 101		100.40	,	100 101	
1.00	Physi ci an	180, 496	C	1 .00, .,		,	1.00
2.00	Physician Assistant	407 470	C	1	0		
3.00	Nurse Practitioner	407, 479	C	407, 47	9 0	10,, .,,	
4.00	Visiting Nurse Other Nurse	00.700		88, 79	-	0 700	
5. 00 6. 00	Clinical Psychologist	88, 798		88, 79	0	88, 798 0	1
7. 00	Clinical Social Worker	0			0 0	0	1
7. 00 7. 10	Marriage and Family Therapist	U		ή '	0	U	7. 10
7. 10	Mental Health Counselor						7. 10
8. 00	Laboratory Techni ci an	0	ر		0	0	1
9. 00	Other Facility Health Care Staff Costs	346, 344		346, 34	-	346, 344	
10.00	Subtotal (sum of lines 1 through 9)	1, 023, 117		1, 023, 11			
11. 00	Physician Services Under Agreement	1,023,117	Č	1,023,11	0	1, 023, 117	ı
12. 00	Physician Supervision Under Agreement	0	Č		0 0	1	
13. 00	Other Costs Under Agreement	0	Ċ		0 0	0	
14. 00	Subtotal (sum of lines 11 through 13)	0	Ċ		0	0	14.00
15. 00	Medical Supplies	0	124, 495	124, 49	5 0	124, 495	15.00
16. 00	Transportation (Health Care Staff)	0	C		0	0	ı
17.00	Depreciation-Medical Equipment	0	C		0 0	0	17. 00
18.00	Professional Liability Insurance	0	C		0	0	18. 00
19.00	Other Health Care Costs	0	C		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	124, 495	124, 49	5 0	124, 495	21.00
22.00	Total Cost of Health Care Services (sum of	1, 023, 117	124, 495	1, 147, 61	2 0	1, 147, 612	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	C	1	0	1	20.00
24. 00	Dental	0	C		0	ľ	24. 00
25.00	Optometry	0	C		0	· -	
25. 01	Tel eheal th	0	C		0	0	25. 01
25. 02	Chronic Care Management	0	C)	0	0	25. 02
26.00	All other nonreimbursable costs	0	C	ין	U 0	0	26.00
27. 00	Nonallowable GME costs						27. 00

318, 264 318, 264

1, 341, 381

0

8, 998

336, 611 345, 609

1, 493, 221

8, 998 18, 347 27, 345

151, 840

0 28.00

29.00

30.00

31.00

32.00

8, 998 336, 611 345, 609

1, 493, 221

0

28.00

FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

and 31)

30)

Total Nonreimbursable Costs (sum of lines 23 through 27)

31.00 Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1329	Peri od: From 01/01/2023	Worksheet M-1
	Component CCN: 15-8511	To 12/31/2023	Date/Time Prepared: 5/29/2024 7:24 am
		RHC I	Cost

			·			5/29/2024 7:2	24 am
					RHC I	Cost	
		Adjustments	Net Expenses				
		•	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00	1			
	FACILITY HEALTH CARE STAFF COSTS			1			
1.00	Physi ci an	0	180, 490	3			1.00
2. 00	Physician Assistant	0					2.00
3. 00	Nurse Practitioner	0	407, 479				3.00
4. 00	Vi si ti ng Nurse	0	407, 47				4.00
5. 00	Other Nurse	0	88, 798				5.00
6. 00	Clinical Psychologist	0					6.00
		0					
7.00	Clinical Social Worker	U	(7.00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	0					8. 00
9.00	Other Facility Health Care Staff Costs	0	346, 34				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 023, 11	7			10.00
11.00	Physician Services Under Agreement	0	(11.00
12.00	Physician Supervision Under Agreement	0	(12.00
13.00	Other Costs Under Agreement	0	(13.00
14.00	Subtotal (sum of lines 11 through 13)	0	(ol			14.00
15.00	Medical Supplies	0	124, 49!	5			15.00
16.00	Transportation (Health Care Staff)	0		ol			16.00
17.00	Depreciation-Medical Equipment	0	(ol			17.00
	Professional Liability Insurance	0	(18.00
	Other Health Care Costs	0	· ·				19. 00
20.00	Allowable GME Costs	-					20.00
21. 00		0	124, 49!	5			21.00
22. 00	, , , ,	0	1, 147, 612	1			22. 00
22.00	lines 10, 14, and 21)	O	1, 147, 012				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
23 00	Pharmacy	0	(23. 00
24. 00	Dental	0					24. 00
25. 00	Optometry	0		ó			25. 00
25. 01	Tel eheal th	0		ó			25. 01
25. 01	4	0					25. 02
26. 00	All other nonreimbursable costs	0					26.00
27. 00	Nonallowable GME costs	U	`	ή			27.00
	1	0	,				
28. 00	Total Nonreimbursable Costs (sum of lines 23	U	(ή			28. 00
	through 27) FACILITY OVERHEAD						1
29.00	Facility Costs	0	8, 998	3			29. 00
30.00	1	0	336, 61				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	345, 60				31.00
31.00	30)	O	343,00] 31.00
32. 00	Total facility costs (sum of lines 22, 28	Λ	1, 493, 22 ⁻				32.00
32.00	and 31)	O	1, 1,0,22				32.00
	lana or,		I	I			1

	Financial Systems MAF SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	u of Form CMS-2 Worksheet M-1	
			Component		From 01/01/2023 To 12/31/2023		nared:
			Component	CCN. 15 0507		5/29/2024 7: 2	
					RHC II	Cost	
		Compensation	Other Costs		1 Reclassi ficat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
	FACULATY HEALTH CARE CTAFE COOTS	1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1 005 000		1 005 00		4 005 000	
1.00	Physi ci an	1, 095, 990	0	.,		,	1.00
2.00	Physician Assistant	0	0	1	0 0	_	
3.00	Nurse Practitioner	103, 157	0	103, 15		103, 157	3.00
4.00	Visiting Nurse	0	0	007 //	0	0	4.00
5.00	Other Nurse	307, 668	0	307, 66	0	307, 668	
6.00	Clinical Psychologist	0	0	1	0	0	6.00
7.00	Clinical Social Worker	O O	U	1	0	0	7.00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor				0		7. 11 8. 00
8. 00 9. 00	Laboratory Technician	719, 266	0	719, 26	6 0	710 244	1
10.00	Other Facility Health Care Staff Costs Subtotal (sum of lines 1 through 9)	2, 226, 081	0	2, 226, 08		719, 266 2, 226, 081	
11. 00	Physician Services Under Agreement	2, 220, 081	0	2, 226, 08	0	2, 220, 081	1
12. 00	Physician Supervision Under Agreement	0	0		0 0	0	
13. 00	,		0		0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)		0		0	0	
15. 00			112, 998	112, 99	8 0	112, 998	
16. 00	· · ·		112, 770	112, //	0 0	112, 770	ı
17. 00			Ô		0 0	o o	
	Professional Liability Insurance		0		0 0	0	18.00
19. 00	Other Health Care Costs		Ö		0 0	0	•
20. 00		1	_			_	20.00
21. 00	Subtotal (sum of lines 15 through 20)	o	112, 998	112, 99	8 0	112, 998	
22. 00		2, 226, 081	112, 998				
	lines 10, 14, and 21)	,	, , , , ,			, , .	
	COSTS OTHER THAN RHC/FQHC SERVICES	·		•		•	ĺ
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	o	0	1	0 0	0	24.00
25.00	Optometry	o	0	1	0 0	0	25.00
25. 01	Tel eheal th	o	0		0	0	25. 01
25. 02	Chronic Care Management	o	0		0	0	25. 02
26.00		o	0		0	0	26.00
27.00							27.00
20 00	T-+-! N:	ا ما		J	ما م		20 00

467, 356

467, 356

2, 693, 437

28.00 0

29.00

30.00

31.00

32.00

12, 155 484, 773 496, 928

2, 836, 007

0

0

12, 155

484, 773 496, 928

2, 836, 007

12, 155 17, 417

29, 572

142, 570

28.00

FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

and 31)

30)

Total Nonreimbursable Costs (sum of lines 23 through 27)

31.00 Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28

Health Financial Systems	MARGARET MARY COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-132	Period: From 01/01/2023	Worksheet M-1
	Component CCN: 15-850	7 To 12/31/2023	Date/Time Prepared: 5/29/2024 7:24 am
		RHC II	Cost

Adjustments
FACILITY HEALTH CARE STAFF COSTS
All location (col. 5 + col. 6) Col. 6) Col. 6 Col
FACILITY HEALTH CARE STAFF COSTS
FACILITY HEALTH CARE STAFF COSTS
FACILITY HEALTH CARE STAFF COSTS 1.00 7.00
FACILITY HEALTH CARE STAFF COSTS
FACILITY HEALTH CARE STAFF COSTS
1.00 Physician 0 1,095,990 2.00
2.00
3. 00
4. 00 5. 00 5. 00 6. 00 6. 00 7. 00 Clinical Psychologist 7. 00 Clinical Social Worker 9. 00 7. 10 Marriage and Family Therapist 7. 11 Mental Health Counselor 8. 00 9. 00 9. 00 9. 00 0 ther Facility Health Care Staff Costs 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 10. 00 10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 19. 00 10. 00 10. 00 11. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 10. 00 10. 00 112. 998 21. 00 22. 00 10. 00 112. 998 22. 00 112. 998 22. 00 112. 998 22. 00 112. 998 22. 00 112. 998 22. 00 113. 00 114. 00 115. 0
5. 00 Other Nurse 0 307, 668 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 0 7.00 7. 10 Marriage and Family Therapist 7.10 7.11 8. 00 Laboratory Technician 0 0 0 9. 00 Other Facility Heal th Care Staff Costs 0 719, 266 9.00 10. 00 Subtotal (sum of lines 1 through 9) 0 2, 226, 081 10.00 11. 00 Physician Services Under Agreement 0 0 11.00 12. 00 Physician Supervision Under Agreement 0 0 11.00 12. 00 Physician Supervision Under Agreement 0 0 12.00 13. 00 Other Costs Under Agreement 0 0 12.00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 14.00 15. 00 Medical Supplies 0 112,998 15.00 16. 00 Transportation (Heal th Care Staff)
6.00 Clinical Psychologist 0 0 0 0 0 7.00
7.00 Clinical Social Worker 0 0 0 0 0 7.00 7.10 Marriage and Family Therapist 7.11 Mental Heal th Counsel or 8.00 Laboratory Technician 0 0 0 8.00 9.00 Other Facility Heal th Care Staff Costs 0 719, 266 9.00 10.00 Subtotal (sum of lines 1 through 9) 0 2,226,081 10.00 11.00 Physician Services Under Agreement 0 0 0 11.00 12.00 Physician Supervision Under Agreement 0 0 0 12.00 13.00 Other Costs Under Agreement 0 0 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 0 0 14.00 14.00 15.00 Medical Supplies 0 112,998 15.00 15.00 16.00 17.00 Depreciation-Medical Equipment 0 0 0 16.00 17.00 18.00 Professional Liability Insurance 0 0 0 0 18.00 19.00 Other Health Care Costs 0 0 0 0 0 0 0 0 0
7. 10 7. 11 Mental Heal th Counsel or 8. 00 Laboratory Technician 9. 00 Other Facility Heal th Care Staff Costs 10. 00 Subtotal (sum of lines 1 through 9) 11. 00 Physician Services Under Agreement 12. 00 Physician Supervision Under Agreement 13. 00 Other Costs Under Agreement 14. 00 Subtotal (sum of lines 11 through 13) 15. 00 Medical Supplies 16. 00 Transportation (Heal th Care Staff) 17. 00 Depreciation-Medical Equipment 18. 00 Other Heal th Care Costs 19. 00 Other Heal th Care Costs 20. 00 Allowable GME Costs 21. 00 Subtotal (sum of lines 15 through 20) 22. 00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES
7. 11 8. 00 Laboratory Technician 9. 00 Other Facility Health Care Staff Costs 0
8.00 9.00 Other Facility Health Care Staff Costs 0 719, 266 9.00 10.00 Subtotal (sum of lines 1 through 9) 0 2, 226, 081 11.00 Physician Services Under Agreement 0 0 0 12.00 Physician Supervision Under Agreement 0 0 0 13.00 Other Costs Under Agreement 0 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 0 0 15.00 Medical Supplies 0 112, 998 16.00 Transportation (Health Care Staff) 17.00 Depreciation-Medical Equipment 0 0 0 18.00 Professional Liability Insurance 0 0 0 18.00 Other Health Care Costs 0 0 0 18.00 Other Health Care Staff) 0 0 0 19.00 Other Health Care Staff) 0 0 0 19.00 Other Health Care Costs 0 0 0 112, 998 15.00 17.00 Subtotal (sum of lines 15 through 20) 18.00 Other Health Care Costs 0 0 0 19.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES
9.00 Other Facility Health Care Staff Costs 0 719, 266 10.00 Subtotal (sum of lines 1 through 9) 0 2,226,081 10.00 11.00 Physician Services Under Agreement 0 0 0 11.00 12.00 Physician Supervision Under Agreement 0 0 0 12.00 13.00 Other Costs Under Agreement 0 0 0 12.00 14.00 Subtotal (sum of lines 11 through 13) 0 0 0 14.00 15.00 Medical Supplies 0 112,998 15.00 16.00 Transportation (Health Care Staff) 0 0 0 18.00 17.00 Depreciation-Medical Equipment 0 0 0 18.00 19.00 Other Health Care Costs 0 0 0 18.00 19.00 Other Health Care Staff O 0 0 18.00 20.00 Allowable GME Costs 0 0 0 12,339,079 1 ines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES
10.00 Subtotal (sum of lines 1 through 9) 0 2,226,081 10.00 11.00 Physician Services Under Agreement 0 0 12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 112,998 15.00 16.00 Transportation (Health Care Staff) 0 0 17.00 Depreciation-Medical Equipment 0 0 18.00 Professional Liability Insurance 0 0 19.00 Other Health Care Costs 0 0 20.00 Allowable GME Costs 0 112,998 21.00 Subtotal (sum of lines 15 through 20) 0 112,998 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES
11. 00 Physician Services Under Agreement 0 0 0 12. 00 Physician Supervision Under Agreement 0 0 0 12. 00 13. 00 Other Costs Under Agreement 0 0 0 0 13. 00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 14. 00 15. 00 Medical Supplies 0 112, 998 15. 00 Transportation (Health Care Staff) 0 0 0 16. 00 17. 00 Depreciation-Medical Equipment 0 0 0 17. 00 Professional Liability Insurance 0 0 0 18. 00 19. 00 Other Health Care Costs 0 0 0 0 19. 00 Other Health Care Costs 0 0 0 0 19. 00 Other Health Care Costs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
12.00
13.00 Other Costs Under Agreement 0 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 14.00 15.00 Medical Supplies 0 112,998 15.00 16.00 Transportation (Health Care Staff) 0 0 0 17.00 Depreciation-Medical Equipment 0 0 0 17.00 Professional Liability Insurance 0 0 0 18.00 19.00 Other Health Care Costs 0 0 0 19.00 Allowable GME Costs 0 0 112,998 19.00 Subtotal (sum of lines 15 through 20) 0 112,998 10.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 0 COSTS OTHER THAN RHC/FQHC SERVICES
14.00 Subtotal (sum of lines 11 through 13) 0 0 0 15.00 15.00 16.00 17.00 16.00 17.00 17.00 17.00 18
15.00 Medical Supplies 0 112,998 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00 17.00 Depreciation-Medical Equipment 0 0 0 18.00 Professional Liability Insurance 0 0 0 19.00 Other Health Care Costs 0 0 0 20.00 Allowable GME Costs 20 21.00 Subtotal (sum of lines 15 through 20) 112,998 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 22.00 COSTS OTHER THAN RHC/FQHC SERVICES
16.00 Transportation (Health Care Staff) 0 0 0 17.00 17.00 Depreciation-Medical Equipment 0 0 0 17.00 18.00 Professional Liability Insurance 0 0 0 18.00 19.00 Other Health Care Costs 0 0 0 19.00 Allowable GME Costs 20.00 Allowable GME Costs 20.00 Subtotal (sum of lines 15 through 20) 0 112,998 21.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 22.00 COSTS OTHER THAN RHC/FQHC SERVICES
17. 00 Depreciation-Medical Equipment 0 0 0 18. 00 18. 00 Professional Liability Insurance 0 0 0 18. 00 19. 00 Other Health Care Costs 0 0 0 19. 00 20. 00 Allowable GME Costs 20. 00 21. 00 Subtotal (sum of lines 15 through 20) 0 112, 998 21. 00 22. 00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 22. 00 COSTS OTHER THAN RHC/FQHC SERVICES
18.00 Professional Liability Insurance 0 0 0 18.00 19.00 Other Health Care Costs 0 0 19.00 20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 112,998 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES
19.00 Other Heal th Care Costs 0 0 0 19.00 20.00 Allowable GME Costs 20.00 Subtotal (sum of lines 15 through 20) 0 112,998 21.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 0 2,339,079 22.00 COSTS OTHER THAN RHC/FQHC SERVICES
19.00 Other Health Care Costs 0 0 0 19.00 20.00 Allowable GME Costs 20.00 Subtotal (sum of lines 15 through 20) 0 112,998 21.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 22.00 COSTS OTHER THAN RHC/FQHC SERVICES
21.00 Subtotal (sum of lines 15 through 20) 0 112,998 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES 21.00 22.00 22.00 22.00 22.00 23.39,079 22.00 23.39,079 23.00 23.00 24.00 24.00 25.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES
lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES
COSTS OTHER THAN RHC/FQHC SERVICES
24. 00 Dental 0 0 0 24. 00
25.00 Optometry 0 0 25.00
25. 01 Tel eheal th 0 0 0 25. 01
25.02 Chronic Care Management 0 0 25.02
26.00 All other nonrelimbursable costs 0 0 26.00
27.00 Nonallowable GME costs
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 28.00
through 27)
FACILITY OVERHEAD
29. 00 Facility Costs 0 12, 155 29. 00
30. 00 Admi ni strati ve Costs 0 484, 773 30. 00
31.00 Total Facility Overhead (sum of lines 29 and 0 496,928 31.00
31. 00 10tal 1aci i i ty overhead (suii oi i i iles 27 aid 0 470, 720 30)
32.00 Total facility costs (sum of lines 22, 28 0 2,836,007 32.00
and 31)

		RGARET MARY COM				u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C	CN: 15-1329	Peri od:	Worksheet M-2	
			Component	CCN: 15-8511	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
4 00	Posi ti ons	0.40	0.50/		4		1 00
1.00	Physician	0. 68					1.00
2.00	Physician Assistant	0.00			1 0		2.00
3. 00 4. 00	Nurse Practitioner	2. 56 3. 24			3	11, 706	
5. 00	Subtotal (sum of lines 1 through 3) Visiting Nurse	0.00			4	11,706	5.00
6. 00	Clinical Psychologist	0.00				0	
7. 00	Clinical Social Worker	0.00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 02	Diabetes Self Management Training (FQHC	0.00				0	7. 02
7.02	only)	0.00	Ĭ				7.02
7. 03	Marriage and Family Therapist						7. 03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4	3. 24	11, 706			11, 706	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	ED RHC/FQHC SEI	RVICES		1. 00	
10.00							10.00
11.00							11.00
12.00						1, 147, 612	12.00
13.00	3.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						13.00
14.00						345, 609	14.00
15.00						856, 672	
16.00	Total overhead (sum of lines 14 and 15)					1, 202, 281	
17.00	Allowable GME overhead (see instructions)					0	
18. 00	Enter the amount from line 16					1, 202, 281	
19. 00	Overhead applicable to hospital-based RHC/FC					1, 202, 281	
20.00	Total allowable cost of hospital-based RHC/F	·UHC services (sum of lines 10	J and 19)		2, 349, 893	20.00

	· · · · · · · · · · · · · · · · · · ·	RGARET MARY COM				u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C	CN: 15-1329	Peri od:	Worksheet M-2	
			Component	CCN: 15-8567	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
					RHC II	Cost	
		Number of FTE	Total Visits	Producti vi t	y Minimum	Greater of	
		Personnel		Standard (1	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	3. 33		•	1 3		1.00
2.00	Physician Assistant	0.00		1	1 0		2.00
3.00	Nurse Practitioner	0. 60			1 1		3.00
4.00	Subtotal (sum of lines 1 through 3)	3. 93		•	4	17, 262	
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0.00				0	
7.00	Clinical Social Worker	0.00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
7. 03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7. 04
8. 00	Total FTEs and Visits (sum of lines 4	3. 93	17, 262			17, 262	8. 00
	through 7)		_			_	
9. 00	Physician Services Under Agreements		0			0	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	ED RHC/FQHC SEI	RVI CES		1.00	
10.00	0.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22)						10.00
11.00	1.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						11.00
12.00						2, 339, 079	12.00
13.00	3.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1. 000000	13.00
14.00	1.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					496, 928	14.00
15.00	00 Parent provider overhead allocated to facility (see instructions)					1, 787, 504	15.00
16.00	Total overhead (sum of lines 14 and 15)					2, 284, 432	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2, 284, 432	18.00
19.00	Overhead applicable to hospital-based RHC/FC	NHC services (Ιί	ine 13 x line	18)		2, 284, 432	19.00
20 00	Total allowable cost of hospital-based RHC/F	OHC services (s	sum of lines 10	0 and 19)		4, 623, 511	20.00

CALCULATION OF RELMBURS	S MARGARET MARY COMMUI EMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	NITY HOSPITAL Provider CCN: 15-1329	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CES	EMENT SETTEEMENT FOR 110311 TAL BASES KNOT WITE	Component CCN: 15-8511	From 01/01/2023 To 12/31/2023		
		71.11.100011	DUO I	5/29/2024 7: 2	4 am
		Title XVIII	RHC I	Cost	
DETERM MATI ON .OF	DATE FOR HOORI TAL DAGER BUG (FOUR OFFINITION			1. 00	
	RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Cost of hospital-based RHC/FQHC Services (fro	m Wks+ M 2 Line 20)		2 240 902	1.0
1	ns/infusions and their administration (from W			2, 349, 893 17, 763	1
	cost excluding injections/infusions (line 1 m			2, 332, 130	
4	om Wkst. M-2, column 5, line 8)			11, 706	
1	s under agreement (from Wkst. M-2, column 5,	line 9)		0	5.
.00 Total adjusted v	sits (line 4 plus line 5)			11, 706	6.
.00 Adjusted cost pe	r visit (line 3 divided by line 6)			199. 23	7.
			Cal cul ati on	of Limit (1)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2023	
				through	
			1.00	12/31/2023) 2. 00	
.00 Per visit paymen	t limit (from CMS Pub. 100-04, chapter 9, §20). 6 or your contractor)	0.00	236. 04	8.
	covered visits (see instructions)	, , , , , , , , , , , , , , , , , , ,	0.00	199. 23	
CALCULATION OF SI					
1 0	visits excluding mental health services (from		0	1, 440	
	uding costs for mental health services (line		0	286, 891	1
9	visits for mental health services (from contr cost from mental health services (line 9 x li	•	0	112 22, 314	1
9	for mental health services (see instructions	•	0	22, 314	1
,	Education Pass Through Cost (see instruction	*		22,011	15.
1	st (sum of lines 11, 14, and 15, columns 1, 2	•	0	309, 205	16.
6.01 Total program ch	arges (see instructions)(from contractor's re	ecords)		403, 429	16.
	eventive charges (see instructions)(from prov			20, 204	
	eventive costs ((line 16.02/line 16.01) times	•		15, 485	
	n-preventive costs ((line 16 minus lines 16.0 K see instructions.)	33 and 18) times .80)		210, 081	16.
	st (see instructions)		0	225, 566	16.
7.00 Primary payer am				0	17.
	ry deductible for RHC only (see instructions)	(from contractor		31, 119	18.
records)					
9.00 Beneficiary coin records)	surance for RHC/FQHC services (see instruction	ons) (from contractor		70, 271	19.
	excluding injections/infusions (see instruct	ions)		225, 566	20.
, ,	vaccines and their administration (from Wkst.			26, 064	ı
	OPPS payments (see instructions)	•		•	21.
	Costs (see instructions)				21.
	ctible and coinsurance (see instructions)				21.
	le Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		251, 630	
	ots (see instructions) sable bad debts (see instructions)			1, 062	
1 -	ots for dual eligible beneficiaries (see inst	ructions)			23. 24.
	S (SEE INSTRUCTIONS) (SPECIFY)	i de ti olis)		0	1
	nstration payment adjustment (see instruction	ns)		0	1
	yment adjustment amount before sequestration			0	25.
•	amount (see instructions)			252, 320	
	ustment (see instructions)			5, 046	1
	yment adjustment amount after sequestration			0.000	
7.00 Interim payments 8.00 Tentative settle	ment (for contractor use only)			288, 869 0	
1	onent/program (line 26 minus lines 26.01, 26.	02. 27. and 28)		-41, 595	
	s (nonallowable cost report items) in accorda	· · · · · · · · · · · · · · · · · · ·	,	41, 373	1
				-	1

CALCULATI OF	ancial Systems MARGARET MARY COMMUN N OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1329	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CES		Component CCN: 15-8567	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
		Title XVIII	RHC II	Cost	4 aiii
				1. 00	
DETE	RMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
. 00 Tota	al Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		4, 623, 511	1. (
2.00 Cost	of injections/infusions and their administration (from W	/kst. M-4, line 15)		19, 309	
3. 00 Tota	al allowable cost excluding injections/infusions (line 1 m	ninus line 2)		4, 604, 202	1
	al Visits (from Wkst. M-2, column 5, line 8)			17, 262	1
	sicians visits under agreement (from Wkst. M-2, column 5,	line 9)		17.2(2	
1	al adjusted visits (line 4 plus line 5) usted cost per visit (line 3 divided by line 6)			17, 262 266. 72	1
.00 Auj t	isted cost per visit (Time's divided by Time o)		Cal cul ati on		/.
			Rate Period	Rate Period 1	
			N/A	(01/01/2023	
				through	
				12/31/2023)	
			1. 00	2. 00	
1	visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	0.00	126.00	1
	e for Program covered visits (see instructions)		0.00	126. 00	9. (
	ULATION OF SETTLEMENT gram covered visits excluding mental health services (from	contractor records)	0	5, 786	10.
-	gram cost excluding costs for mental health services (line		0	729, 036	
	gram covered visits for mental health services (from contr		0	0	1
	gram covered cost from mental health services (line 9 x li	,	0	0	1
4.00 Li mi	t adjustment for mental health services (see instructions	s) .	0	0	14.
	duate Medical Education Pass Through Cost (see instruction				15.
1	al Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	729, 036	1
1	al program charges (see instructions)(from contractor's re	•		1, 560, 681	1
1	al program preventive charges (see instructions)(from prov al program preventive costs ((line 16.02/line 16.01) times	•		121, 969 56, 975	1
	al Program non-preventive costs ((Time 10.02/Time 10.07) times	•		468, 434	1
	les V and XIX see instructions.)			1007 101	
	al program cost (see instructions)		0	525, 409	16.
	nary payer amounts			86	1
	Beneficiary deductible for RHC only (see instructions)	(from contractor		86, 519	18.
1	ords)	(6		270 422	10
	eficiary coinsurance for RHC/FQHC services (see instruction ords)	ons) (from contractor		270, 432	19.
1	program cost excluding injections/infusions (see instruct	i ons)		525, 323	20.0
1	gram cost of vaccines and their administration (from Wkst.	•		6, 524	1
21. 50 Tota	al program IOP OPPS payments (see instructions)				21.
1	al program IOP Costs (see instructions)				21.
	gram IOP deductible and coinsurance (see instructions)			504 047	21.
	al reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		531, 847	
	owable bad debts (see instructions) usted reimbursable bad debts (see instructions)				23. 23.
	owable bad debts for dual eligible beneficiaries (see inst	ructions)			24.
1	RADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	1 40 11 0113)		0	1
1	neer ACO demonstration payment adjustment (see instruction	ıs)		0	1
25.99 Demo	onstration payment adjustment amount before sequestration			0	25.
1	reimbursable amount (see instructions)			532, 444	1
	uestration adjustment (see instructions)			10, 649	1
1	onstration payment adjustment amount after sequestration			0 E11 4E7	1
	erim payments cative settlement (for contractor use only)			511, 657 0	
	ance due component/program (line 26 minus lines 26.01, 26.	02 27 and 28)		10, 138	1
1	tested amounts (nonallowable cost report items) in accorda	•		10, 138	1
	oter I, §115.2		.	ĕ	1

	Financial Systems MARGARET MARY COM				u of Form CMS-2	
COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co	CN: 15-1329	Peri od: From 01/01/2023	Worksheet M-4	
		Component		To 12/31/2023		pared: 4 am
			XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1, 023, 117		17 1, 023, 117	1, 023, 117	
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000310	0. 0013	0. 000000	0.000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	317	1, 3	47 O	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	4, 053	2, 9!	58 0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4, 370			0	5. 00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 147, 612	1, 147, 6 ⁻	1, 147, 612	1, 147, 612	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	1, 202, 281	1, 202, 2			7. 00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 003808	0. 0037!	0. 000000	0.000000	8.00
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	4, 578			0	
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	8, 948				10.00
11.00	Total number of injections/infusions (from your records)	99		17 0	0	
12.00	Cost per injection/infusion (line 10/line 11)	90. 38				
13. 00	Number of injection/infusion administered to Program beneficiaries	13	,	48 0	0	
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13	1, 175	24, 8	0	0	14.00
	and 13.01, as applicable)				COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI O	
					N	
				1. 00	2. 00	
15. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		f columns 1,		17, 763	15.00
16. 00	Total Program cost of injections/infusions and their admin				26, 064	16. 00
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou	int to Wkst. M-3	3, line 21)			

13.00 Number of injection/infusion administered to Program 13.01 Number of COVID-19 vaccine injections/infusions 14.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION N 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 19,309)		Financial Systems MARGARET MARY COM	MUNITY HOSPITA	L	In Lie	u of Form CMS-2	2552-10
Component CCN: 15-8567 To	COMPU	TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co	CN: 15-1329			
PNEUMOCOCAL NFLUENZA COVID-19 MONOCLONAL NATI BODY PRODUCTS			Component	CCN: 15-8567		Date/Time Pre	pared: 4 am
VACCINES VACCINES VACCINES VACCINES VACCINES ANTIBODY PRODUCTS							
1.00						ANTI BODY	
2.00 Ratio of injection/infusion staff time to total health care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 2) 3.00 Injections/infusions and related medical supplies costs 99 6, 171 0 0 0 5.00 Direct cost of injections/infusions (line 3 plus line 4) 108 9, 661 0 0 0 6.00 Total direct cost of the hospital-based RHC/FOHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wst. M-2, line 19) 2, 284, 432 2, 2			1.00	2.00	2. 01		
Care staff time	1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2, 226, 081	2, 226, 0	81 2, 226, 081	2, 226, 081	1.00
20	2. 00		0. 000004	0. 0015	0. 000000	0.000000	2.00
(from your records) Direct cost of injections/infusions (line 3 plus line 4) 6.00 Total direct cost of the hospital-based RHC/FOHC (from 2, 339, 079 2	3. 00	2)	9	3, 4	90 0	0	3.00
6.00 Total direct cost of the hospital -based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 8.00 Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 10.00 Total injection/infusion costs and their administration costs (sum of lines 5 and 9) 11.00 Total number of injections/infusions (from your records) 12.00 Cost per injection/infusion administered to Program beneficiaries 13.01 Number of COVID-19 vaccine injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 19,309 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 19,309	4. 00	(from your records)	99	6, 1	71 0	0	
Worksheet M-1, col. 7, line 22 7.00 Total overhead (from Wkst. M-2, line 19) 2, 284, 432 4, 24, 24, 24, 44, 24, 44, 44, 44, 44,						_	
8.00 Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 10.00 Total injection/infusion costs and their administration costs (sum of lines 5 and 9) 11.00 Total number of injections/infusions (from your records) 12.00 Cost per injection/infusion (line 10/line 11) 13.00 Number of injection/infusion administered to Program beneficiaries 13.01 Number of COVID-19 vaccine injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 19,309 10.00 0.00013 10.00 0.00013 10.00 0.00013 10.00 0.00013 10.00 0.00013 10.00 0.00013 10.00 0.00013 10.00 0.00013 10.00 0.00013 10.00 0.00013 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.0000000 10.0000000 10.0000000 10.00000000		Worksheet M-1, col. 7, line 22)					
cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 10.00 Total injection/infusion costs and their administration costs (sum of lines 5 and 9) 11.00 Total number of injections/infusions (from your records) 12.00 Cost per injection/infusion (line 10/line 11) 13.00 Number of injection/infusion administered to Program beneficiaries 13.01 Number of COVID-19 vaccine injections/infusions and their administered to MA enrollees 14.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N ADMINISTRATIO N 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 19,309							
10.00 Total injection/infusion costs and their administration costs (sum of lines 5 and 9) 11.00 Total number of injections/infusions (from your records) 12.00 Cost per injection/infusion (line 10/line 11) 13.00 Number of injection/infusion administered to Program beneficiaries 13.01 Number of COVID-19 vaccine injections/infusions and their administered to MA enrollees 14.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO NAME ADMINISTRATIO Services (sum of columns 1, 19,309)		cost (line 5 divided by line 6)					
11.00 Total number of injections/infusions (from your records) 12.00 Cost per injection/infusion (line 10/line 11) 13.00 Number of injection/infusion administered to Program 13.01 Number of COVID-19 vaccine injections/infusions administered to MA enrollees 14.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1,			l control of the cont			1	/
12.00 Cost per injection/infusion (line 10/line 11) 13.00 Number of injection/infusion administered to Program							
13. 00 Number of injection/infusion administered to Program 0 beneficiaries 13. 01 Number of COVID-19 vaccine injections/infusions 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1				
beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees Program cost of injections/infusions and their of administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION No. 1.00 2.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 19,309			213.00				12.00
administered to MA enrollees Program cost of injections/infusions and their of administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION N 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 19, 309)		benefi ci ari es	0	1	24 0		
administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO NO 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 19, 309	13. 01	administered to MA enrollees			0	0	13. 01
INJECTIONS / INFUSIONS AND ADMINISTRATIO N N 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 19, 309	14. 00	administration costs (line 12 times the sum of lines 13	0	6, 5	24 0		14.00
INFUSIONS AND ADMINISTRATIO NS AND ADMINISTRATIO NS AND ADMINISTRATIO NS AND ADMINISTRATIO NS ADMINISTRATIO							
ADMINISTRATION N 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 19, 309							
N 1.00 2.00							
1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 19,309							
15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 19,309					1. 00		
	15. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		f columns 1,			15. 00
16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)	16. 00	Total Program cost of injections/infusions and their admin	istration cost	•		6, 524	16.00

Health Financial Systems	MARGARET MARY COMMUN	NITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER FOR	Provider CCN: 15-1329 Component CCN: 15-8511	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 7:24 am

		Component CCN. 13-8311	10 12/31/2023	5/29/2024 7: 24	
			RHC I	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			288, 869	1.0
2. 00	Interim payments payable on individual bills, either submit			0	2.0
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				3. (
	revision of the interim rate for the cost reporting period.	. Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3.
3. 02				0	3.
3. 03				0	3.
3. 04				0	3.
3. 05				0	3.
	Provider to Program				ĺ
. 50	<u>-</u>			0	3.
. 51				0	3.
. 52				0	3.
. 53				0	3.
. 54				0	3.
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	. 98)		0	3.
1. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans		;	288, 869	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR			•	
5. 00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5.
5. 02				0	5.
. 03				0	5.
	Provider to Program				
5. 50				0	5.
. 51				0	5.
. 52				0	5.
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	. 98)		0	5.
. 00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.
. 01	SETTLEMENT TO PROVIDER			o	6.
. 02	SETTLEMENT TO PROGRAM			41, 595	
	Total Medicare program liability (see instructions)			247, 274	7.
	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		Contractor	NPR Date	
7. 00					
		0	Number 1.00	(Mo/Day/Yr) 2.00	

Health Financial Systems	MARGARET MARY COMMUN	NITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER FOR	Provi der CCN: 15-1329 Component CCN: 15-8567	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 7:24 am

				5/29/2024 7: 2	4 am
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			511, 657	1.0
2. 00	Interim payments payable on individual bills, either submit	tted or to be submitted to		0	2.0
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
. 00	List separately each retroactive lump sum adjustment amount based on subsequent				3. (
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01				0	3.
. 02				l ol	3.
. 03				l ol	3.
. 04				o	3.
. 05				o	3.
	Provider to Program		<u>'</u>		
. 50				0	3.
51				l ol	3.
52				l ol	3.
53				l ol	3.
54				l ol	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.		l ol	3.	
. 00				511, 657	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after des	sk review. Also show date of			5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	5.
02				l ol	5.
03				l ol	5.
	Provider to Program				
50				0	5.
51				0	5.
52				l ol	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			l ol	5.
00	· · · · · · · · · · · · · · · · · · ·				6.
01	SETTLEMENT TO PROVIDER			10, 138	6.
02	SETTLEMENT TO PROGRAM			0	6.
00	Total Medicare program liability (see instructions)			521, 795	7.
. 55	Total mode ode o program readering (300 reader dott only)		Contractor	NPR Date	,.
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	