Contractor	5. [ 1 ]Cost Report Status	6. Date Received:	10. NPR Date:
use only	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
<u>,</u>	(2) Settled without Audit	8. [ N ] Initial Report for this Provider CCN	12.[0]Ifline 5, column 1 is 4: Enter
	(3) Settled with Audit	9. [ N ]Final Report for this Provider CCN	number of times reopened = $0-9$ .
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

#### CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SULLIVAN COUNTY COMMUNITY HOSPITAL (15-1327) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(C:	~	$\mathbf{n}$	2	
1.51	u	ne	(J)	

Officer or Administrator of Provider(s)

Title

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	223, 844	-64, 846	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	33, 415	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	257, 259	-64, 846	0	0	200.00

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

Date

	AND HOSPITAL HEALTH CARE COMPLEX			ovider CC	N: 15-132	F	eriod: rom 01/01/ o 12/31/	2016 2016	Workshe Part I Date/Ti 5/26/20	me Pre	epared
LIC	<u>1.00</u> Dispital and Hospital Health Care Co		00	3.00			4	1.00			
	treet: 2200 NORTH SECTION STREET	P0 Box: 1	0								1.
	ity: SULLIVAN	State: I		Code: 478	82- 0	County	: SULLI VAN				2.
		Component Na				/i der	Date		nt Syst		
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) SL		COMMUNITY HOSPITA	AL								4.
	ubprovider - IPF ubprovider - IRF										5.
	ubprovider - (Other)										6
0 Sv	wing Beds - SNF	SULLI VAN COUNTY	15Z3	27 454	60		06/01/2005	N	0	N	7.
_		COMMUNI TY HOSPI TA	AL .								
	wing Beds - NF										8.
	ospital-Based SNF ospital-Based NF										10.
	ospital-Based OLTC										111.
00 Hc	ospital-Based HHA	SULLI VAN COUNTY H	HOME 1575	42 454	60		07/23/2002	N	P	N	12.
		HEALTH									1.0
	eparately Certified ASC ospital-Based Hospice										13.
	ospital-Based Health Clinic - RHC										14.
	ospital-Based Health Clinic - FQHC										16.
	ospital-Based (CMHC) I										17.
	enal Dialysis ther										18
00 101	the						From:		То	):	19.
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	ost Reporting Period (mm/dd/yyyy)						01/01/2	016	12/31/	/2016	20.
	ype of Control (see instructions) patient PPS Information						9				21.
	pes this facility qualify and is it	currently receiv									
			und payments	for disp	roportio	nate	N				22
sh	hare hospital adjustment, in accord						N				22.
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Is t m the me <u>r "N" fo</u> Out-of State Medicai paid day</td> <td>i ry" i ckl e i ng N" 1. o be ir yes iter od on result nter od of the s wi th of umn he ithod or no. of d Me ys e wi th of un of of of of of of of of of of</td> <td>N N N N State H edicaid igible Jupaid 4.00 0</td> <td>edicai MO day</td> <td>N N vs Mecc c c C</td> <td>ther di cai d days</td> <td>222. 222. 223. 23.</td>	f this provider is an IPPS hospital cord and and the prior cost reporting period and the advertion of the porting period occurring prior to priod? Enter in column 1, "Y" for y eporting period occurring prior to por no for the portion of the cost r see instructions) s this a newly merged hospital that etermined at cost report settlement r "N" for no, for the portion of the n column 2, "Y" for yes or "N" for r after October 1. Id this hospital receive a geograph f the OMB standards for delineating n column 1, "Y" for yes or "N" for rior to October 1. 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	Financial Systems SULLIVAN COL TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		MMUNITY HOSPITA Provider CC	N: 15-1327	Peri od:		u of For Workshe		
					From 01/01/ To 12/31/		Part I Date/Ti 5/26/20		
					Urban/Rur		Date of	Geogr	
26.00	Enter your standard geographic classification (not wa	ge) sta	atus at the beg	inning of the	1.00	1	2.0	0	26.00
27.00	reporting period. Enter in column 1, "1" for urban or	ge) sta "2" fo	atus at the end or rural. If ap			1			27.00
35. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35.00
					Begi nni		Endi	0	
36.00	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for number	1.00		2.0	10	36.00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	S.	·			0			37.00
37. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo				N				37.01
38. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38.00
	enter subsequent dates.				Y/N		Y/		
39.00	Does this facility qualify for the inpatient hospital	paymer	nt adjustment f	or low volume	1.00 N		2. C		39.00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	)? Ente uiremer or "N"	er in column 1 nts in accordan for no. (see i	"Y" for yes ce with 42 nstructions)					
40.00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. E	Enter "Y" for y		. N		N		40.00
						V 1.00	2.00	XI X 3.00	
45.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	t for a	di sproporti onat	e share in ac	cordance	N	N	N	45.00
46.00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46.00
47. 00 48. 00	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47.00 48.00
56.00	Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y"	for yes	N			56.00
57.00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of th ", comp	r "N" for no in nis cost report plete Worksheet	column 1. If ing period?	column 1 Enter "Y"				57.00
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemer complet	nt for physicia te Wkst. D-5.		as	N			58.00
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health	•			9	N N			59.00 60.00
	provider-operated criteria under §413.85? Enter "Y"	for yes Y/N	s or "N" for no IME	. (see instru Direct GME	ICTIONS)		Direct	GME	
(1.00		1.00	2.00	3.00	4.00		5.0		10.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.0	00				61.01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.0	bo				61.02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0. 00	0.0	DO				61.03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	00				61.04
61.05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0.00	0.0	ю				61.05

SPI	TAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	ATA	Provider CC		eriod: rom 01/01/2016	Worksheet S-2 Part I	
					To		Date/Time Pre 5/26/2017 2:2	
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
1.06	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0.00	0.00			61.0
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
1. 10	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instr column 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61.
1. 20	3	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00	0.00	61.
							1.00	
	ACA Provisions Affecting the Hea Enter the number of FTE resident					od for which	0.00	1/2
2.00	your hospital received HRSA PCRE			a fin this cost	reporting peri	od for which	0.00	62.
2. 01	Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	riod of HRSA THC prog	gram. (s	see instruction		your hospital	0.00	62.
3. 00	Has your facility trained reside "Y" for yes or "N" for no in col					eriod? Enter	N	63.
					Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
					Nonprovi der	Hospi tal	2))	
					Si te 1.00	2.00	3.00	-
	Section 5504 of the ACA Base Yea period that begins on or after J				This base year	is your cost r	eporting	
1. 00		yes, or your facili ber of unweighted nou tations occurring in number of unweighted ur hospital. Enter in	ty trair n-primar all nor d non-pr n columr	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00	0. 000000	64.
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	Si te 3. 00	4.00	5.00	
i. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column				0.00	0.00	0. 000000	65.

	Financial Systems		UNTY COMMUNITY HOSPIT			eu of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	.TA Provider C		eriod: rom 01/01/2016 o 12/31/2016	Date/Time Pre 5/26/2017 2:2	pared:
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider Setting	1.00 gsEffective fo	2.00 pr cost report	3.00 ing periods	
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0. 0	0. 000000	66. 00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(7.00	Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00	(7.00
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	0.0	0. 000000	67.00
					1.0	0 2.00 3.00	
	Inpatient Psychiatric Facility P					0 2.00 0.00	
	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	pproved GME teaching 004? Enter "Y" for y lity train residents (D)? Enter "Y" for y	, program in the yes or "N" for r s in a new teach yes or "N" for r	most N no. (see ni ng no.	0	70.00
75.00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re		(IRF), or does it o	contain an IRF	N		75.00
	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	and "N" for no. e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	pproved GME teaching ember 15, 2004? Enter new teaching program for no. Column 3: If	program in the - "Y" for yes or n in accordance f column 2 is Y,	"N" for with 42	0	76.00
						1.00	
	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no.				period? Enter	N N	80. 00 81. 00
	TEFRA Providers Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (	(excluded unit) under			N	85. 00 86. 00
87.00	Is this hospital a "subclause (I for yes or "N" for no.			(1)(B)(iv)(II)?	'Enter "Y"	N	87.00
					V	XI X	
	Title V and XIX Services				1.00	2.00	
90.00	Does this facility have title V yes or "N" for no in the applica		hospital services? E	Enter "Y" for	N	Y	90.00
91.00	Is this hospital reimbursed for	title V and/or XIX th			N	Y	91.00
92.00	full or in part? Enter "Y" for y Are title XIX NF patients occupy	ing title XVIII SNF b	oeds (dual certificat			N	92.00
	instructions) Enter "Y" for yes Does this facility operate an IC	or "N" for no in the	applicable column.		N	N	93.00
	"Y" for yes or "N" for no in the Does title V or XIX reduce capit applicable column.	applicable column.			N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		Peri od:	LIEU	Workshe		2552-1 2
			From 01/01/ To 12/31/		Part I Date/Ti		
			V		5/26/20 XI		23 pm
			1.00		2.0		_
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N		0. C N		95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	plicable colum	۱.	0.00		0.0	00	97.00
105.00 Does this hospital qualify as a critical access hospital (C/ 106.00 If this facility qualifies as a CAH, has it elected the all-	,	od of navmer	Y N				105.00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column	t reimbursemen	t for I&R	N				107. 00
yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 s this a rural hospital qualifying for an exception to the	. 25 and the p	rogram is cos					108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal			h	Docnin	atory	108.00
	1.00	Occupationa 2.00	1 Speec 3.00		Respir 4.(		-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N		N		109.00
				F	1.0	00	-
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (4	10A Demo)fo	~	N		110.00
,				1. 00	2.00	3.00	-
Miscellaneous Cost Reporting Information				-	2.00		
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	. If column 2 i nt for long te	s "E", enter rm care (incl	in column udes	N		0	115.00
16.00 Is this facility classified as a referral center? Enter "Y" 17.00 Is this facility legally-required to carry malpractice insur	2		"N" for	N Y			116. 00 117. 00
no. I18.00Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i	f the policy	is	1			118.00
cramin-made. Enter 2 m the portey is decurrence.		Premi ums	Losse	s	Insura	ance	
		1.00	2.00		3. 0		_
18.01List amounts of malpractice premiums and paid losses:		1.00 102,3		0			
118.01 List amounts of malpractice premiums and paid losses:						(	
		102,3 than the	97		3. (	(	_
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Holo §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment	dule listing co d Harmless prov n column 1, "Y" ualifies for tl	102,3 than the ost centers /ision in ACA ' for yes or ne Outpatient	97 1.00 N		3. (	00	118.0
<ul> <li>118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheq and amounts contained therein.</li> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qualified Harmless provision in ACA \$3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implation.</li> </ul>	dule listing co d Harmless prov n column 1, "Y ualifies for tl nts? (see instr	102,3 than the ost centers / sion in ACA / for yes or ne Outpatient ructions)	97 1.00 N		3. 0	00	118.0 119.0 120.0
<ul> <li>118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein.</li> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for no.</li> <li>121.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the second secon</li></ul>	dule listing co d Harmless prov n column 1, "Y ualifies for th nts? (see instr antable devices Enter "Y" for	102,3 than the ost centers ' for yes or ne Outpatient ructions) s charged to yes or "N"	97 1.00 N N		3. 0	00	118. 02 119. 00 120. 00 121. 00
<ul> <li>18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.</li> <li>19.00 D0 NOT USE THIS LINE</li> <li>20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for no.</li> <li>21.00 Did this facility incur and report costs for high cost implapatients? Enter "Y" for yes or "N" for no.</li> <li>22.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information</li> </ul>	dule listing co d Harmless prov n column 1, "Y ualifies for ti nts? (see instr antable device: Enter "Y" for he Worksheet A	102,3 than the ost centers ' for yes or ne Outpatient ructions) s charged to yes or "N" line number	97 1.00 N N Y N		3. 0	00	118. 0. 119. 0( 120. 0( 121. 0( 122. 0(
<ul> <li>118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheq and amounts contained therein.</li> <li>119. 00 D0 NOT USE THIS LINE</li> <li>120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment for no.</li> <li>121. 00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no.</li> <li>122. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included.</li> <li>17 Transplant Center Information</li> <li>125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> </ul>	dule listing co d Harmless prov n column 1, "Y ualifies for th nts? (see instr antable devices Enter "Y" for he Worksheet A or yes and "N"	102,3 than the ost centers ' for yes or ne Outpatient ructions) s charged to yes or "N" line number	97 1.00 N N Y N N		3. 0	00	118. 02 119. 00 120. 00 121. 00 122. 00
<ul> <li>18. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheq and amounts contained therein.</li> <li>19. 00 D0 NOT USE THIS LINE</li> <li>20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendments?</li> <li>21. 00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no.</li> <li>22. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included.</li> <li>25. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26. 00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2</li> </ul>	dule listing co d Harmless prov n column 1, "Y ualifies for th nts? (see instr antable devices Enter "Y" for he Worksheet A or yes and "N" nter the certin 2.	102,3 than the ost centers ' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date	97 1.00 N N Y N N		3. 0	00	118. 0. 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00
<ul> <li>118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheq and amounts contained therein.</li> <li>119. 00 D0 NOT USE THIS LINE</li> <li>120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendment for no.</li> <li>121. 00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>121. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information</li> <li>125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126. 00 If this is a Medicare certified kidney transplant center, entire in column 1 and termination date, if applicable, in column 2</li> </ul>	dule listing co d Harmless prov n column 1, "Y ualifies for ti nts? (see instr antable device: Enter "Y" for he Worksheet A cor yes and "N" nter the certifi 2. ter the certifi 2.	102,3 than the ost centers 'ision in ACA 'for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date	97 1.00 N N Y N N		3. 0	00	118. 02 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00
<ul> <li>118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.</li> <li>119. 00 D0 NOT USE THIS LINE</li> <li>120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in Enter in column 2, "Y" for yes or "N" for no.</li> <li>121. 00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.</li> <li>122. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included.</li> <li>17 Transplant Center Information</li> <li>125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126. 00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>127. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>128. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> </ul>	dule listing co d Harmless prov n column 1, "Y ualifies for th nts? (see instr antable devices Enter "Y" for he Worksheet A or yes and "N" nter the certifi 2. ter the certifi 2.	102,3 than the ost centers ' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date	97 1.00 N N Y N N		3. 0	00	118. 0. 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00 128. 00
<ul> <li>118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.</li> <li>119. 00 D0 NOT USE THIS LINE</li> <li>120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121. 00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no.</li> <li>122. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information</li> <li>125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126. 00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>128. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2</li> </ul>	dule listing co d Harmless prov n column 1, "Y ualifies for th nts? (see instr antable devices Enter "Y" for he Worksheet A or yes and "N" nter the certifi 2. ter the certifi 2. er the certific	102,3 than the post centers ' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date cation date i	97 1.00 N N Y N N		3. 0	00	118. 07 118. 07 118. 07 118. 07 118. 07 120. 00 121. 00 122. 00 125. 00 126. 00 126. 00 127. 00 128. 00 129. 00 130. 00
and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, end in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, e	dule listing co d Harmless prov n column 1, "Y ualifies for th nts? (see instr antable devices Enter "Y" for he Worksheet A cor yes and "N" nter the certifi 2. ter the certifi 2. ter the certifi 2. er the certifi 2. enter the certifi antable certific enter the certific	102,3 than the ost centers 'ision in ACA 'for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date cation date i tification	97 1.00 N N Y N N		3. 0	00	118. 02 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00 128. 00 129. 00

Health Financial Systems	SULLI VAN COUNTY CO	MMUNITY HOSPITA	AL.		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX		Provider CC			d:	Worksheet S-2	
				From	01/01/2016	Part I	
				То	12/31/2016	Date/Time Pre 5/26/2017 2:2	
					1.00	2.00	
133.00 If this is a Medicare certified oth			cation da	ate			133.00
in column 1 and termination date, i 134.00 If this is an organ procurement or			n column	1			134.00
and termination date, if applicable				'			134.00
All Providers							
140.00 Are there any related organization					Y		140.00
chapter 10? Enter "Y" for yes or "I				osts			
are claimed, enter in column 2 the 1.00	home office chain number.		ions)		3.00		
If this facility is part of a chain			uah 143 ti	he name ai		of the	
home office and enter the home offi						or the	
141.00Name:	Contractor's Name:		Contr	actor's N	lumber:		141.00
142.00 Street:	PO Box:						142.00
143. 00 Ci ty:	State:		Zip (	Code:			143.00
						1.00	-
144.00 Are provider based physicians' cos	ts included in Worksheet A	47				Y	144.00
						•	
					1.00	2.00	
145.00 If costs for renal services are cla					Ν	N	145.00
inpatient services only? Enter "Y"							
no, does the dialysis facility incl period? Enter "Y" for yes or "N" t		for this cost	reportinț	3			
146.00 Has the cost allocation methodology		isty filed cost	renort?		Ν		146.00
Enter "Y" for yes or "N" for no in				lf			
yes, enter the approval date (mm/de	d/yyyy) in column 2.						
						1.00	-
147 00 Was there a change in the statistic	al bacic2 Entor "V" for y	oc or "N" for	20			1.00 N	147.00
147.00 Was there a change in the statistic 148.00 Was there a change in the order of						N	147.00
149.00 Was there a change to the simplifie		2		for no.		N	149.00
	g	Part A	Part		Title V	Title XIX	
		1.00	2.00		3.00	4.00	
Does this facility contain a provi	der that qualifies for an	exemption from	n the app	lication	of the lowe	r of costs	
or charges? Enter "Y" for yes or "I 155.00 Hospi tal	N° TOT NO TOT EACH COMPON	ent tor Part A N	and Part N	B. (See 4	<u>42 CFR 9413</u> N	N N	155.00
156. 00 Subprovi der – TPF		N	N		N	N	156.00
157.00 Subprovider - IRF		N	N		N	N	157.00
158. 00 SUBPROVI DER							158.00
159.00 SNF		N	N		N	N	159.00
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
161.00 CMHC			N		N	N	161.00
						1.00	-
Multicampus							
165.00 Is this hospital part of a Multicar	npus hospital that has one	e or more campu	ises in di	fferent (	BSAs?	N	165.00
Enter "Y" for yes or "N" for no.							
-	Name	County	State	Zip Code		FTE/Campus	-
166.00 If line 165 is yes, for each	0	1.00	2.00	3.00	4.00	5.00	166.00
campus enter the name in column						0.00	100.00
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)							
						1.00	-
Health Information Technology (HIT)							
167.00 Is this provider a meaningful user	under §1886(n)? Enter ")	Y" for yes or "	N" for no	).		Y	167.00
168.00 If this provider is a CAH (line 10			e 167 is '	'Y"), ente	er the	(	168.00
reasonable cost incurred for the HI 168.01 If this provider is a CAH and is no			unal i for	for a har	dshi n		168. 01
exception under §413.70(a)(6)(ii)?					usin p		100.01
169.00 If this provider is a meaningful us	ser (line 167 is "Y") and				enter the	0.00	169.00
transition factor. (see instruction	ns)						

Health Financial Systems	SULLIVAN COUNTY COMM	IUNI TY HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 15-1327	Period: From 01/01/2016	Worksheet S-2 Part I	2
			To 12/31/2016		epared: 23 pm
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	ginning date and ending da	te for the reporting	01/01/2016	12/31/2016	170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provi	der have any days for indi	viduals enrolled in	N	(	171.00
section 1876 Medicare cost plans re					
"Y" for yes and "N" for no in colum		nter the number of section	n		
1876 Medicare days in column 2. (se	e instructions)				

leal th Fin	ancial Systems SULLIVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	eu of Form CMS	6-2552-1
HOSPI TAL A	ND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2016	Worksheet S- Part II	-2
				To 12/31/2016	Date/Time Pr	repared:
					5/26/2017 2:	23 pm
				Y/N	Date	_
Gen	eral Instruction: Enter Y for all YES responses. Enter M	for all NO re	snonses Ente	1.00	2.00	
	dd/yyyy format.		Sponses. Ente			
COM	PLETED BY ALL HOSPITALS					
	vider Organization and Operation			-	1	
	the provider changed ownership immediately prior to the			N		1.0
rep	orting period? If yes, enter the date of the change in o	column 2. (see			N/ /1	_
			Y/N 1.00	Date 2.00	V/I 3.00	_
. 00 Has	the provider terminated participation in the Medicare F	Drogram2 lf	1.00 N	2.00	3.00	2.0
yes	, enter in column 2 the date of termination and in colur untary or "I" for involuntary.		IN IN			2.0
	the provider involved in business transactions, includir	na management	N			3.0
con	tracts, with individuals or entities (e.g., chain home of	offices, drug				
	medical supply companies) that are related to the provid					
off	icers, medical staff, management personnel, or members o	of the board				
	directors through ownership, control, or family and othe	er similar				
rel	ationships? (see instructions)	-			-	_
			Y/N	Туре	Date	_
Ein	ancial Data and Deports		1.00	2.00	3.00	
	ancial Data and Reports umn 1: Were the financial statements prepared by a Cert	tified Public	Y	A		4.0
	ountant? Column 2: If yes, enter "A" for Audited, "C" 1		I I	A		4.0
	"R" for Reviewed. Submit complete copy or enter date ava					
	umn 3. (see instructions) If no, see instructions.					
	the cost report total expenses and total revenues diffe	erent from	N			5.0
tho	se on the filed financial statements? If yes, submit red	conciliation.				
				Y/N	Legal Oper.	_
				1.00	2.00	_
	roved Educational Activities umn 1: Are costs claimed for nursing school? Column 2:	If yoo io th		N		
	legal operator of the program?	TT yes, is tr	ie provider is	IN		6.0
.00 Are	costs claimed for Allied Health Programs? If "Y" see in	nstructions		N		7.0
	e nursing school and/or allied health programs approved		during the	N		8.0
	t reporting period? If yes, see instructions.		a dar ing the			
	costs claimed for Interns and Residents in an approved	graduate medic	cal education	Ν		9.0
pro	gram in the current cost report? If yes, see instruction	ns.				
	an approved Intern and Resident GME program initiated of	or renewed in t	the current	N		10.0
COS	t reporting period? If yes, see instructions.					
	GME cost directly assigned to cost centers other than I	I & R IN AN App	proved	N		11. C
Tea	ching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
Bad	Debts					
	the provider seeking reimbursement for bad debts? If yes	s, see instruct	tions.		Y	12.0
3.00 If	line 12 is yes, did the provider's bad debt collection p	oolicy change d	during this co	st reporting	N	13.0
per	iod?lfyes, submit copy.					
	line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	°yes, see ins	tructions.	N	14.0
	Complement				N	1 15 0
5. UU   UI d	total beds available change from the prior cost reporti		<u>yes, see inst</u> rt A		N N	15.0
		Y/N	Date	Y/N	Date	_
		1.00	2.00	3.00	4.00	-
PS&F	R Data	1.00	2.00	0.00	1.00	
	the cost report prepared using the PS&R Report only?	Y	03/13/2017	Y	03/13/2017	16.0
lf	either column 1 or 3 is yes, enter the paid-through					
dat	e of the PS&R Report used in columns 2 and 4 .(see					
	tructions)					
	the cost report prepared using the PS&R Report for	N		N		17.0
tot	als and the provider's records for allocation? If					
	her column 1 or 3 is yes, enter the paid-through date					
	columns 2 and 4. (see instructions)	N		N		18. (
in	ling 16 or 17 is yes were adjustments made to DCOD		1	IN		18.0
in B.00  f	line 16 or 17 is yes, were adjustments made to PS&R	IN IN				
8.00  in Rep	ort data for additional claims that have been billed					
8.00   f Rep but	ort data for additional claims that have been billed are not included on the PS&R Report used to file this					
8.00 If Rep but cos	ort data for additional claims that have been billed are not included on the PS&R Report used to file this t report? If yes, see instructions.	N		N		19.0
8.00   f Rep but cos 9.00   f	ort data for additional claims that have been billed are not included on the PS&R Report used to file this			N		19. C

Health Financial Systems

SULLI VAN	COUNTY	COMMUNI TY	HOSPI TAL

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1327	Peri od:	Worksheet S-2	2
				From 01/01/2016		
				To 12/31/2016	Date/Time Pro	
		Descri	ption	Y/N	Y/N	
		(	<u>,</u>	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	Ν		N		21.00
			•		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)			
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made duri	ng the cost	N	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	oorting period?	Ν	24.00		
25.00	Have there been new capitalized leases entered into during instructions.	lf yes, see	N	25.00		
26.00	Were assets subject to Sec.2314 of DEFRA acquired during t	he cost reporti	ng period? If	yes, see	Ν	26.00
27.00	instructions. Has the provider's capitalization policy changed during th	e cost reportin	a period? [f	ves submit	N	27.00
27.00	copy.	o ooot i opoi tiii	g por our ri	Joo! 000		
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	ntered into dur	ing the cost	reporting	N	28.00
29.00	Did the provider have a funded depreciation account and/or	eserve Fund)	Y	29.00		
30.00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	see	N	30.00		
31.00	instructions.	couper of now	dobt2 If yor	600	Y	31.00
31.00	Has debt been recalled before scheduled maturity without i instructions.		debt? IT yes,	see	T	31.00
32.00	Purchased Services Have changes or new agreements occurred in patient care se	nui coc furni cho	d through cor	tractual	N	32.00
32.00	arrangements with suppliers of services? If yes, see instr		a through cor	iti actual	IN	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertainin	g to competit	ive bidding? If		33.00
	no, see instructions.					
	Provi der-Based Physi ci ans		and the second		N	24.00
34.00	Are services furnished at the provider facility under an a If yes, see instructions.	rrangement with	provider-bas	sed physicians?	N	34.00
35.00	If line 34 is yes, were there new agreements or amended ex		its with the p	orovi der-based		35.00
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date	
				1.00	2.00	
	Home Office Costs					
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	repared by the	home office?			37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of			38.00
	the provider? If yes, enter in column 2 the fiscal year en	d of the home o	offi ce.			
39.00	If line 36 is yes, did the provider render services to oth see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the	home office?	lf yes, see			40.00
	instructions.					
		1.	00	2.	00	-
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	BRANDENBURG		BOB		41.00
	respectively.					
42.00	Enter the employer/company name of the cost report	BKD, LLP				42.00
12 00	preparer.	(217) 202 2707				42 00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 383-3787		BBRANDENBURG@B	ND. CUM	43.00

Heal th	Financial Systems SULLIV	AN COUNTY CO	OMMUNI TY HOSPI TAL	In Lie	eu of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUEST	I ONNAI RE	Provider CCN: 15-1327	Period: From 01/01/2016	Worksheet S-2 Part II	
				To 12/31/2016		pared: 3 pm
			3.00		-	
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/p	position	PARTNER			41.00
	held by the cost report preparer in columns 1,	2, and 3,				
	respecti vel y.					
42.00	Enter the employer/company name of the cost rep	port				42.00
	preparer.					
43.00	Enter the telephone number and email address of	f the cost				43.00
	report preparer in columns 1 and 2, respectivel	Iу.				

	Financial Systems SULL AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	IVAN COUNTY CON	Provider CC		Period:	u of Form CMS-2 Worksheet S-3	
HUSPII	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der CC	N: 15-1327	From 01/01/2016 To 12/31/2016	Part I	pared:
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00	21	7,68			1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			.,			
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,68			
8.00	INTENSIVE CARE UNIT	31.00	4	1, 46	4, 896. 00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	10.00					12.00
13.00	NURSERY	43.00	0.5	0.45	54 444 00	0	13.00
14.00	Total (see instructions)		25	9, 15	50 51, 144. 00		14.00
15.00 16.00	CAH visits					0	15.00 16.00
17.00	SUBPROVIDER - IPF SUBPROVIDER - IRF						17.00
17.00	SUBPROVIDER - TRF						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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P. )	101.00				l v	23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	30, 00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALI FIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Tri ps						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00

	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	F	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Pre 5/26/2017 2:2	pared
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		6.00	7.00	Patients 8.00	& Residents 9.00	Payrol I 10, 00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1, 261	70	2, 096		10.00	1.0
. 00	HMO and other (see instructions)	159	118				2.0
. 00	HMO I PF Subprovi der	0	0				3.0
. 00	HMO IRF Subprovider	0	0				4. C
. 00	Hospital Adults & Peds. Swing Bed SNF	361	0	36			5.0
. 00	Hospital Adults & Peds. Swing Bed NF		0	105	5		6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 622	70	2, 562	2	-	7.(
. 00	INTENSIVE CARE UNIT	126	15	205	5		8.0
00	CORONARY CARE UNIT						9.
0. 00	BURN INTENSIVE CARE UNIT						10.
1. 00	SURGI CAL INTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY		150	232			13.
4.00	Total (see instructions)	1, 748	235	2, 999	0.00	199.65	
5.00	CAH visits	0	0	(	)		15.
6. 00	SUBPROVIDER - IPF						16.
7.00	SUBPROVIDER - IRF						17.
3. 00	SUBPROVIDER						18.
9.00	SKILLED NURSING FACILITY						19.
0.00	NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE	0.0/5					21.
2.00	HOME HEALTH AGENCY	3, 065	32	4, 218	0.00	7.02	
3.00	AMBULATORY SURGICAL CENTER (D. P. )						23.
4.00				,			24.
4.10	HOSPICE (non-distinct part)	0	0	(			24.
5.00	CMHC - CMHC	0			0.00	0.00	25.
5.00	RURAL HEALTH CLINIC	0	0	(		0.00	
5.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	l		0.00	
7.00	Total (sum of lines 14-26)		254	1 02	0.00	206.67	27. 28.
9.00 9.00	Observation Bed Days	0	254	1, 932	2		28.
	Ambul ance Trips	0		1'			
0.00	Employee discount days (see instruction)			12			30.
1.00	Employee discount days - IRF	o	_				31.
2. 00 2. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room	0	0	15 (			32. 32.
	outpatient days (see instructions)				1		1

	Financial Systems SULL AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	<u>IVAN COUNTY COM</u>	Provider C		Period: From 01/01/2016 To 12/31/2016		pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT		0	43		763	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY	0. 00	0	43	31 12	763	11. 00 12. 00 13. 00
21.00 22.00 23.00 24.00 24.10 25.00	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0. 00					21.00 22.00 23.00 24.00 24.10 25.00
26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	RURAL HEALTH CLINIC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0.00 0.00 0.00					23.00 26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01 33.00

		LIVAN COUNTY CON				u of Form CMS-2	
HOME F	IEALTH AGENCY STATI STI CAL DATA			CN: 15-1327 CCN: 15-7542	Period: From 01/01/2016 To 12/31/2016	Worksheet S-4 Date/Time Pre	pared:
					Home Health	5/26/2017 2:2 PPS	<u>s pili</u>
					Agency I		
0.00	County			-	1.	00	0.00
0.00	county	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	2, 281		0 0	2, 281	
2.00	Unduplicated Census Count (see instructions)	0.00	110.00		0.00 0.00 0.00 0.00	0.00	2.00
		Enter the numbe	er of hours in	Staff	Contract	Total	
		your normal	work week				
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00			2.00	1
4.00	Director(s) and Assistant Director(s)			0.0		0.00	1
5.00 6.00	Other Administrative Personnel Direct Nursing Service			0.0		0.00 2.05	1
7.00	Nursi ng Supervi sor			0.0		0.00	
8.00	Physical Therapy Service			1.4	42 0.00	1.42	8.00
9.00	Physical Therapy Supervisor			0. (		0.00	1
10.00	Occupational Therapy Service			0.4		0.40	
11.00 12.00	Occupational Therapy Supervisor Speech Pathology Service			0.0		0.00 0.04	1
13.00	Speech Pathology Supervisor			0.0		0.00	1
14.00	Medical Social Service			0. (			14.00
15.00	Medical Social Service Supervisor			0.0			15.00
16.00	Home Health Aide			1.			16.00
17.00 18.00	Home Health Aide Supervisor Other (specify)			0.0		0.00 0.00	1
16.00	HOME HEALTH AGENCY CBSA CODES			0.0	0.00	0.00	10.00
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost				2		19.00
	reporting period.						
20.00	List those CBSA code(s) in column 1 serviced			45460			20.00
	during this cost reporting period (line 20						
20. 01	contains the first code).			99915			20.01
20.01	<u> </u>	Full Ep	i sodes	///13			20.01
			With Outliers	LUPA Epi sode	es PEP Only	Total (cols.	
		Outliers		0.00	Epi sodes	1-4)	
	PPS ACTIVITY DATA	1.00	2.00	3.00	4.00	5.00	
21.00	Skilled Nursing Visits	998	<u>ς</u>		17 9	1, 033	21.00
22.00	Skilled Nursing Visit Charges	142, 537	1, 279	2, 42	23 1, 287	147, 526	22.00
23.00	Physical Therapy Visits	892	21		14 14	941	
24.00 25.00	Physical Therapy Visit Charges Occupational Therapy Visits	151, 613 341	3, 570 13		53 2, 380 2 3	159, 916 359	
26.00	Occupational Therapy Visits	57, 970	2, 210		40 510	61, 030	
27.00	Speech Pathol ogy Vi si ts	27	2, 210	3	0 0	30	
28.00	Speech Pathology Visit Charges	4, 455	495		0 0	4, 950	
	Medical Social Service Visits	0	C		0 0	0	1
29.00		0	C 16		0 0 2 13	0 764	
30.00	Medical Social Service Visit Charges	7221			- 13	704	1 01.00
	Home Health Aide Visits	733 64, 504	1, 408		76 1, 144	67.232	32.00
30. 00 31. 00				3 1	76 1, 144 35 39	67, 232 3, 127	
30. 00 31. 00 32. 00 33. 00	Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	64, 504	1, 408	3 1		3, 127	33.00
30. 00 31. 00 32. 00 33. 00 34. 00	Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges	64, 504 2, 991 0	1, 408 62 0		35 39 0 0	3, 127 0	33.00 34.00
30. 00 31. 00 32. 00 33. 00	Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28,	64, 504	1, 408		35 39 0 0	3, 127	33.00 34.00
30. 00 31. 00 32. 00 33. 00 34. 00	Home Health Aide Visits Home Health Aide Visits Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) Total Number of Episodes (standard/non	64, 504 2, 991 0	1, 408 62 0	3 1 2 5, 20	35 39 0 0	3, 127 0	33.00 34.00 35.00
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	64, 504 2, 991 0 421, 079	1, 408 62 0	3 11 2 5, 20 2 5, 20	35 39 0 0 92 5, 321	3, 127 0 440, 654 160 0	<ul> <li>33. 00</li> <li>34. 00</li> <li>35. 00</li> <li>36. 00</li> </ul>

Heal th	Financial Systems SULLIVAN COUNTY COMM	UNI TY HOSPI TA	AL	In Lie	eu of Form CMS-:	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-1327	Peri od:	Worksheet S-1	0
				From 01/01/2016 To 12/31/2016		nared
				10 12/31/2010	5/26/2017 2:2	
	Uncompared and indigent ease east computation				1.00	
1.00	Uncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by li	ne 202 colum	8)	0. 328450	1.00
1.00	Medicaid (see instructions for each line)	I vided by II		1 0)	0. 320430	1.00
2.00	Net revenue from Medicaid				3, 516, 642	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplement	al payments	from Medicaid	1?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments fr	om Medicaid			152, 848	5.00
6.00	Medi cai d charges				25, 797, 252	6.00
7.00	Medicaid cost (line 1 times line 6)				8, 473, 107	7.00
8.00	Difference between net revenue and costs for Medicaid program	(line 7 min	us sum of lir	nes 2 and 5; if	4, 803, 617	8.00
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions	for each line	e)			1
9.00	Net revenue from stand-al one CHIP				0	
	Stand-alone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP	(lipo 11 mi	nuc lino 0, i	f , zoro thon		
12.00	enter zero)		nus i i ne 9, i		0	12.00
	Other state or local government indigent care program (see in	structions fo	or each line)			
13.00	Net revenue from state or local indigent care program (Not in				2, 189, 410	1 13.00
14.00	Charges for patients covered under state or local indigent ca				10, 693, 040	•
	10)					
	State or local indigent care program cost (line 1 times line				3, 512, 129	•
16.00	Difference between net revenue and costs for state or local i	ndigent care	program (lin	ne 15 minus line	1, 322, 719	16.00
	13; if < zero then enter zero)					
17.00	Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to	funding char	ity caro		0	17.00
	Government grants, appropriations or transfers for support of				0	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and Loc			(sum of lines	6, 126, 336	
17.00	8, 12 and 16)	ar margent	cure program		0, 120, 000	17.00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
	Charity care charges for the entire facility (see instruction		438, 50			
	Cost of patients approved for charity care (line 1 times line	20)	144, 0			
	Partial payment by patients approved for charity care		32, 0			•
23.00	Cost of charity care (line 21 minus line 22)		111, 9	2, 019, 660	2, 131, 636	23.00
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patie	nt days beyo	nd a length o	of stay limit		24.00
	imposed on patients covered by Medicaid or other indigent car		5	5		
25.00	If line 24 is "yes," charges for patient days beyond an indi	gent care pr	ogram's leng <sup>+</sup>	h of stay limit	0	25.00
	Total bad debt expense for the entire hospital complex (see i				20, 398, 742, 307	
27.00	Medicare bad debts for the entire hospital complex (see instr				694, 656	
	Non-Medicare and non-reimbursable Medicare bad debt expense (				20, 398, 047, 651	
	Cost of non-Medicare and non-reimbursable Medicare bad debt e	xpense (line	1 times line	28)	6, 699, 738, 751	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				6, 701, 870, 387	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	II ne 30)			6, 707, 996, 723	31.00

CLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CC		Peri od:	Worksheet A	
					From 01/01/2016 To 12/31/2016	Date/Time Pre 5/26/2017 2:23	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	- 1			1		4
00	00100 NEW CAP REL COSTS-BLDG & FIXT		608, 501	608, 501		608, 501	1.
00	00200 NEW CAP REL COSTS-MVBLE EQUIP	12/ 200	949, 459	949, 459		949, 459	
00	00400 EMPLOYEE BENEFITS DEPARTMENT	136, 200	4,036,253	4, 172, 453		4, 172, 453	
D1 D2	00550 I S/ACCOUNTI NG/MARKETI NG 00540 BUSI NESS OFFI CE & ADMI TTI NG	574, 549 725, 983	753, 330 340, 449	1, 327, 879 1, 066, 432		1, 147, 263	
)2 )3	00560 OTHER ADMINISTRATIVE AND GENERAL	156, 941	1, 935, 342	2, 092, 283		1, 066, 432 2, 092, 283	
)) )()	00700 OPERATION OF PLANT	426, 947	633, 784	1, 060, 731		1, 060, 731	7.
00	00800 LAUNDRY & LINEN SERVICE	43, 177	30, 169	73, 346		73, 346	
00	00900 HOUSEKEEPI NG	354, 583	47, 444	402, 027		402, 027	9.
00	01000 DI ETARY	332, 194	227, 453	559, 647		559, 647	
00	01100 CAFETERI A	0	0	(		0	
	01300 NURSING ADMINISTRATION	388, 641	54, 225	442, 866	6 0	442, 866	
	01400 CENTRAL SERVICES & SUPPLY	132, 554	8, 208	140, 762		140, 762	
00	01500 PHARMACY	366, 386	1, 010, 797	1, 377, 183		1, 377, 183	
00	01600 MEDICAL RECORDS & LIBRARY	358, 756	32, 436	391, 192	2 0	391, 192	16.
00	01900 NONPHYSICIAN ANESTHETISTS	0	584, 000	584, 000	0 0	584, 000	19.
	INPATIENT ROUTINE SERVICE COST CENTERS						
00	03000 ADULTS & PEDIATRICS	1, 587, 403	73, 573	1, 660, 976	6 426, 667	2, 087, 643	
	03100 I NTENSI VE CARE UNI T	459, 724	15, 702	475, 426		475, 426	
00	04300 NURSERY	0	0		92, 886	92, 886	43.
	ANCILLARY SERVICE COST CENTERS						
00	05000 OPERATI NG ROOM	683, 144	288, 675	971, 819		846, 234	
00	05200 DELIVERY ROOM & LABOR ROOM	497, 116	34, 756	531, 872		12, 319	
00	05300 ANESTHESI OLOGY	0	3, 826	3, 826		3, 826	
00	05400 RADI OLOGY-DI AGNOSTI C	587, 332	383, 535	970, 867		967, 013	
01	05401 ULTRASOUND	0	232, 600	232, 600		232, 600	
00	05600 RADI OI SOTOPE	0	102, 988	102, 988		102, 988	
00		620, 781	832, 073	1, 452, 854		1, 452, 854	
00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	44, 588 30, 733	44, 588 30, 733		44, 588 30, 733	
00	06500 RESPIRATORY THERAPY	446, 137	30, 733 88, 440	534, 577		506, 145	
00	06600 PHYSI CAL THERAPY	668, 892	18, 686	687, 578		687, 578	
01	06601 SPORTS THERAPY	000, 072	10, 000	007, 570		087, 578	66
00	06700 OCCUPATI ONAL THERAPY	114, 703	1, 291	115, 994		115, 994	
00	06800 SPEECH PATHOLOGY	65, 764	684	66, 448		66, 448	
	07000 ELECTROENCEPHALOGRAPHY	03,704	3, 710	3, 710		3, 710	
	07001 CARDI OPULMONARY	49, 224	4, 893	54, 117		54, 117	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	214, 376	214, 376		372, 247	
00	07200 IMPL. DEV. CHARGED TO PATIENT	0	147, 983	147, 983		147, 983	
00	07300 DRUGS CHARGED TO PATIENTS	0	0	. (		0	
	OUTPATIENT SERVICE COST CENTERS	i					1
00	08800 RURAL HEALTH CLINIC	0	0	(	0 0	0	88
00	09000 CLI NI C	0	0	(	0 0	0	90.
01	09001 JV CLINIC	0	0	(	0 0	0	90.
	09100 EMERGENCY	862, 424	600, 744	1, 463, 168	3 0	1, 463, 168	91.
00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
1.00	10100 HOME HEALTH AGENCY	432, 546	63, 452	495, 998	3 0	495, 998	101
	SPECIAL PURPOSE COST CENTERS	- I			1		4
3. 00	· _ /	11, 072, 101	14, 439, 158	25, 511, 259	9 – 180, 616	25, 330, 643	1118.
	NONREI MBURSABLE COST CENTERS						1.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1(0,005	1/0 000			190
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	168, 335	168, 335	5 17, 965	186, 300	
	19201 MS0 CLINICS	0	0	(			192
		0	0	(			192
	07950 MEALS ON WHEELS	0	0	(			194.
	07951 GUEST MEALS	0	0	(	0 1		194.
	07952 MARKETI NG		~	-	0 162, 651	162, 651	101

Provider CCN: 15-1327

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

Cost Center Description         Adjustments         Mark Expenses         1.02/26/2017.2.2.1 mm           Cost Center Description         6.00         7.00         7.00         7.00           Cost Center Description         6.00         7.00         7.00         7.00           Cost Center Description         7.00         7.00         7.00         7.00           Cost Center Description         7.00         7.00         7.00         7.00           Cost Center Description         7.00         7.00         7.00         7.00         7.00           Cost Center Description         7.00<						ime Prepared:
ENERGY CE COST CENTERS         6.00         7.00           1000 DUTION INF CAP ARL CASTS FLUES & LINE A         12,000         627,201         1.00           1000 DUTION INF CAP ARL CASTS FLUES & LINE A         12,000         627,201         1.00           1000 DUTION INF CAP ARL CASTS FLUES & LINE A         13,0174         3.042,277         5.01           100 DOSOD IS/ACCOUNT NOLVARKET ING         -1,330,174         3.042,277         5.03           100 DOSOD DURINES OFFICE A ADMITTINO         0         1.006,432         5.02           100 DOSOD DURINES OFFICE A ADMITTINO         -1,20,20         1,342,277         5.03           100 DOSOD DURINES OFFICE         0         402,027         0         0           100 DOSOD DURINES OFFICE         0         402,027         0         0         0           11:00 DURING CAPETRIA A         -121,210         -121,210         110,00         1100		Cost Center Description	Adjustments	Net Expenses	5/20/2	<u>517 2.25 pm</u>
CREAR         STRUCT COST CENTERS           1.00         001000 MER CAP REL COSTS-MUDE EQUIP         -80.048         689.411         2.00           2.01         00200 NER CAP REL COSTS-MUDE EQUIP         -80.048         689.411         2.00           2.01         00200 NER CAP REL COSTS-MUDE EQUIP         -80.048         689.411         2.00           2.02         00200 NER CAP REL COSTS-MUDE EQUIP         -80.048         689.411         2.00           3.02         00200 NER CAP REL COSTS-MUDE EQUIP         -80.048         689.411         2.00           3.02         00200 NER AMIN SISTATIVE AND INFORMATIVE AND INFORMAL         -710.200         1.302.077         5.03           3.00         00200 AURRY & LINEN SERVICE         0         7.346         8.00         9.00           9.00         00200 AURRY & LINEN SERVICE         1.217.270         10.100         11.00         <						
1.00         00100 NEW CAR REL COSTS-BLOB & FIXT         13.800         622.301         1.00           2.00         00200 NEW CAR REL COSTS-MULE BULP         -80.048 809,411         2.00           1.00         00400 (IMPLOYLE BREH ITS MPARTHENI         -1,130,714         3.042,279         4.00           5.01         00550 (IMPLOYLE BREH ITS MPARTHENI         -1,130,714         3.042,279         4.00           5.03         00560 (IMPLOYLE BREH ITS MPARTHENI         -1,130,714         3.042,279         5.03           5.03         00560 (IMPLOYLE BREH ITS MPARTHENI         -1,132,05         5.03         7.00           0.00         00560 (IAUNEXY & LINEN SERVICE         0         7.3,366         8.00         9.00 <td< td=""><td></td><td>GENERAL SERVICE COST CENTERS</td><td>6.00</td><td>7.00</td><td></td><td></td></td<>		GENERAL SERVICE COST CENTERS	6.00	7.00		
1.00     00400 EMPLOYE BENEFITS DEPARTMENT     -1,10,174     3,042,279     4.00       5.01     00550 USACDUNT HAVARAKETIN     -9,006     1,382,277     5.01       5.02     00540 USANESS OFFICE & AMINITING     -9,006     1,382,277     5.03       5.01     00550 UFER ADM INTERSTIT CONSTRUCT     -1,320     1,037,524     7.00       5.01     00550 UFER ADM INTERSTIT CONSTRUCT     -0,006     4.00     5.02       5.01     00500 UFER ADM INTERSTIT     EPANT     -13,205     7.01       5.02     001000 DIFTAR     FANT     -121,210     10.00       11.00     01000 DIFTAR ADM INTSTATION     -20,352     422,514     13.00       11.00     01000 DIFTAR ADM INTSTATION     -20,352     422,514     13.00       15.00     01500 PARABACY     -3,434     1,373,749     16.00       16.00     01500 UNINSING CAND ADSTATISTS     -564,000     0     16.00       17.00     01900 ONORPHOLICAL RECORDS & LIBRARY     -0,906     394,226     30.00       19.00     10300 INTERSIN WIG CARE UNIT     0     2,057,454     43.00       10.00     01000 DIFRALTING INFORME SERVICE COST CENTERS     -0     0     0.00       00     03000 INTERSIN WIG CARE UNIT     0     2,057,454     43.00       10.0	1.00		13, 800	622, 301		1.00
9. 01         00550 [SACCOUNT ING/MARKET ING         -9.000         1,138,257         5.01           02         00560 [OTHER AKIN INSTRATI LE ALMIN TITING         -710,206         1,382,277         5.03           0.0000 [DERATION OF PLANT         -13,202         1,382,277         5.03           0.00000 [DERATION OF PLANT         -13,202         73,346         6.00           0.00000 [DERATION OF PLANT         -13,202         73,346         6.00           0.00000 [DERATION OF PLANT         -13,202         73,346         6.00           0.00000 [DIANNEN ALMINISTRATI EN MOLETING         -20,352         422,514         13.00           0.0000 [DIANNEN ALMINISTRATI EN MOLETING         -20,352         422,514         13.00           1.000 [DIANNEN ALMINISTRATION         -20,352         422,514         13.00           1.000 [DIANNEN ALMINISTRATION         -504,600         34.00         16.00	2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-80, 048	869, 411		2.00
9. 02       00540 UUSINESS OFFICE & ADMITTING       0       1.060, 432       5. 03         0.03       00700 OFFER ADMINISTRATIVE AND GENERAL       -710, 206       1.382, 077       5. 03         7. 00       00700 OFFER ADMINISTRATIVE AND GENERAL       -710, 206       1.382, 077       5. 03         0.03       00700 OFFER ADMINISTRATIVE AND GENERAL       -710, 206       1.332, 046       8. 00         0.00       00700 OFFER ADMINISTRATIVE AND GENERAL       -710, 206       4.22, 027       9. 00         0.00       00700 OFFER ADMINISTRATION       -721, 210       1.330, 01       110, 00         11.00       01500 NURSIN GADMINISTRATION       -721, 213, 01       113, 00       114, 00         11.00       01500 OFFERATURINSTRATION       -721, 213, 01       113, 00       116, 00         11.00       01500 PHARAMINISTRATION       -721, 213, 01       110, 00       110, 00         11.00       01500 NURSING WELLCAL RECORDS & LIBRARY       -5, 94, 000       0       15, 00         11.00       01500 NURSING WELLCAL RECORDS & LIBRARY       -5, 94, 000       0       10, 00         11.00       01500 OFFEATING ROBA RECORD T       0       2, 667, 643       50, 00         10.00       01500 OFFEATING ROBA RECORD T       0       2, 2866 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
9. 03       00500 OTHER AND IN STRATURE AND GENERAL       -710, 206       1, 382, 077						
7. 00         00702 0FEBATION OF FLANT         -13, 205         1, 047, 526         7, 00           8. 00         00800 LUNRY & LINN SERVICE         0         7, 00         9,			-			
8.00         000000 LAUNORY & LINEN SERVICE         0         73, 346         8.00           9.00         00000 DUESKEPF NOLSKEPF NOL						
9.00         00000 HULSERSEPING         0         402, 027         9.00           10.00         01000 CAFETERIA         -121, 210         121, 210         10.00           11.00         01100 CAFETERIA         -121, 210         121, 210         13.00           13.00         01400 CAFETERIA         -20, 352         422, 514         13.00           14.00         01400 CANTRAL SERVICES & SUPPLY         -2, 386         138, 376         15.00           15.00         01400 CONTRAL SERVICES & SUPPLY         -3, 434         1, 373, 749         16.00           10.00         01400 CONTRAL SERVICES & COST CENTERS         -564, 000         19.00         19.00           30.00         03000 ADULTS A FEDIATING COST CENTERS         -564, 000         31.00						
10.00       01000       DI CHETERI A       1.0.0       110.00 <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td>			-			
13.00       01300       NUESING ADMINISTRATION       -20, 352       422, 514       13.00         14.00       01400       CHTRAL SERVICES & SUPPLY       -23, 366       138, 376       14.00         15.00       01500       PHARMACY       -3, 434       1, 373, 749       15.00         16.00       01600       NECONFECT       -584, 000       0       16.00         17.00       NEMPARCINES       -584, 000       0       19.00         NEMPARCINE ROUTINE SCRIVE COST CENTERS       -0       2,087, 442       30.00         30.00       03000 ADULTS & PEDIATRICS       0       47,542       31.00         30.00       05500 DELIVERY NOR & LABOR ROM       0       846, 234       55.00         50.00       05500 DELIVERY NOR & LABOR ROM       0       232, 600       54.01         54.00       054.00       DELIVERY NOR NERSUM       55.00       56.00         54.00       054.00       DELIVERY NOR NERSUM       64.00       66.00       66.00         66.00       06000 LABORATORY       0       3.23       66.00       66.00       66.00         66.00       06000 LABORATORY       0       0.232, 600       54.01       56.00       56.00         50.00       <			0			
14.00     01400     CENTRAL SERVICES & SUPPLY     -2,386     138,376       15.00     01500     PHARMACY     -3,441     1,37,3749       16.00     01500     PHARMACY     -6,966     384,226       10.01     01000     ONDENTRY CLAIL RECORDS & LIBRARY     -6,966     384,226       10.01     0100     ONDENTRY CLAIL RECORDS & LIBRARY     -6,966     384,226       10.01     0100     ONDENTRY CLAIL RECORDS & LIBRARY     -6,966     384,226       11.00     03100     INTERSIVE CARE UNIT     0     475,424     31.00       31.00     03100     INTERSIVE CARE UNIT     0     92,086     43.00       MACILLARY SERVICE COST CENTERS     0     0     12,219     52.00       52.00     DISJOO DELUTERY NOM & LABOR NOM     0     12,219     52.00       53.00     DISJOO DELUTERY NOM & LABOR NOM     0     12,219     53.00       54.00     DISJOO DELUTERY NOM & LABOR NOM     0     12,219     53.00       54.00     DISJOO DELUTERY NOM & LABOR NOM     0     12,214     50.00       55.01     DISJOO DELUTERY NOM & LABOR NOM     0     12,214     50.00       56.01     DISJOO DELUTERY NOM & LABOR NOM     0     12,214     50.00       56.01     DISJOO DELUTERY NO	11.00	01100 CAFETERI A	-121, 210	-121, 210		11.00
15. 00     01500     PHARMACY     -3, 434     1, 373, 749     15. 00       16. 00     1000     NECORES & LIBRARY     -6, 966     34, 226     16. 00       19. 00     11900     NEMPHYSICIAN ANESTHETISTS     -584, 000     0     19. 00       19. 00     11900     NEMPHYSICIAN ANESTHETISTS     -584, 000     0     30. 00       30. 00     33000     AULTS & PEDIATRICS     0     2, 087, 443     30. 00       31. 00     015000     INFERSIVE CARE UNIT     0     475, 426     31. 00       43. 00     MARCILLARY SERVICE COST CENTERS     92, 886     55. 00     55. 00       50. 00     05000     DELIVERY ROM & LABOR ROM     0     12, 319     52. 00       52. 00     05000     DELIVERY ROM & LABOR ROM     0     232, 600     54. 01       54. 00     DS400     NAULDICSCY-LARONSTIC     -1, 400     965, 513     54. 01       54. 00     DS400     DAULOSCY-LARONSTIC     -3, 100     54. 01     56. 00       66. 00     06000     LABORTORY     0     30, 733     64. 00       66. 00     06000     LABORTORY     0     30, 733     64. 00       66. 00     06000     MESPHATORY     0     0, 733     64. 00       66. 00						
16:00       01600 MEDICAL RECORDS & LIBRARY       -6,966       384,226       16.00         10:00       1000 MORPHYSICL TAL AMESTHETSTS       -584,000       0       19.00         10:00       03000 ADULTS & PEDIATRIC S       0       2,087,643       31.00       30.00         31:00       03000 INTERSIVE CARE UNIT       0       475,4286       43.00       43.00         AND DELS REVICE COST CENTERS       0       9,2,087,643       31.00       31.00       30.00       31.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       52.00       052.00 OPERATING ROOM       0       12,319       52.00       53.00       53.00       53.00       53.00       53.00       53.00       54.01       54.01       55.00       56.00       5						
19:00   01900   NOPPHYSI CLAN. ANESTHET ISTS       -584,000   0        19:00         10:00   02000   ADULTS & PEDI ATRI CS       0       20:00   02000   ADULTS & PEDI ATRI CS       30:00         30:00   0100   NTERSI VE CARE UNI T       0       475,426   33:00       31:00         30:00   0100   NTERSI VE CARE UNI T       0       92,886   34:00       43:00         AMACILLARY SERVICE COST CENTRES       92,886   34:00       50:00       52:00         50:00   05000   PELI VEPK PROM & LABOR ROOM       0       14:2,319   52:00       53:00       53:00         50:00   05000   PROI OLGY OF IVAR SUDARD ROOM       0       12:2,319   52:00       54:00       54:00         50:00   05000   PROI OLGY OF IVAR SUDARD ROOM       0       12:2,319   52:00       54:00       56:00         50:00   05000   PROI OLGY OF IVAR SUDARD ROOM       0       12:2,319   56:00       56:00       56:00         50:00   05000   PROI OLGY OF IVAR SUDARD ROOM       0       12:2,319   56:00       56:00       56:00         50:00   02:00 STORI NG, PROCESSING & TRANS.       0       14:4,588   56:00       56:00       56:00         60:00   04:00   NTRAI SVE PRAY       0       56:01       56:00       56:00       56:00       56:00       56:00       56:00       56:00       56:00       56:00       56:00						
INPATIENT ROUTINE SERVICE COST CENTERS						
10.00       0.0000 (ADULTS & PEDIATRICS       0       2.087,643       30.00         31.00       0.010 (INTERS) VE CARE UNI T       0       475,426       31.00         43.00       0.000 (INTERS) VE CARE UNI T       0       92,886       43.00         AMCULARY SERVICE COST CENTERS       50.00       0.0000 (PEDIATING KOOM & LADOR ROOM 0       12,319       50.00       52.00       52.00       52.00       52.00       52.00       52.00       52.00       52.00       52.00       53.00       0.000 (RADIOLOCY-DIACNOSTIC - 1.400       945,613       54.00       54.00       54.00       54.00       56.00	19.00		-384,000	0		19.00
11.00       03100       INTENSIVE CARE UNIT       0       475,426       31.00         03.00       04300       NURSERY       0       92,886       43.00         AACULLARY SERVICE COST CENTERS       0       050.00       050.00       050.00       550.00       55.00       56.00 <td>30.00</td> <td></td> <td>0</td> <td>2,087,643</td> <td></td> <td>30.00</td>	30.00		0	2,087,643		30.00
ANCILLARY SERVICE COST CENTERS	31.00		0	475, 426		31.00
50.00         050.00         0FERATING ROOM         0         846,234         50.00           52.00         052000         DELIVERY ROOM & LABOR ROOM         0         3.239         52.00           53.00         05400         DESOD DELIVERY ROOM & LABOR ROOM         0         3.236         53.00           54.00         05400         DESOD RADIOLORY-DIA GROSTIC         -1,400         965.613         54.01           54.01         05401         ULTRASOUND         0         232,600         54.01           55.00         05600 RADIOLORY-DIA GROSTIC         0         102,988         66.00           0.00         DEADOR LABORATORY         0         30,733         64.00           0.00         DEADOR JITRAREVANDUS THERAPY         0         667.578         66.00           0.00         DECOLOPYISI CLITHERAPY         0         67.578         66.00           0.00         DECOLOPYISI CLITHERAPY         0         67.00         67.00         67.00           0.00         DECOLOPYISI CLITHERAPY         0         0         70.00         70.00         70.00           0.00         0         0.00         0.00         0.00         70.00         70.00         70.00         70.00         70.00 <td>43.00</td> <td></td> <td>0</td> <td>92, 886</td> <td></td> <td>43.00</td>	43.00		0	92, 886		43.00
52.00         IOS200         DELIVERY ROMA & LABOR ROM         0         12.19         52.00           53.00         OS300 ANESTHESIOLGY         0         3.826         53.00           54.01         05400 RADIGUEY-DLAGNOSTIC         -1,400         965,613         54.00           54.01         05401 ULTRASDUND         0         222,600         54.01           56.00         05600 RADIGUEY         0         102,988         56.00           60.00         06000 BLODO STOPE         0         102,988         63.00           61.00         06000 BLODO STORING, PROCESSING & TRANS.         0         44,588         63.00           64.00         06400 INTRAVENOUS THERAPY         0         506,145         65.00           66.00         06000 RESPIRATORY THERAPY         0         67.00         67.00         66.00           66.01         06000 SPEECH PATHOLOGY         0         0         70.00         70.00           67.00         06700 OCLUPATI ONAL THERAPY         0         3.710         70.00           70.00         07000 ELECTRENECHALCOGRAPHY         0         3.710         70.00           70.00         07000 ELECTRENECHALDCOGRAPHY         0         3.710         72.00           70.00<			T	1	1	
53.00       NESTHESI OLOGY       0       3.826       53.00         54.00       OS400 RADI CLOSY- DLAGNOSTI C       -1,400       965,613       54.00         54.01       OS401 ULTRASOUND       0       232,600       54.01         56.00       OS600 RADI CLOSY- DLAGNOSTI C       -1,400       965,613       56.00         56.00       OS600 RADI OLSOTOPE       0       102,988       56.00         60.00       OS000 LABORATORY       3.133       1,455,987       60.00         63.00       OS000 INTRAVENUS THERAPY       0       30.733       64.00         64.00       OS00 PHYSI CLI THERAPY       0       30.733       64.00         66.01       OS00 OCOUPATI SCAL THERAPY       0       667,578       66.00         66.00       OS00 OCUPATI SCAL THERAPY       0       15,994       66.01         67.00       OS000 SPECE PATHOLOGY       0       66.448       68.00         70.00       OTOOD CLEATORENCEPHALOGRAPHY       0       54,117       70.01         71.00       OTOOD CLEATORENCEPHALOGRAPHY       0       147,983       72.00         73.00       OTOOD MULAS LES CHARGED TO PATI ENTS       -1,193       371,054       72.00         72.00       OTOOD MUL			-			
54.00     054.00     RADI OLOCY-DI AGNOSTI C     -1,400     965,613     54.01       54.01     054.01     054.01     0     232,600     54.01       56.00     060.00     060.00     060.00     0000     LABORATORY     60.00       60.00     060.00     0000     0000     0000     0000     60.00       61.00     060.00     0000     0000     000     64.00     60.00       62.00     06500     RESPI RATORY     1455,987     60.00       63.00     06600     000     66.01     66.00     66.00       64.00     000     000     00     66.01     66.01       66.01     06600     PHYSI CAL THERAPY     0     67.78     66.00       60.00     000     0     0     66.01     66.01       61.01     06600     SPECET PATHOLOCY     0     0     64.00       70.00     0700     CETROENCEPHALOGRAPHY     0     3,710     70.00       71.00     07001     CAROLOPULMONARY     -1,193     37,1054     71.00       72.00     07200     INPL. DEV. CHARGED TO PATI ENTS     0     0     72.00       73.00     0000     0000     0     0     0     0 <t< td=""><td></td><td></td><td>-</td><td></td><td></td><td></td></t<>			-			
54.01       05401       ULTRASOUND       0       232,600       54.01         60.00       06000       LABORATORY       0       102,998       56.00         60.00       063.00       06400       INTRAVENUS THERAPY       0       30,733       64.00         61.00       06400       INTRAVENUS THERAPY       0       30,733       64.00         65.00       06500       PESPIRATORY THERAPY       0       667,578       66.00         60.00       06600       PNSICAL THERAPY       0       67,00       66.00       66.00         60.00       06600       PHSICAL THERAPY       0       687,578       66.00         61.00       06600       PHSICAL UNAL THERAPY       0       115,994       67,00         62.00       06800       SPECH PATHOLOGY       0       66,448       67,00         63.00       070.00       07000 ELECTROENCEPHALOGRAPHY       0       3,110       70.01         70.00       07000 ELECTROENCEPHALOGRAPHY       0       147,983       72.00       73.00         70.00       07000 ELECTROENCEPHALOGRAPHY       0       147,983       72.00       73.00       00       90.01       90.01       90.01       90.01       90.00			e e e e e e e e e e e e e e e e e e e			
56.00         05600         RADIO I SOTOPE         0         102, 988         56.00           60.00         06000         LABORATORY         3, 133         1, 455, 987         60.00           63.00         06300         BLODD STORING, PROCESSING & TRANS.         0         44, 588         63.00           64.00         06400         INTRAVENOUS THERAPY         0         30, 733         64.00           65.00         06500         RSPI RATORY THERAPY         0         506, 145         65.00           66.01         06610         06600         PHYSI CAL THERAPY         0         67.00         66.00           66.01         066700         DCUPATI ONAL THERAPY         0         115, 994         67.00           68.00         06600         SPECH PATHOLOGY         0         3, 710         70.00           70.00         70.00         GUIDARY         0         3, 710         71.00           71.00         7000 LIDCETRONCEPHALOGRAPHY         0         54, 117         70.01           71.00         7000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         -1, 193         371, 054         72.00           73.00         0000 OSUNAL HEALTALCLINIC         0         0         0         90.00         90.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
60.00         06000         LABORATORY         3, 133         1, 455, 987         60.00           63.00         06300         BLOOD STORING, PROCESSI NG & TRANS.         0         44, 588         64.00           64.00         D6400         INTRAVENUUS THERAPY         0         30, 733         64.00           65.00         D6500         RESPI RATORY THERAPY         0         506, 145         65.00           66.01         06601         PHSTICAL THERAPY         0         687, 578         66.00           66.00         06800         SPECTAL THERAPY         0         66.448         68.00           60.00         06800         SPECTH PATHOLOGY         0         66.448         68.00           70.00         07000         CUEDATIONAL THERAPY         0         3,710         70.00           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         -1,193         371,054         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0         0         72.00         72.00           73.00         07300         D80800         RURAL HEALTH ACLINIC         323,924         92.00         90.00         90.00         90.01         90.01         90.01         90.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
64.00       06400       INTRAVENUUS THERAPY       0       30,733       64.00         65.00       06500       RESPIRATORY THERAPY       0       506,145       65.00         66.01       06601       PHYSICAL THERAPY       0       67.00       66.00       66.01         67.00       0COUPTIONAL THERAPY       0       0       0       66.01         68.00       06400       SPECH PATHOLOGY       0       66.448       68.00         70.00       07001       CAUDATIONAL THERAPY       0       3,710       70.00         70.00       07001       CAUDAVIDULMONARY       0       3,710       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       -1,193       371,054       71.00         73.00       07300       DUPL. DEV. CHARGED TO PATIENTS       0       0       72.00       72.00         00       07300       DUPL. DEV. CHARGED TO PATIENTS       0       0       0       90.01         73.00       07300       DUPL. DEV. CHARGED TO PATIENTS       0       0       0       90.01         74.00       0100       JV CLINIC       323,924       323,924       90.01       90.01         90.01       JV CLINIC <td>60.00</td> <td></td> <td>3, 133</td> <td></td> <td></td> <td>60.00</td>	60.00		3, 133			60.00
65.00       06500       RESPI RATORY THERAPY       0       506, 145       66.00         66.00       06600       06601       Sports THERAPY       0       687, 578       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0       115, 994       67.00       68.00         68.00       06800       SPECH PATHOLOGY       0       66.448       68.00         70.00       07001       ELECTROENCEPHALOGRAPHY       0       54, 117       70.01         71.00       07001 CARDI OPULMONARY       0       54, 117       70.01       70.01         71.00       07200 IMPL. DEV. CHARGED TO PATI ENTS       -1, 193       371, 054       71.00       72.00         73.00       07300 DRUGS CHARGED TO PATI ENT       0       0       0       72.00       73.00       00001 JV CLINIC       323, 924       90.01       90.00       9	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	44, 588		63.00
66.00       06000       PHYSI CAL THERAPY       0       687, 578       66.00         66.01       06001       SPORTS THERAPY       0       0       0         67.00       00       0000       0       66.01       66.01         67.00       00       0000       0       66.01       67.00       66.01         68.00       06000       SPEECH PATHOLOGY       0       66.448       68.00         70.00       07000       LECTROENCEPHALOGRAPHY       0       3.710       70.01         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       -1,193       311,054       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       -1,193       311,054       71.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       72.00       72.00         00       0       0       0       0       0       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       90.01       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00			0			
66.01       06001       SPORTS THERAPY       0       0       66.01         67.00       0CCUPATIONAL THERAPY       0       115,994       66.01         68.00       06800       SPEECH PATHOLOGY       0       66.448       68.00         70.01       07001       CARDIOPULMONARY       0       3,710       70.01         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       -1,193       371,054       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0       147,983       72.00         73.00       07300       DRUGS CHARGED TO PATIENT       0       0       72.00         00.00       00000       CLINIC       0       0       90.00         00.00       00000       0       0       0       90.00         00.00       09000       LINIC       323,924       323,924       90.01         90.00       90000       LINIC       0       1,463,168       91.00         92.00       09200       DESKENATION BEDS (NON-DISTINCT PART)       0       495,998       90.01         91.00       GHORE MERLINES L-117)       -2,342,723       22,987,920       92.00         07000 GIFT, FLOWER, COFFEE SHOP & CAN			0			
67.00       06700       OCCUPATIONAL THERAPY       0       115,994       67.00         68.00       06800       SPECH PATHOLOGY       0       66.448       68.00         70.00       07000       ELECTRENCEPHALGGRAPHY       0       3,710       70.01         71.00       07001       CARDIOPULMONARY       0       54,117       70.01         72.00       7200       INPLCAL SUPPLIES CHARGED TO PATIENTS       -1,193       371,054       71.00         73.00       07300       DRUGS CHARGED TO PATIENT       0       0       147,983       72.00         73.00       07300       DRUGS CHARGED TO PATIENT       0       0       0       73.00         00       07300       DRUGS CHARGED TO PATIENT       0       0       0       73.00         00       07300       DRUGS CHARGED TO PATIENT       0       0       0       90.00         90.00       09000       CLINIC       323,924       323,924       90.01       90.00         91.00       09100       DERCENCY       0       1,463,168       91.00       92.00         92.00       09200       DSERVATI ON BEDS (NON-DI STINCT PART)       0       14,463,168       91.00         92.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td>			0			
68.00       66800       SPEECH PATHOLOGY       0       66, 448       68.00         70.00       07000       CELTROENCEPHALOGRAPHY       0       3, 710       70.00         70.01       CARDIO POLLMONARY       0       54, 117       70.00         71.00       07000       MEDI CAL SUPPLIES CHARGED TO PATIENTS       -1, 193       371, 054       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       147, 983       72.00         73.00       OT300       RUGS CHARGED TO PATIENTS       0       0       73.00         0.01       OT300       RUGR CHARGED TO PATIENTS       0       0       73.00         0.01       OT300       RUGR CHARGED TO PATIENTS       0       0       73.00         0.01       OP000       CLINIC       0       0       0       00.00         90.00       D9000       RERGENCY       0       1,463, 168       90.00       90.01         91.00       PSLOE       0       1,463, 168       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00 </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td>			0			
70.00       07000       ELECTROENCEPHALOGRAPHY       0       3,710       70.00         70.01       07001       CARDI OPULMONARY       0       54,117       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       -1,193       371,054       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0       147,983       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       73.00         00       0       0       0       0       73.00         00       00000       CLINIC       0       0       70.00         90.01       90001       LV CLINIC       0       0       90.01         91.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0       1,463,168       90.01         92.00       092000       OBSERVATION BEDS (NON-DISTINCT PART)       0       495,998       101.00         101.00       HOME HEALTH AGENCY       0       495,998       101.00       101.00         101.00       IOMER MURSABLE COST CENTERS       10       100.00       190.00       192.01       192.01 MSC CLINICS       0       192.01         101.00       IOMEREMBURSABLE COST CENT						
70. 01       07001       CARDI OPULMONARY       0       54, 117         71. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       -1, 193       371, 054       71. 00         72. 00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       147, 983       72. 00         73. 00       07300       DRUGS CHARGED TO PATIENTS       0       0       73. 00       73. 00         00007300       RURAL HEALTH CLINIC       0       0       0       73. 00       90000       88. 00       08800       RURAL HEALTH CLINIC       0       0       90. 00       90000       9000       9000       0       90. 01       90. 00       90. 00			0			
72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0       147,983       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       73.00         0UTPATIENT SERVICE COST CENTERS       0       0       0       88.00       0800       RURAL HEALTH CLINIC       0       0       90.00			0			
73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       73.00         0UTPATIENT SERVICE COST CENTERS       0       0       0       88.00       08800       RURAL HEALTH CLINIC       0       0       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.00       90.00       90.00       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01       90.01       91.00       92.00       005ERVATION BEDS (NON-DISTINCT PART)       0       1, 463, 168       91.00       92.00       92.00       05ERVATI ON BEDS (NON-DISTINCT PART)       92.00       92.00       92.01       92.00       92.01       92.00       92.01       92.00       92.01       90.01       92.00       92.01       90.01	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-1, 193	371, 054		71.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0         0         88.00           90.00         09000         CLINIC         0         0         90.01           90.01         09001         JV CLINIC         323,924         323,924         90.01           91.00         09100         EMERGENCY         0         1,463,168         91.00           92.00         09SERVATION BEDS (NON-DISTINCT PART)         0         1463,168         92.00           0THER REIMBURSABLE COST CENTERS         0         495,998         0         101.00           101.00         HOME HEALTH AGENCY         0         495,998         0         101.00           SPECIAL PURPOSE COST CENTERS         0         0         495,998         0         101.00           118.00         SUBTOTALS (SUM OF LINES 1-117)         -2,342,723         22,987,920         118.00         118.00           190.00         GI9200         PHYSICIANS' PRIVATE OFFICES         0         186,300         192.00         192.00           192.01         19200         HSO CLINICS         0         0         192.03         192.03         192.03         192.03         192.03         192.03         19						
88.00       08800       RURAL HEALTH CLINIC       0       0       0       90.01       90.01       90.00       92.00       92.01       92.01       92.01       92.01       92.01       92.01       92.01       92.01       <	73.00		0	0		73.00
90.00         09000         CLINIC         0         0         0         90.00         90.01         90.00	00.00		0			
90.01       09001       JV CLINIC       323,924       323,924       90.01         91.00       09100       EMERGENCY       0       1,463,168       91.00         92.00       09200       0BSERVATION BEDS (NON-DISTINCT PART)       92.00       92.00         0THER REIMBURSABLE COST CENTERS       92.00       92.00       92.00         010100       HOME HEALTH AGENCY       0       495,998       101.00         10100       SPECIAL PURPOSE COST CENTERS       118.00       101.00         NONREI MBURSABLE COST CENTERS         118.00       SUBTOTALS (SUM OF LINES 1-117)       -2,342,723       22,987,920       118.00         190.00       IPQL00       FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       190.00         192.01       19200       PHYSICI ANS' PRI VATE OFFICES       0       186,300       192.00         192.01       19201       MSO CLINICS       0       0       192.03       192.03         192.03       IPA       0       0       192.03       192.03       192.03       192.03       192.03         194.00       O7950       MEALS ON WHEELS       0       0       194.00       194.00       194.00       194.01         194.					•	
91. 00       09100       EMERGENCY       0       1, 463, 168       91. 00         92. 00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART)       92. 00       92. 00         OTHER REIMBURSABLE COST CENTERS         101. 00       10100       HOME HEALTH AGENCY       0       495, 998       101. 00         SPECI AL PURPOSE COST CENTERS         118. 00         SUBTOTALS (SUM OF LINES 1-117)       -2, 342, 723       22, 987, 920       118. 00         NONREL MBURSABLE COST CENTERS         190. 00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       190. 00         192. 01       19200       PHSI CI ANS' PRI VATE OFFI CES       0       186, 300       192. 00         192. 01       19201       MSO CLI NI CS       0       0       192. 01         192. 03       19203       FPA       0       0       192. 03         194. 00       07950       MEALS ON WHEELS       0       0       194. 00         194. 00       07951       GUEST MEALS       0       0       194. 01         194. 02       07952       MARKETI NG       0       162, 651       194. 02			-			
92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         92.00           OTHER         REI MBURSABLE COST CENTERS         0         495,998         101.00           101.00         10100   HOME HEALTH AGENCY         0         495,998         101.00           SPECI AL PURPOSE COST CENTERS         0         495,998         101.00           NONREI MBURSABLE COST CENTERS         118.00         118.00         118.00           NONREI MBURSABLE COST CENTERS         118.00         190.00         19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         186,300         192.01         192.01         192.01         192.01         192.01         192.01         192.01         192.01         192.03         192.03         192.03         192.03         192.03         192.03         192.03         192.03         194.00         194.00         194.00         194.00         194.01         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02         194.02 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
101.00         10100         HOME         HEALTH         AGENCY         0         495, 998         101.00           SPECI AL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1-117)         -2, 342, 723         22, 987, 920         118.00           NONREI MBURSABLE COST CENTERS           190.00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         186, 300         192.00           192.01         1920 OLI NI CS         0         0         192.00         192.01           192.03         19203         FPA         0         0         192.03           194.00         07950         MEALS ON WHEELS         0         0         194.00           194.01         07951         GUEST MEALS         0         0         194.01           194.02         07952         MARKETI NG         0         162, 651         194.02	92.00					92.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1-117)         -2, 342, 723         22, 987, 920         118.00           NONREI MBURSABLE COST CENTERS         NONREI MBURSABLE COST CENTERS         190.00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         0         186, 300         192.00           192.01         19200 CLI NI CS         0         0         192.00         192.01           192.03         FPA         0         0         192.03         192.03         192.03         192.03         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.01         194.01         194.02         194.02         0         194.02         0         194.02 <td></td> <td></td> <td>1</td> <td>1</td> <td>1</td> <td></td>			1	1	1	
SUBTOTALS         (SUM OF LINES 1-117)         -2, 342, 723         22, 987, 920         118.00           NONREI MBURSABLE         COST CENTERS         190.00         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         192.00         192.01         192.01         192.01         192.03         192.03         192.03         192.03         192.03         192.03         192.03         192.03         192.03         192.03         194.00         0         192.03         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.00         194.01         194.01         194.01         194.02	101.00		0	495, 998		101.00
NONREI MBURSABLE COST CENTERS         0         0         190.00         190.00         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         190.00         192.00         192.00         192.00         192.00         192.01         192.01         192.01         192.01         192.01         192.03 <t< td=""><td>110.00</td><td></td><td>2 242 722</td><td>22.007.020</td><td></td><td>110.00</td></t<>	110.00		2 242 722	22.007.020		110.00
190.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       190.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       186, 300       192.00         192.01       19201       MSO CLI NI CS       0       0       192.01       192.01         192.03       19203       FPA       0       0       192.03       192.03         194.00       07950       MEALS ON WHEELS       0       0       194.00       194.01         194.02       07952       MARKETI NG       0       162, 651       194.02	118.00		-2, 342, 723	22, 987, 920		118.00
192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       0       186, 300       192.00         192.01       19201       MS0 CLI NI CS       0       0       192.01         192.03       19203       FPA       0       0       192.03         194.00       07950       MEALS ON WHEELS       0       0       194.00         194.01       07951       GUEST MEALS       0       0       194.01         194.02       07952       MARKETI NG       0       162, 651       194.02	190 00		0	0		190 00
192.01       192.01       MSO_CLINICS       0       0       192.01         192.03       19203       FPA       0       0       192.03         194.00       07950       MEALS_ON_WHEELS       0       0       194.00         194.01       07951       GUEST_MEALS       0       0       194.01         194.02       07952       MARKETING       0       162,651       194.02			0			
192.03       192.03       FPA       0       0       192.03         194.00       07950       MEALS ON WHEELS       0       0       194.00         194.01       07951       GUEST MEALS       0       0       194.01         194.02       07952       MARKETI NG       0       162,651       194.02			0	0		
194. 01     07951     GUEST MEALS     0     0     194. 01       194. 02     07952     MARKETI NG     0     162, 651     194. 02	192.03	19203 FPA	0	0		
194. 02 07952 MARKETI NG 0 162, 651 194. 02			0	0		
			0	0	1	
200.00   101AL (SUM OF LINES 118-199)   -2,342,723   23,336,871   200.00			0			
	200. UU	η TINE (SUM OF LINES TID-199)	-2, 342, 723	23, 330, 8/1	1	1200.00

Heal th	Financial Systems	SULL	IVAN COUNTY CON	MUNITY HOSPI	TAL	In Lie	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provider (	CCN: 15-1327	Period: From 01/01/2016 To 12/31/2016	Worksheet A- Date/Time Pr	
						10 12/31/2010	5/26/2017 2:	23 pm
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - ADVERTISING RECLASS							
1.00	MARKETI NG	194.02	72,808	<u> </u>				1.00
	0		72, 808	89, 843				
	B - DELIVERY ROOM RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	406, 254	20, 413				1.00
2.00	NURSERY	43.00	81, 151	11, 735				2.00
	0		487, 405	32, 148				
	C - OR SUPPLY COST	·	·					
1.00	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	129, 439				1.00
	PATI ENTS							
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
	0 — — — — — — —	T		129, 439				
	D - MOB EXPENSE RECLASS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	17, 965				1.00
	0	T		17, 965				
	E - OXYGEN RECLASS							
1.00	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	28, 432				1.00
	PATI ENTS							
	0			28, 432				
500.00	Grand Total: Increases		560, 213	297, 827				500.00

Heal th	Financial Systems	SULI	LIVAN COUNTY CO	MMUNITY HOSPI	TAL	In Lie	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provider (	CCN: 15-1327	Period: From 01/01/2016 To 12/31/2016	Worksheet A- Date/Time Pr 5/26/2017 2:	epared:
		Decreases	-					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	,		
	6.00	7.00	8.00	9.00	10.00			
	A - ADVERTISING RECLASS							
1.00	I S/ACCOUNTI NG/MARKETI NG	5. 01	72, 808	89, 843		0		1.00
	0		72, 808	89, 843				
	B - DELIVERY ROOM RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	487, 405	32, 148		0		1.00
2.00		0.00	0	0		0		2.00
	0		487, 405	32, 148				
	C - OR SUPPLY COST							
1.00		0.00	0	0		0		1.00
2.00	OPERATING ROOM	50.00	0	125, 585	i	0		2.00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 854		0		3.00
	0		0	129, 439				
	D - MOB EXPENSE RECLASS							
1.00	I S/ACCOUNTI NG/MARKETI NG	5. 01	0	17,965		0		1.00
	0		0	17, 965				
	E - OXYGEN RECLASS							
1.00	RESPIRATORY THERAPY	65.00	0	28, 432		0		1.00
	0 — — — — — — — — — — — — — — — — — — —		o	28, 432				
500.00	Grand Total: Decreases		560, 213	297, 827				500.00

Heal th Financia	l Systems		
RECONCI LI ATI ON	OF CAPITAL	COSTS	CENTERS

# SULLIVAN COUNTY COMMUNITY HOSPITAL Provider CCN: 15-1327

In Lieu of Form CMS-2552-10 Period: Worksheet A-7 From 01/01/2016 Part I To 12/21/2014 Part T

					o 12/31/2016		pared:
				Acqui si ti ons		0/20/2011 2.2	
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	1, 042, 227	0	(	0 0	0	1.00
2.00	Land Improvements	345, 187	0	(	0 0	0	2.00
3.00	Buildings and Fixtures	17, 909, 494	0	(	0 0	0	3.00
4.00	Building Improvements	0	0	(	0 0	0	4.00
5.00	Fixed Equipment	1, 138, 047	0	(	0 0	33, 629	5.00
6.00	Movable Equipment	14, 797, 430	1, 855, 081	(	1, 855, 081	52, 386	6.00
7.00	HIT designated Assets	0	0	(	0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35, 232, 385	1, 855, 081	(	1, 855, 081	86, 015	8.00
9.00	Reconciling Items	0	0	(	0 0	0	9.00
10.00	Total (line 8 minus line 9)	35, 232, 385	1, 855, 081	(	1, 855, 081	86, 015	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	1, 042, 227	0				1.00
2.00	Land Improvements	345, 187	0				2.00
3.00	Buildings and Fixtures	17, 909, 494	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	1, 104, 418	0				5.00
6.00	Movable Equipment	16, 600, 125	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	37, 001, 451	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	37, 001, 451	0				10.00

Heal th	Financial Systems SULI	IVAN COUNTY CO	MMUNITY HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period:	Worksheet A-7	
					From 01/01/2016		pared <sup>.</sup>
					12, 01, 2010	5/26/2017 2:2	<u>3 pm</u>
		SU	IMMARY OF CAPI	TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	564, 037	30, 664	13, 800	0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	857, 337	82, 039	(	10, 083	0	2.00
3.00	Total (sum of lines 1-2)	1, 421, 374	112, 703	13, 800	10, 083	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	608, 501				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	949, 459				2.00
3.00	Total (sum of lines 1-2)	0	1, 557, 960				3.00

ECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part III Date/Time Prep	
						5/26/2017 2:23	3 pm
		COM	PUTATION OF RAT	ITOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col			
				2)			
	DART LLL DECONCLULATION OF CARLEAL COST	1.00	2.00	3.00	4.00	5.00	
. 00	PART III - RECONCILIATION OF CAPITAL COSTS	20, 401, 326		20 401 22	0 551244	0	1.0
. 00	NEW CAP REL COSTS-BLDG & FIXT	20, 401, 328		20, 401, 32 16, 600, 12		0	2.0
. 00	Total (sum of lines 1-2)	37, 001, 451		37,001,45		0	3.0
. 00			TION OF OTHER (		SUMMARY 0	0	5.1
		ALLOUA	ITON OF OTHER (		JOIMMANT O		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel ate				
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS		1				
. 00	NEW CAP REL COSTS-BLDG & FIXT	0	-		0 564, 037	30, 664	1.
. 00	NEW CAP REL COSTS-MVBLE EQUIP	0	-		0 777, 470	82, 039	2.0
. 00	Total (sum of lines 1-2)	0	0		0 1, 341, 507	112, 703	3. (
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
					Capi tal -Rel ate	of cols. 9	
			,	,	d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS		1				
00	NEW CAP REL COSTS-BLDG & FIXT	27,600			0 0	622, 301	1.
. 00	NEW CAP REL COSTS-MVBLE EQUIP	-181			0 0	869, 411	2.
. 00	Total (sum of lines 1-2)	27, 419	10, 083		0 0	1, 491, 712	3.

### SULLIVAN COUNTY COMMUNITY HOSPITAL

	Financial Systems	SULLI	VAN COUNTY CO	MMUNITY HOSPITAL		u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1327	Period: From 01/01/2016	Worksheet A-8	
						Date/Time Prep 5/26/2017 2:23	
				Expense Classification o			5 pm
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Pacie (Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		C	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	1.00
2.00	2) Investment income - NEW CAP		C	NEW CAP REL COSTS-MVBLE	2.00	0	2.00
2.00	REL COSTS-MVBLE EQUIP (chapter		L	EQUIP	2.00	0	2.00
3.00	2) Investment income - other		C		0.00	11	3. 00
4.00	(chapter 2) Trade, quantity, and time		C		0.00	0	4.00
	discounts (chapter 8)		C				
5.00	Refunds and rebates of expenses (chapter 8)		C		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		C		0.00	0	6.00
7.00	Telephone services (pay	А	-443	OTHER ADMINISTRATIVE AND	5.03	0	7.00
	stations excluded) (chapter 21)			GENERAL			
8.00	Television and radio service (chapter 21)	А	-5,520	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		C		0.00		
10.00	Provider-based physician adjustment	A-8-2	-584,000			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.00
12.00	Related organization	A-8-1	184, 331			0	12.00
13.00	transactions (chapter 10) Laundry and linen service		C		0.00	о	13.00
14.00 15.00	Cafeteria-employees and guests Rental of quarters to employee	В	-121, 210	CAFETERI A	11.00 0.00		14.00 15.00
	and others		L		0.00		
16.00	Sale of medical and surgical supplies to other than		C		0.00	0	16.00
17.00	patients Sale of drugs to other than	В	-3 131	PHARMACY	15.00	0	17.00
	patients						
18.00	Sale of medical records and abstracts	В	-6, 966	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		C		0.00	0	19.00
20.00	Vending machines	В	107	OTHER ADMINISTRATIVE AND	5.03	0	20. 00
21.00	Income from imposition of		C	GENERAL	0.00	о	21.00
	interest, finance or penalty charges (chapter 21)						
22.00	Interest expense on Medicare		C		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	C	PHYSICAL THERAPY	66.00		24.00
24.00	therapy costs in excess of	A-0-3	C		00.00		24.00
25.00	limitation (chapter 14) Utilization review –		C	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation (chapter 21)						
26.00	Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL		C	FIXT NEW CAP REL COSTS-MVBLE	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		ſ	EQUI P NONPHYSI CI AN ANESTHETI STS	19.00		28.00
29.00	Physicians' assistant		C		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		ſ	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31.00	Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
	limitation (chapter 14)					i l	

Heal th	Financial Systems	SULL	IVAN COUNTY CO	MMUNI TY HOSPI TAL	In Lie	eu of Form CMS-:	2552-10
	MENTS TO EXPENSES			Provider CCN: 15-1327	Period: From 01/01/2016	Worksheet A-8	
					Го 12/31/2016	Date/Time Pre 5/26/2017 2:2	
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for	A	-79, 867	NEW CAP REL COSTS-MVBLE	2.00	9	32.00
33.00	Depreciation and Interest PHYSICIAN RECRUITMENT	А	E0 707	EQUI P OTHER ADMI NI STRATI VE AND	5.03	0	33.00
33.00	PHYSICIAN RECRUITMENT	А	-50,727	GENERAL	5.03	0	33.00
33.01	FLOWERS & PLANTS	А	-1 680	OTHER ADMINI STRATI VE AND	5.03	0	33.01
00.01			1,000	GENERAL	0100		00.01
33.02	SALES TAX	A	-8, 799	OTHER ADMINISTRATIVE AND	5.03	0	33.02
				GENERAL			
33.03	LOBBYING EXPENSES	A	-1, 163	OTHER ADMINISTRATIVE AND	5.03	9	33.03
				GENERAL		_	
33.04	SALES OF SUPPLIES	В	-1, 193	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	33.04
33.05	ATM RENTAL AND COMISSION	В	1 /26	PATI ENTS OTHER ADMI NI STRATI VE AND	5.03	0	33.05
33.05	ATM RENTAL AND COMPSTON	в	-1,430	GENERAL	5.05		33.05
33.06	MI SC I NCOME	В	-1.669	OTHER ADMINI STRATI VE AND	5.03	0	33.06
		_	.,	GENERAL		-	
33.07	EDUCATION REVENUE	В	-20, 352	NURSING ADMINISTRATION	13.00	0	33.07
33.08	DOMESTIC HEALTHCARE CLAIMS	В		EMPLOYEE BENEFITS DEPARTMEN			00.00
33.09	MI SC I NCOME	В		LABORATORY	60.00		
33. 10	HOSPITAL ASSESSMENT FEE	A	-459, 973	OTHER ADMINISTRATIVE AND	5.03	0	33. 10
00.44			4 005	GENERAL	5.00		00.44
33. 11	SURETY BONDS	В	-1,335	OTHER ADMINISTRATIVE AND	5.03	0	33. 11
33 10	MI SC I NCOME	В	_1 400	GENERAL RADI OLOGY-DI AGNOSTI C	54.00	0	33, 12
33.12	BOND I SSUANCE COST	A		NEW CAP REL COSTS-BLDG &	1.00		
55.15			15,000	FIXT	1.00	1	00.10
50.00	TOTAL (sum of lines 1 thru 49)		-2, 342, 723				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(2) Additional ediustreate results are determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	SULLI VAN COUNTY C	OMMUNITY HOSPITAL	In Lie	eu of Form CMS-	2552-10
STATEME	NT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2016 To 12/31/2016		narad
				10 12/31/2010	5/26/2017 2:2	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:			_		
1.00		NEW CAP REL COSTS-MVBLE EQUI		0	181	1.00
2.00			FITNESS CENTER - HR	0	4, 740	2.00
3.00			FITNESS CENTER - FISCAL ACCT	0	9, 006	3.00
4.00		OTHER ADMINISTRATIVE AND GEN		0	5, 893	4.00
4.01			FITNESS CENTER - MAINT	0	7, 685	4.01
4.02	14.00	CENTRAL SERVICES & SUPPLY	FITNESS CENTER - MATERIALS N	0	2, 386	4.02
4.06	5. 03	OTHER ADMINISTRATIVE AND GEN	MSO	0	177, 195	4.06
4.07	90. 01	JV CLINIC	JV PAIN MANAGEMENT CLINIC	323, 924	0	4.07
4.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	JV PAIN MANAGEMENT CLINIC	67, 493	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
5.00	0		0	391, 417	207, 086	5.00

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

1140 110					or this parts	
				Related Organization(s) and/	or Home Office	
						1
						1
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	1
	1.00	2.00	3.00	4.00	5.00	
	B INTERPRIATIONSHID TO RELAT	TED OPCANIZATION(S) AND/OP HO				

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish

the information requested under Part B of this worksheet.

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

6.00	С	0.00 FI TNESS CENTER 100.00	6.00
7.00	С	0.00 FI TNESS CENTER 100.00	7.00
8.00	С	0.00 FI TNESS CENTER 100.00	8.00
9.00	С	0.00 FI TNESS CENTER 100.00	9.00
10.00	С	0.00 FI TNESS CENTER 100.00	0 10.00
10.01	С	0.00 FI TNESS CENTER 100.00	0 10.01
10.02	С	0.00 FI TNESS CENTER 100.00	0 10.02
10.03	С	0.00 JV PAIN CLINIC 100.00	0 10.03
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

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

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

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

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

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

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

					5/26/2017 2:2	23 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRAN	SACTIONS WITH RELATED O	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	-181	11				1.00
2.00	-4, 740	0				2.00
3.00	-9, 006	0				3.00
4.00	-5, 893	0				4.00
4.01	-7,685	0				4.01
4.02	-2, 386	0				4. 02
4.06	-177, 195	0				4.06
4.07	323, 924	0				4.07
4.08	67, 493	0				4.08
4.09	0	0				4.09
4.10	0	0				4.10
5.00	184, 331					5.00

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

nus not	been posted to norkaneet A,	cordinate and of 2, the amount arrowable should be that eated the cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6.00		
E	3. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00 FI TNESS CENTER	6.00
7.00 FI TNESS CENTER	7.00
8.00 FI TNESS CENTER	8.00
9.00 FI TNESS CENTER	9.00
10.00 FI TNESS CENTER	10.00
10. 01 FI TNESS CENTER	10.01
10. 02 FI TNESS CENTER	10.02
10.03 JV PAIN CLINIC	10.03
100.00	100.00

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

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

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

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

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

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

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

Health Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT

## SULLIVAN COUNTY COMMUNITY HOSPITAL

In Lieu of Form CMS-2552-10 Worksheet A-8-2

Heal th	Financial System	ns SU	LLIVAN COUNTY C	COMMUNITY HOSPI	TAL	In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSICI	AN ADJUSTMENT		Provider (		Period:	Worksheet A-8	3-2
						From 01/01/2016 To 12/31/2016		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60. 00 L	ABORATORY	24,000	0	24,000	0 0	0	1.00
2.00	19.00 N	IONPHYSICIAN ANESTHETISTS	584,000	584,000	0	0 0	0	2.00
3.00	0.00		0	0	0	0 0	0	3.00
4.00	0.00		0	0	0	ol o	0	4.00
5.00	0.00		0	0	(		0	
6.00	0.00		0	0			0	6.00
7.00	0.00		0	0	(		0	
8.00	0.00		0	0			0	8.00
9.00	0.00		0	0			0	
9.00 10.00	0.00		0	0		-	0	
200.00	0.00		(00,000	E E A 000	-	-	0	
200.00		Cost Center/Physician	608, 000 Unadj usted RCE		24,000 Cost of	Provi der	Physician Cost	
	Wkst. A Line #	I denti fi er	Limit				of Malpractice	
		rdentrirer		Unadjusted RCE			Insurance	
				Limit	Continuing	Share of col.	Insurance	
	1.00	2.00	8.00	9.00	Education 12.00	12 13.00	14.00	
1.00		ABORATORY						1.00
			0				-	
2.00		IONPHYSI CI AN ANESTHETI STS	0	0			0	
3.00	0.00		0	0	-	-	0	3.00
4.00	0.00		0	0	0		0	4.00
5.00	0.00		0	0	0	-	0	
6.00	0.00		0	0	0		0	
7.00	0.00		0	0	C	-	0	
8.00	0.00		0	0	C	°	0	8.00
9.00	0.00		0	0	C		0	
10.00	0.00		0	0	C	0 0	0	
200.00			0	0	0	,	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adj ustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14				-	
1 00	1.00	2.00	15.00	16.00	17.00	18.00		1.00
1.00			0					1.00
2.00		IONPHYSI CI AN ANESTHETI STS	0	0				2.00
3.00	0.00		0					3.00
4.00	0.00		0	0	C			4.00
5.00	0.00		0	0		-		5.00
6.00	0.00		0	0	C			6.00
7.00	0.00		0	0				7.00
8.00	0.00		0	0	C	0 0		8.00
9.00	0.00		0			0 0		9.00
10.00	0.00		0	0	C	0 0		10.00
200.00			0	0	C	584,000		200.00
								-

In Lieu of Form CMS-2552-10 Period: Worksheet B From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared:

			Te	b 12/31/2016		
		CAPI TAL REL	ATED COSTS		5/26/2017 2:2	
Cost Center Description	Net Expenses for Cost	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS	Subtotal	
	Allocation		24011	DEPARTMENT		
	(from Wkst A					
	<u>col.7)</u>	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	47	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	622, 301	622, 301				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	869, 411		869, 411			2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00550 I S/ACCOUNTI NG/MARKETI NG	3, 042, 279 1, 138, 257	3, 629 15, 923	5, 179 22, 727	3, 051, 087	1, 314, 108	4.00 5.01
5. 02 00540 BUSINESS OFFICE & ADMITTING	1, 138, 257	13, 421	19, 156	137, 201 198, 519	1, 314, 108	5.01
5. 03 00560 OTHER ADMINISTRATIVE AND GENERAL	1, 382, 077	22, 007	31, 410	42, 915	1, 478, 409	
7.00 00700 OPERATION OF PLANT	1, 047, 526	70, 749	100, 980	116, 748	1, 336, 003	
8.00 00800 LAUNDRY & LINEN SERVICE	73, 346	3, 689	5, 265	11, 807	94, 107	8.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY	402, 027 559, 647	8, 612 16, 823	12, 292 24, 012	96, 960 90, 838	519, 891 691, 320	9.00 10.00
11. 00 01100 CAFETERIA	-121, 210	6, 124	8, 740	90, 030 0	-106, 346	
13.00 01300 NURSING ADMINISTRATION	422, 514	3, 762	5, 370	106, 273	537, 919	
14.00 01400 CENTRAL SERVICES & SUPPLY	138, 376	15, 703	22, 412	36, 247	212, 738	
	1, 373, 749	9, 546	13, 625	100, 188	1, 497, 108	
16.00 01600 MEDI CAL RECORDS & LI BRARY 19.00 01900 NONPHYSI CI AN ANESTHETI STS	384, 226	19, 879 0	28, 373 0	98, 101 0	530, 579 0	
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		0	0	0	17.00
30. 00 03000 ADULTS & PEDIATRICS	2, 087, 643	104, 924	149, 755	545, 172	2, 887, 494	30.00
31. 00 03100 I NTENSI VE CARE UNI T	475, 426	27, 730	39, 579	125, 711	668, 446	
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	92, 886	2, 221	3, 170	22, 191	120, 468	43.00
50. 00 05000 OPERATI NG ROOM	846, 234	89, 647	127, 953	186, 805	1, 250, 639	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	12, 319	3, 115	4, 446	2, 655	22, 535	
53.00 05300 ANESTHESI OLOGY	3, 826	0	0	0	3, 826	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	965, 613	37, 716	53, 832	160, 605	1, 217, 766	
54. 01 05401 ULTRASOUND 56. 00 05600 RADI 0I SOTOPE	232, 600 102, 988	2, 268 2, 802	3, 237 3, 999	0	238, 105 109, 789	
60. 00 06000 LABORATORY	1, 455, 987	20, 212	28, 849	169, 752	1, 674, 800	
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	44, 588	1, 267	1, 809	0	47, 664	63.00
64. 00 06400 I NTRAVENOUS THERAPY	30, 733	2, 248	3, 209	0	36, 190	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	506, 145 687, 578	16, 730 27, 430	23, 879 39, 150	121, 996 182, 908	668, 750 937, 066	
66. 01 06601 SPORTS THERAPY	007, 578	27,430	37, 150	182, 908	937,000 0	
67. 00 06700 OCCUPATI ONAL THERAPY	115, 994	5, 477	7, 817	31, 365	160, 653	
68.00 06800 SPEECH PATHOLOGY	66, 448	1, 207	1, 723	17, 983	87, 361	
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 710	1,474	2, 104	0	7, 288	
70. 01 07001 CARDI OPULMONARY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	54, 117 371, 054	7, 685 0	10, 968 0	13, 460	86, 230 371, 054	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	147, 983	0	0	0	147, 983	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC	0	0	0	0	0	88.00 90.00
90. 01 09001 JV CLINIC	323, 924	13, 168	0	60, 670		
91. 00 09100 EMERGENCY	1, 463, 168	39, 717	56, 688	235, 829	1, 795, 402	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	495, 998	0	0	118, 279	614 077	101 00
SPECIAL PURPOSE COST CENTERS	495, 990	0	0	110, 279	614, 277	101.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	22, 987, 920	616, 905	861, 708	3, 031, 178	22, 954, 912	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 515	5, 018	0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 MS0 CLI NI CS	186, 300	0	0	0	186, 300	192.00 192.01
192. 01 19201 MS0_CLINICS 192. 03 19203 FPA	0	0	0	0		192.01
194. 00 07950 MEALS ON WHEELS	0	0	0	0		194.00
194.01 07951 GUEST MEALS	0	0	0	0	0	194.01
194. 02 07952 MARKETI NG	162, 651	1, 881	2, 685	19, 909	187, 126	
200.00Cross Foot Adjustments201.00Negative Cost Centers		0	0	0		200. 00 201. 00
201.00   TOTAL (sum Lines 118-201)	23, 336, 871	622, 301	869, 411	3, 051, 087		
				-,,,,,,,,,	2, 220, 071	

Heal th	Financial Systems SUL	LIVAN COUNTY COM	MUNITY HOSPITA	AL	In Lie	eu of Form CMS-:	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod:	Worksheet B	
					rom 01/01/2016 o 12/31/2016	Date/Time Pre	
	Cost Center Description	IS/ACCOUNTING/	Subtotal	BUSINESS	Subtotal	5/26/2017 2:2 0THER	3 pm
	cost center bescription	MARKETING	Subtotal	OFFICE &	Subtotal	ADMI NI STRATI VE	
				ADMI TTI NG		AND GENERAL	
		5.01	5A. 01	5.02	5A. 02	5.03	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550 I S/ACCOUNTI NG/MARKETI NG	1, 314, 108					5. 01
5.02	00540 BUSINESS OFFICE & ADMITTING	77, 736	1, 375, 264	1, 375, 264			5.02
5.03	00560 OTHER ADMINI STRATI VE AND GENERAL	88, 573	1, 566, 982	101, 547			5.03
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	80, 041 5, 638	1, 416, 044 99, 745	91, 765 6, 464			7.00 8.00
9.00	00900 HOUSEKEEPING	31, 147	551, 038	35, 709			9.00
10.00	01000 DI ETARY	41, 418	732, 738	47, 484			10.00
11.00	01100 CAFETERI A	0	-106, 346	C			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	32, 227	570, 146	36, 948	607, 094	46, 520	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	12, 745	225, 483	14, 612			
15.00	01500 PHARMACY	89, 693	1, 586, 801	102, 831			15.00
16. 00 19. 00	01600 MEDI CAL RECORDS & LI BRARY 01900 NONPHYSI CI AN ANESTHETI STS	31, 788 0	562, 367 0	36, 444			16.00 19.00
19.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	Ĺ		0	19.00
30.00	03000 ADULTS & PEDIATRICS	172, 997	3, 060, 491	198, 322	3, 258, 813	249, 713	30.00
31.00	03100 I NTENSI VE CARE UNI T	40, 047	708, 493	45, 913			
43.00	04300 NURSERY	7, 217	127, 685	8, 274	135, 959	10, 418	43.00
	ANCI LLARY SERVI CE COST CENTERS				1	1	
50.00	05000 OPERATING ROOM	74, 927	1, 325, 566	85, 902			50.00
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	1, 350 229	23, 885 4, 055	1, 548 263			52.00 53.00
53.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	72, 958	4,055	83, 644			
54.00	05401 ULTRASOUND	14, 265	252, 370	16, 355			1
56.00	05600 RADI OI SOTOPE	6, 578	116, 367	7, 541			
60.00	06000 LABORATORY	100, 339	1, 775, 139	115, 036	1, 890, 175	144, 838	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2, 856	50, 520	3, 274			1
64.00	06400 I NTRAVENOUS THERAPY	2, 168	38, 358	2, 486			1
65.00		40, 065	708, 815	45, 934			1
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 SPORTS THERAPY	56, 141	993, 207	64, 364			66. 00 66. 01
67.00	06700 OCCUPATI ONAL THERAPY	9, 625	170, 278	11, 035		-	
68.00	06800 SPEECH PATHOLOGY	5, 234	92, 595	6, 001			1
70.00	07000 ELECTROENCEPHALOGRAPHY	437	7, 725	501			1
70. 01	07001 CARDI OPULMONARY	5, 166	91, 396	5, 923			1
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	22, 230	393, 284	25, 486			
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	8, 866	156, 849	10, 164			
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0		0	0	73.00
88.00	08800 RURAL HEALTH CLINIC	0	0	(	0	0	88.00
	09000 CLINIC	0	0	C	0	0	
90.01	09001 JV CLINIC	23, 830	421, 592	27, 321	448, 913	34, 399	90.01
	09100 EMERGENCY	107, 564	1, 902, 966	123, 320	2, 026, 286	155, 268	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
101 00	OTHER REIMBURSABLE COST CENTERS	36, 802	651, 079		651, 079	40.900	101.00
101.00	SPECIAL PURPOSE COST CENTERS	30, 802	051,079	Ĺ	031,079	49, 690	101.00
118.00		1, 302, 897	22, 943, 701	1, 362, 411	22, 930, 848	1, 637, 416	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8, 533	C	8, 533	654	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	186, 300	C	186, 300		192.00
	19201 MSO CLINICS	0	0	C	0		192.01
	19203 FPA 07950 MEALS ON WHEELS	0	0	(	0		192.03
	07950 MEALS ON WHEELS 07951 GUEST MEALS	0	0	(	0		194. 00 194. 01
	07951 GUEST MEALS	11, 211	0 198, 337	12, 853	211, 190		194.01
200.00			0	12,000	0	10, 100	200.00
201.00		0	0	C	0		201.00
202.00	TOTAL (sum lines 118-201)	1, 314, 108	23, 336, 871	1, 375, 264	23, 336, 871	1, 668, 529	202.00

Health Financial Systems	SULLI VAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1327 Pe Fr To	riod: om 01/01/2016 12/31/2016	Worksheet B Part I Date/Time Pre	epared:
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/26/2017 2:2 CAFETERI A	23 pm
cost center bescription	PLANT	LINEN SERVICE	HOUSEREELTING	DILIAN		
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						1 1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00550 I S/ACCOUNTI NG/MARKETI NG						5.01
5. 02 00540 BUSINESS OFFICE & ADMITTING						5.02
5. 03 00560 OTHER ADMINI STRATI VE AND GENERAL						5.03
7.00 00700 OPERATION OF PLANT	1, 623, 348					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	12,059					8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	28, 153 54, 998			918, 384		9.00 10.00
11. 00 01100 CAFETERIA	20, 019			563, 116	485, 551	
13. 00 01300 NURSI NG ADMI NI STRATI ON	12, 299			0	13, 761	
14. 00 01400 CENTRAL SERVICES & SUPPLY	51, 334			0	10, 529	
15.00 01500 PHARMACY	31, 206	0	13, 007	0	14, 282	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	64, 985	0	27, 086	0	28, 772	16.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS	242.007	FF 020	142.0(0)	20/ 127	100 (77	1 20 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	343, 007 90, 652			206, 137 11, 904	128, 677 25, 158	
43. 00 04300 NURSERY	7, 262			0	4, 691	
ANCI LLARY SERVI CE COST CENTERS	1,202	3, 304	5, 027	Ÿ	4,071	40.00
50. 00 05000 OPERATI NG ROOM	293, 067	16, 709	122, 152	7, 012	38, 815	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	10, 184	734	4, 245	0	556	52.00
53. 00 05300 ANESTHESI OLOGY	0	-	U U	0	C	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	123, 298			0	31, 066	
54. 01 05401 ULTRASOUND 56. 00 05600 RADI OI SOTOPE	7, 414 9, 159			0	0	
60. 00 06000 LABORATORY	66, 076			0	48, 857	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	4, 143			0	40,007	
64. 00 06400 I NTRAVENOUS THERAPY	7, 349			0	0	
65. 00 06500 RESPI RATORY THERAPY	54, 692	499	22, 796	0	24, 880	65.00
66. 00 06600 PHYSI CAL THERAPY	89, 671	10, 724	37, 375	0	34, 471	
66. 01 06601 SPORTS THERAPY	0	0	-	0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	17, 904 3, 947	0		0	4, 274	
68. 00 06800 SPEECH PATHOLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 819		., = . =	0	3, 232 0	
70. 01 07000 CARDI OPULMONARY	25, 122			0	2, 537	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT				0	2,007	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	C	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS		-	-			
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC	0			0	0	
90.00 09000 CLINIC 90.01 09001 JV CLINIC	43, 047			0		90. 00 90. 01
91. 00 09100 EMERGENCY	129, 840			0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		20,010	01,110	J.	027 107	92.00
OTHER REI MBURSABLE COST CENTERS	· · ·					
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	C	101.00
SPECIAL PURPOSE COST CENTERS	4 (05 70)	10/ 10/	(50,500)	700.440		1
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 605, 706	126, 406	652, 508	788, 169	482, 076	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 492	0	4, 790	0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0			0		192.00
192. 01 19201 MS0 CLINICS	0	-		0		192.01
192. 03 19203 FPA	0	0	0	0	C	192.03
194.0007950 MEALS ON WHEELS	0	0	0	130, 215		194.00
194.01 07951 GUEST MEALS	0	0	0	0		194.01
194.0207952 MARKETING	6, 150	0	2, 563	0	3, 475	194.02
200.00Cross Foot Adjustments201.00Negative Cost Centers	0		0	0	0	200. 00 201. 00
202.00 TOTAL (sum lines 118-201)	1, 623, 348	-	-	918, 384	485, 551	
	1, 023, 340	1 120, 400	1 007,001	710, 504	-00, 001	1-02.00

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1327	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 5/26/2017 2:2	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	NONPHYSI CI AN ANESTHETI STS	
		13.00	14.00	15.00	16.00	19.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550 I S/ACCOUNTI NG/MARKETI NG						5.01
5.02	00540 BUSINESS OFFICE & ADMITTING						5. 02
5.03	00560 OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00		604 000					11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	684, 800	341, 752				13.00 14.00
14.00	01500 PHARMACY	0	6, 814	1, 884, 41	12		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	34	1, 004, 4	0 765, 573		16.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	0	1
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				<u> </u>		1
30. 00	03000 ADULTS & PEDIATRICS	301, 868	26, 309		0 70, 143	0	30.00
31.00	03100 INTENSIVE CARE UNIT	59, 001	1, 724		0 5, 175	0	31.00
43.00	04300 NURSERY	11, 026	1, 554		0 2, 193	0	43.00
	ANCI LLARY SERVI CE COST CENTERS	- I I					
50.00	05000 OPERATI NG ROOM	90, 516	32, 646		0 61, 990	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 287	345		0 488	0	
53.00	05300 ANESTHESI OLOGY	0	0		0 9, 364	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	5, 866		0 143, 279	0	
54.01 56.00	05401 ULTRASOUND 05600 RADI OI SOTOPE	0	0		0 25, 916 0 5, 120	0	
60.00	06000 LABORATORY	0	33, 420		0 141, 598	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	33, 420		0 8, 772	0	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 5, 387	0	1
65.00	06500 RESPI RATORY THERAPY	0	15, 672		0 32, 134	0	
66.00	06600 PHYSI CAL THERAPY	0	2,008		0 19, 273	0	
66. 01	06601 SPORTS THERAPY	0	0		0 0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	45		0 4,017	0	
68. 00	06800 SPEECH PATHOLOGY	0	93		0 884	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 551	0	70.00
70. 01	07001 CARDI OPULMONARY	5, 921	0		0 3, 730	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	142, 710		0 63, 901	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	56, 733		0 4, 880	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1, 884, 41	12 35, 979	0	73.00
00 00			ol		0 0	0	
	08800 RURAL HEALTH CLINIC 09000 CLINIC	0	0		0 0	0	88.00
90.00	09001 JV CLINIC	35, 353	0		0 11, 949	0	
	09100 EMERGENCY	122, 730	15, 102		0 101, 541	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	122, 700	10, 102		101,011	0	92.00
	OTHER REIMBURSABLE COST CENTERS	1 1	1				
101.00	10100 HOME HEALTH AGENCY	57, 098	677		0 7, 309	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00		684, 800	341, 752	1, 884, 41	12 765, 573	0	118.00
100 07	NONREI MBURSABLE COST CENTERS		-1		0		100.0-
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00 192.01
	19201 MSO CLINICS 3 19203 FPA	0	0		0	0	192.01
	07950 MEALS ON WHEELS	0	0				192.03
	07950 MEALS ON WHEELS	0	0				194.00
	207951 GUEST MEALS	0	0				194.02
200.00			0				200.00
	5	0	0		0		201.00
201.00	Negative Cost Centers	U				0	

UST ALL	LOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1327	From 01/01/2016 F	Vorksheet B Part I
						Date/Time Prepared: 5/26/2017 2:23 pm
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
. 00 0 . 00 0 . 00 0	ENERAL SERVICE COST CENTERS 10100 NEW CAP REL COSTS-BLDG & FIXT 10200 NEW CAP REL COSTS-MVBLE EQUIP 10400 EMPLOYEE BENEFITS DEPARTMENT 10550 I S/ACCOUNTING/MARKETING					1. 0 2. 0 4. 0 5. 0
. 03 0 . 00 0 . 00 0	10540 BUSINESS OFFICE & ADMITTING 10560 OTHER ADMINISTRATIVE AND GENERAL 10700 OPERATION OF PLANT 10800 LAUNDRY & LINEN SERVICE 10900 HOUSEKEEPING					5. 0 5. 0 7. 0 8. 0 9. 0
0.00 0 1.00 0 3.00 0 4.00 0	11000 DI ETARY 11100 CAFETERI A 11300 NURSI NG ADMI NI STRATI ON 11400 CENTRAL SERVI CES & SUPPLY					10. 0 11. 0 13. 0 14. 0
6.000 9.000	11500 PHARMACY 11600 MEDICAL RECORDS & LIBRARY 11900 NONPHYSICIAN ANESTHETISTS NPATLENT ROUTINE SERVICE COST CENTERS					15. 0 16. 0 19. 0
1.00 0 3.00 0	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT 4300 NURSERY NCILLARY SERVICE COST CENTERS	4, 783, 575 1, 047, 978 179, 434	0 0 0	4, 783, 5 1, 047, 9 179, 4	78	30. 0 31. 0 43. 0
	5000 OPERATI NG ROOM	2, 182, 532	0	2, 182, 5	32	50.0
	5200 DELIVERY ROOM & LABOR ROOM	45, 221	0	45, 2		52.0
3.00 0	5300 ANESTHESI OLOGY	14, 013	0	14, 0	13	53.0
	15400 RADI OLOGY-DI AGNOSTI C	1, 841, 939	0	1, 841, 9		54.0
	5401 ULTRASOUND	325, 737	0	325, 7		54.0
	5600 RADI OI SOTOPE	151, 500	0	151, 5		56.0
		2, 352, 879	0	2, 352, 8		60.0
	6300 BLOOD STORI NG, PROCESSI NG & TRANS. 6400 I NTRAVENOUS THERAPY	72, 558 59, 773	0	72, 5 59, 7		63. 0 64. 0
	6500 RESPI RATORY THERAPY	963, 256	0	963, 2		65.0
	6600 PHYSI CAL THERAPY	1, 332, 131	0	1, 332, 1		66.0
	6601 SPORTS THERAPY	0	Ő	1,002,1	0	66.0
	6700 OCCUPATI ONAL THERAPY	228, 908	0	228, 9	08	67.0
8.00 0	6800 SPEECH PATHOLOGY	115, 952	0	115, 9	52	68.0
	7000 ELECTROENCEPHALOGRAPHY	16, 235	0	16, 2		70.0
		152, 557	0	152, 5		70.0
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7200 IMPL. DEV. CHARGED TO PATIENT	657, 470 241, 424	0	657, 4 241, 4		71.0
	7300 DRUGS CHARGED TO PATIENTS	1, 920, 391	0	1, 920, 3		73.0
	UTPATIENT SERVICE COST CENTERS			.,,.		
8.00 0	8800 RURAL HEALTH CLINIC	0	0		0	88.0
	19000 CLI NI C	0	0		0	90.0
	9001 JV CLINIC	608, 396	0	608, 3		90.0
	19100 EMERGENCY	2, 681, 138	0	2, 681, 1	38	91.0
	9200 OBSERVATION BEDS (NON-DISTINCT PART) THER REIMBURSABLE COST CENTERS		0			92.0
	0100 HOME HEALTH AGENCY	766, 053	0	766, 0	53	101.0
	PECIAL PURPOSE COST CENTERS	700,000		700,0		
18.00	SUBTOTALS (SUM OF LINES 1-117)	22, 741, 050	0	22, 741, 0	50	118.0
	ONREIMBURSABLE COST CENTERS					
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	25, 469	0	25, 4		190. 0
	9200 PHYSI CI ANS' PRI VATE OFFI CES	200, 576	0	200, 5		192.0
	9201 MSO CLINICS	0	0		0	192.0
	9203 FPA 17950 MEALS ON WHEELS	120 215	0	120 2	0	192. 0 194. 0
	17950 MEALS ON WHEELS 17951 GUEST MEALS	130, 215	0	130, 2	0	194. 0
	17951 GUEST MEALS	239, 561	0	239, 5	-	194.0
00.00	Cross Foot Adjustments	237, 301	0	207, 0	0	200. 0
01.00	Negative Cost Centers	0	0		0	201.0
02.00	TOTAL (sum lines 118-201)	23, 336, 871	0	23, 336, 8	71	202.0

Heal th	Fi nanc	;i al	Syste	ems		
				DEI	ATED	0

#### SULLI VAN COUNTY COMMUNI TY HOSPI TAL

Heal th	Financial Systems SU	LIVAN COUNTY CO	MMUNITY HOSPITA	AL	In Lie	u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CC		eriod: com 01/01/2016 o 12/31/2016	Worksheet B Part II Date/Time Pre 5/26/2017 2:2	epared: 23 pm
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New	FLXT	EQUI P		BENEFITS	
		Capital				DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					1	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 629	5, 179	8, 808	8, 808	
5.01	00550 I S/ACCOUNTI NG/MARKETI NG	0	15, 923	22, 727	38, 650	396	
5.02	00540 BUSINESS OFFICE & ADMITTING	0	13, 421	19, 156	32, 577	573	
5.03	00560 OTHER ADMINISTRATIVE AND GENERAL	0	22, 007	31, 410	53, 417	124	
7.00	00700 OPERATION OF PLANT	0	70, 749	100, 980	171, 729	337	
8.00	00800 LAUNDRY & LINEN SERVICE	0	3, 689	5, 265	8, 954	34	
9.00	00900 HOUSEKEEPI NG	0	8, 612	12, 292	20, 904	280	
10.00	01000 DI ETARY	0	16, 823	24, 012	40, 835	262	10.00
11.00	01100 CAFETERI A	0	6, 124	8, 740	14, 864	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	3, 762	5, 370	9, 132	307	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	15, 703	22, 412	38, 115	105	14.00
15.00	01500 PHARMACY	0	9, 546	13, 625	23, 171	289	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	19, 879	28, 373	48, 252	283	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00		0	104, 924	149, 755	254, 679	1, 576	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	27, 730	39, 579	67, 309	363	31.00
43.00		0	2, 221	3, 170	5, 391	64	43.00
	ANCILLARY SERVICE COST CENTERS	-	I				
50.00	05000 OPERATING ROOM	0	89, 647	127, 953	217, 600	539	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 115	4, 446	7, 561	8	
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	37, 716	53, 832	91, 548	463	
54.01	05401 ULTRASOUND	0	2, 268	3, 237	5, 505	0	
56.00	05600 RADI OI SOTOPE	0	2, 802	3, 999	6, 801	0	
60.00	06000 LABORATORY	0	20, 212	28, 849	49, 061	490	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1, 267	1,809	3, 076	0	
64.00	06400 I NTRAVENOUS THERAPY	0	2, 248	3, 209	5, 457	0	
65.00		0	16, 730	23, 879	40, 609	352	
66.00	06600 PHYSI CAL THERAPY	0	27, 430	39, 150	66, 580	528	
66.01	06601 SPORTS THERAPY	0	0	0	0	0	
67.00	06700 OCCUPATIONAL THERAPY	0	5,477	7,817	13, 294	91	
68.00 70.00	06800 SPEECH PATHOLOGY 07000 ELECTROENCEPHALOGRAPHY	0	1, 207	1, 723 2, 104	2, 930 3, 578	52 0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1, 474 7, 685	10, 968	18, 653	39	
70.01	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,085	10, 988	18, 053	0	1
72.00		0	0	0	0	0	
		0	0	0	0	0	
75.00	OUTPATIENT SERVICE COST CENTERS	Ч	U U	0	<u>Ч</u>	0	/ /3.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00		0	0	0	0	0	
90.01	09001 JV CLINIC	0	13, 168	0	13, 168	175	
91.00		0	39, 717	56, 688	96, 405	680	
92.00					0		92.00
	OTHER REIMBURSABLE COST CENTERS		I		-1		1
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	341	101.00
	SPECIAL PURPOSE COST CENTERS						
		0	616, 905	861, 708	1, 478, 613	8, 751	118.00
118.00							1
	NONREI MBURSABLE COST CENTERS						1100 00
	NONREI MBURSABLE COST CENTERS	0	3, 515	5, 018	8, 533	0	190.00
190.00		0	3, 515 0	5, 018 0	8, 533 0		190.00
190. 00 192. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					0	
190.00 192.00 192.01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES			0		0 0	192.00
190. 00 192. 00 192. 01 192. 03	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRIVATE OFFICES 19201 MSO CLINICS			0 0		0 0 0	192. 00 192. 01
190. 00 192. 00 192. 01 192. 03 194. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRI VATE OFFI CES 19201 MSO CLINI CS 3 19203 FPA			0 0 0		0 0 0 0	192. 00 192. 01 192. 03
190. 00 192. 00 192. 01 192. 03 194. 00 194. 01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 MSO CLINICS 3 19203 FPA 0 07950 MEALS ON WHEELS			0 0 0 0		0 0 0 0 0	192.00 192.01 192.03 194.00 194.01 194.02
190.00 192.00 192.01 192.03 194.00 194.01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 MSO CLINICS 19203 FPA 007950 MEALS ON WHEELS 07951 GUEST MEALS 207952 MARKETING		0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0 57	192.00 192.01 192.03 194.00 194.01 194.02 200.00
190.00 192.00 192.01 192.03 194.00 194.01 194.02	19000GIFT, FLOWER, COFFEE SHOP & CANTEEN19200PHYSICIANS' PRIVATE OFFICES19201MSO CLINICS19203FPA07950MEALS ON WHEELS07951GUEST MEALS07952MARKETINGCross Foot Adjustments		0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0 57 0	192.00 192.01 192.03 194.00 194.01 194.02

Cost Center Description         IS/ACCOUNTING/ INVESTOR         USINESS OF CENTER         OTHER OF CENTER			LIVAN COUNTY CON	-			u of Form CMS-2	2552-10
MARKETING         OFFICE & ADMINISTRATIVE         PLANT         LINEN SERVICE           6.01         6.02         5.03         7.00         8.00           1.00         COTOLON SERVICE COST CENTERS         5.01         5.03         7.00         8.00           2.00         02200 NEW CAP EL COSTS-MUGLE FOULP         5.03         7.00         8.00         1.1           2.01         00220 NEW CAP EL COSTS-MUGLE FOULP         5.03         7.00         8.00           3.01         00550 LINESS OFFICE A ADMITTINE NO         2.310         35.400         5.101         100.801         5.101         100.801         5.101         100.801         5.101         100.801         5.101         100.801         5.101         100.801         5.101         100.801         5.101         100.801         1.101         6.102         2.211         1.0.841         10.952         7.81         10.952         7.81         10.952         7.81         10.952         7.81         10.952         7.81         10.952         7.81         10.952         7.81         10.952         7.81         10.952         7.81         10.952         7.81         10.952         7.91         10.91         10.91         10.91         10.91         10.952         7.91	ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	1		Date/Time Pre	pared: 3 pm
EINERAL SERVICE COST CENTERS         11           0.00000         New CAP RTL COSTS - MUBLE EQUIP         21           0.00000         New CAP RTL COSTS - MUBLE EQUIP         21           0.00000         New CAP RTL COSTS - MUBLE EQUIP         21           0.00000         New CAP RTL COSTS - MUBLE EQUIP         21           0.00000         New CAP RTL COSTS - MUBLE EQUIP         21           0.00000         New CAP RTL COSTS - MUBLE EQUIP         25           0.000000         New CAP RTL COSTS - MUBLE EQUIP         25           0.000000         NEW CAP RTL COSTS - MUBLE EQUIP         25           0.000000         NEW CAP RTL COSTS - MUBLE EQUIP         26           0.000000         NEW CAP RTL COSTS - MUBLE EQUIP         26           0.000000         NEW SEW CAP RTL COSTS - MUBLE EQUIP         27           1.1         1.2         2.107         1.544         10.984           1.1         1.2         2.107         1.544         10.994         30           1.1         1.2         2.107         1.544         10.994         30         11.300           1.1         1.2         2.17         1.1         1.1         1.1         11.1         1.1         1.1         11.1         1.1		Cost Center Description		OFFICE &	ADMI NI STRATI V			
1:00         00100 (NIN CAP REL COSTS -MULE COUP         1.1           0:00         00400 (PNE CAP REL COSTS -MULE COUP)         2.1           0:00         00400 (PNE CAP REL COSTS -MULE COUP)         2.1           0:00         00400 (PNE CAP REL COSTS -MULE COUP)         35,460           0:00         00400 (PNE CAP REL COSTS -MULE COUP)         35,460           0:00         00400 (PNE CAP REL COSTS -MULE COUP)         35,460           0:00         00400 (PNE CAP REL COSTS -MULE COUP)         35,460           0:00         00400 (PNE CAP REL COSTS -MULE COUP)         1.8           0:00         00400 (PNE CAP REL COSTS -MULE COUP)         1.8           0:00         00400 (PNE CAP REL COSTS -MULE COUP)         1.8           0:00         00000 (PNE TAP) (PNE TAP)         2.2           0:00         00000 (PNE TAP) (PNE TAP)         2.2           0:00         00000 (PNE TAP) (PNE TAP)         2.6           0:00         00000 (PE TAP)         2.6           0:00         00000 (PNE TAP)         2.6           0:00         0000 (PNE CAP REL COST CENTERS         1.1           0:00         00000 (PNE CAP REL COST CENTERS         1.1           0:00         00000 (PNE CAP REL COST CENTERS         2.14           0:00			5.01	5.02	5.03	7.00	8.00	
2:00         02200 kFB CAP REL COSTS -MORE E GUIP         2.01         2.02         02200 kFB CAP REL COSTS -MORE E GUIP         4.4           5:01         00550 (5:ACCOUNT ING/MARKET ING         39,046         5.1         5.1         5.01         5.03         00560 (DTFE A ADM IN STRAT IVF ADD EXPERAL         2.53         2.51         5.01         00560 (DTFE A ADM IN STRAT IVF ADD EXPERAL         2.53         2.51         6.27         1.54         10.0561         5.1           0.00         00560 (DTFE A ADM IN STRAT IVF ADD EXPERAL         2.53         2.51         6.27         1.54         10.0561         5.1           0.00         00000 (DTE ARY         1.233         1.224         1.764         10.0561         5.1         7.07         6.128         9.70         0.13.3           1.00         01000 (AETERIA A         0         0         0         2.231         3.611.1         10.057         5.144         5.12         2.452         4.522         3.77         6.44         5.720         0.13.4           1.00         01000 (AETERIA A         0         0         0         0.01         1.617         7.211         0.13.4           1.00         01000 (AETERIA A         0.13.4         0.140         1.617         7.217         0.13.4	1 00				1			1 1 00
4.00         DOLGO (LIMICOPE) ELEMENT IS DEPARTMENT         9         4         4         4         4         4         4         5         7         10         00								2.00
5. 01         00550         ISJACCOUNT INCAMARET IN INC         39,046         5.           5. 02         00560         0THER AMUNI ISTRATI VE A MD GENERAL         2,632         2,618         56,791         5.           5. 03         00560         0THER AMUNI ISTRATI VE AMD GENERAL         2,632         2,618         56,791         5.           5. 03         00560         0THER AMUNI ISTRATI VE AMD GENERAL         2,632         2,618         56,791         5.           5. 04         006000         LAMREN & LINEN SERVICE         166         2,621         1,344         10,958         6.           5. 00         00000         01000         CARSTERIA         0         0         0         2,221         361         11.           5. 00         01400         DERMARCY         2,466         2,662         3,477         0         15.           5. 00         01400         DERMARCY         2,444         940         1,017         7,241         0         16.           5. 00         03000         AMESTHET ISTS         0         0         0         16.         16.         17.         7.48         18.         16.         16.         16.         16.         16.         16.         16. <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>4.00</td>								4.00
5.02         0C340 BUSI NESS OFFICE & AURITING         2,310         35,400         5.1           5.03         0C360 OFFER AURINISTATIVE AND CENERAL         2,2375         2,366         4,071         150.81         5.1           7.00         00700 OFFER AURINISTATIVE AND CENERAL         2,375         2,366         4,071         150.81         5.1           7.00         00700 OFFERATION OF PLANT         2,2775         2,366         4,071         150.81         7.1           7.00         00700 OFFERATION OF PLANT         2,2101         6.123         7.1         7.4           7.00         00700 OFFERATION OF PLANT         1,231         1.222         1.016         6.123         7.9         1.016           11.00         01700 OFFERAT         SERVICE         5.7         0         1.3         0         0         1.3           11.00         01500 PHARBARCY         2,665         2,652         4,552         3.477         1.5         1.6           11.00         01500 PHARBARCY         2,665         2,652         3.677         1.68         1.68           11.00         01500 PHARBARCY         2,665         2,671         1.617         7.7         2.41         1.66         1.617         1.617 <td< td=""><td></td><td></td><td>39,046</td><td></td><td></td><td></td><td></td><td>5.01</td></td<>			39,046					5.01
5.03         00560         OTHER ANN IN STRATI VE AND GENERAL         2, 632         2, 418         56, 71         5.1           8.00         00800         LANDRY & LINEN SERVICE         168         167         287         1, 384         10, 981           9.00         00800         LANDRY & LINEN SERVICE         168         167         287         1, 384         10, 981           10.00         01000         DIFARY         1, 231         1, 224         2, 107         6, 128         389         10           11.00         010100         CHETERIA NO STRATI W         0         0         0         0         17         2, 211         38         11           11.00         010300         CHETERIA NO STRATI W         2, 655         2, 652         4, 562         4, 562         4, 562         4, 572         10         16           10.00         01600         MARSTHETI ISTS         0         0         0         0         10         16           10.00         01300         MARSTHETI ISTS         0         0         0         0         10         16           11.00         01300         MARSTHETI ISTS         0         0         0         0         0         0 <td></td> <td></td> <td></td> <td>35, 460</td> <td></td> <td></td> <td></td> <td>5.02</td>				35, 460				5.02
8. 00         000000 LAUNORY & LINEN SERVICE         168         167         287         1.344         10. 96         8.           10. 00         01000 DIETARY         1.231         1.224         2.107         6.128         39         10.           11. 00         01000 DIETARY         0.323         1.639         1.370         0         13.           13. 00         01300 NURSING AMIN STRATION         957         953         1.639         1.370         0         14.           14. 00         01400 CHIAQ, CENRA, SERVICE S         90         0         0.77         648         5.722         0         14.           16. 00         01000 MEDICAL, RECORDS & LIBARY         2.664         2.652         7.71         0.0         0         0         0         0         0         0         0         0         0         0         0.0         0.00	5.03	00560 OTHER ADMINISTRATIVE AND GENERAL	2, 632	2, 618	58, 79	1		5.03
9         00000000         00000000         00000000         000000000000000000000000000000000000	7.00		2, 378	2, 366				7.00
10.00         01000 DIEFARY         1,231         1,224         2,107         6,128         39         10.1           11.00         01300 NURSING ADMINISTRATION         957         953         1,639         1,370         0         13.4           14.00         01400 CENTRAL SERVICE SA SUPPLY         379         377         6.48         5,720         0         14.4           15.00         01500 PHARMACY         2,665         2,652         4,562         3,477         0         15.6           19.00         01900 NON-HYSI CLAN ANESTHEITISTS         0         <							10, 954	8.00
11.00       01100 CAFETERIA       0       0       0       2,231       36       11.1         13.00       01400 CENTRAL SERVICES & SUPPLY       379       377       648       5,720       0       14.1         16.00       01600 CENTRAL SERVICES & SUPPLY       379       377       648       5,720       0       14.1         16.00       01600 PARAMACY       2.665       2.652       4.562       3.477       0       15.1         16.00       01600 MEDICAL RECROSS & LIBRARY       944       940       1.617       7.241       0       16.1         10.00       003000 MONTYSICIAN MARSTRETISTS       0       0       0       0       0       0       0       19.1         13.00       03300 INTERSIN VE CARE UNIT       1.190       1.184       2.037       10.01       378       31.0       0300 MESS RPUICE COST CENTERS       5.144       51.1       3.811       32.665       1.468       50.0       5.3.00       53.00							-	9.00
13.00       01300 NURSI KG ADMINISTRATION       957       953       1,639       1,570       0       13.1         14.00       01400 CENTRAL SERVICES & SUBRAY       2,665       2,652       3,477       0       15.0         15.00       01500 PHARMACY       2,665       2,652       3,477       0       16.1         19.00       0100 NON-PHYSICIAN ANESTHETISTS       0								10.00
14.00       01400 CENTRAL SERVICES & SUPPLY       370       377       648       5,720       0       14.1         15.00       01500 PHARMACY       1 BRARY       944       940       1,617       7,241       0       16.1         16.00       01600 MEDICAL, RECORDS & LIBRARY       944       940       1,617       7,241       0       16.1         10.00       0000 0300 MEDIS (AL, NESTHETISTS       0       0       0       0       0       0       19.4         13.00       03100 INTENSIVE CARE UNIT       1.190       1.184       2.037       10.101       388       31.4         30.0       03300 INTESSIVE COST CENTERS       -			-	-				11.00
15.00       01500       PHARMACY       2,665       2,652       4,562       3,477       0       15.0         19.00       01500 NOMPHYSICIAL ANESTHETISTS       0							-	
16 0.00         0 1000         VECORDS & LIBRARY         944         940         1.61         7.241         0         16.0           10         D1000000000000000000000000000000000000					1			15.00
19:00         019:00         00         0 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>16.00</td></th<>								16.00
INPATIENT ROUTINE SERVICE COST CENTERS								19.00
13.1 00       00       0100       INTERSIVE CARE UNIT       1.190       1.184       2.037       10.101       378       31.1         34.00       43.00       43.00       43.00       43.00       43.00       43.00         ANCILLARY SERVICE COST CENTERS						•		1
43.00         [04300]	30.00	03000 ADULTS & PEDIATRICS	5, 144	5, 112	8, 79	7 38, 218	4, 849	30.00
ANCILLARY SERVICE COST CENTERS         -           ANCILLARY SERVICE COST CENTERS         -           50.00         05000 OPECATING ROOM         2,226           52.00         05200 DELUVERY MOOM & LABOR ROOM         2,226           53.00         05300 ANESTHESI OLOGY         7           7         7         13,738           54.00         05400 RAD OLOGY-DI AGNOSTI C         2,168         2,157           54.01         05400 RAD OLOGY-DI AGNOSTI C         2,168         2,157           54.00         05600 RADI OLOGY-DI AGNOSTI C         2,168         2,157           54.01         05600 RADI OLOGY-DI AGNOSTI C         2,981         2,966           53.00         05300 RADI OLOGY-DI AGNOSTI C         2,981         2,966           63.00         05300 RADI OLOGY-DI AGNOSTI C         2,981         2,966           63.00         06300 RADI NESPI REATORY         2,981         2,966           64.00         06400 INTRAVENUS THERAPY         1,900         1,84           65.00         06500 RESPI RATORY THERAPY         1,900         1,84           65.00         06600 PHYSI CAL THERAPY         0         0         0           67.00         06700 OCCUPATIONAL THERAPY         286         285         490 </td <td>31.00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>31.00</td>	31.00							31.00
50:00       05000 (DEPATI NG ROOM       2,226       2,215       3,811       32,655       1,448       50.         52:00       05200 DELU VERY NGOM & LABOR ROOM       40       40       40       69       1,135       64       52.         53:00       05300 ARESTHESI OLOCY       7       7       12       0       63.88       54.1         54:01       05401 ULTRASOUND       424       422       726       826       54.6         56:00       05600 RADIOLOCY-DIAGNOSTIC       2,981       2,966       51.03       7,362       32       66.1         63:00       05600 ILABORATIORY       2,981       2,966       51.03       7,362       32       66.1         64:00       06400 INTRAVENDUS THERAPY       64       64       110       819       0       64.6         65:00       06500 RESPI RATIORY THERAPY       1,190       1,184       2,038       6,094       43       65.         66:00       06600 SPREST STHERAPY       0       0       0       0       0       67.6         66:00       06600 SPREST THERAPY       1,668       1,660       2,855       490       1,995       0       67.6         70:00       00       0	43.00		214	213	36	7 809	286	43.00
52:00       DS200       DELIVERY ROM & LABOR ROM       40       40       69       1.135       64       52.0         53:00       DS300 ANESTHESIOLOGY       7       7       12       0       0       53.8         54:00       DS400 RADIOLOGY-DIAGNOSTIC       2.168       2.157       3.711       13.738       638       54.5         54:00       DS400 RADIOLOGY-DIAGNOSTIC       2.168       2.157       3.711       13.738       638       54.5         56:00       DSG00 RADIOLOGY-DIAGNOSTIC       2.981       2.966       5.103       7.362       32.6       60.6         66:00       DG600 RESPIRATORY THERAPY       64       64       110       819       64.6         66:00       DG600 RESPIRATORY THERAPY       1.668       1.660       2.855       9.992       929       66.6         66:00       DG600 RESPIRATORY THERAPY       1.668       1.660       2.855       9.992       929       66.6         66:00       DG600 RESPIRATORAL THERAPY       1.864       2.85       490       1.995       67.6         68:00       D68000 RESPIRATONAL THERAPY       1.668       1.660       2.857       9.992       929       66.6         70:01       OTODO CL	50.00		0.00/	0.045	0.01		4 440	50.00
53.00       OBSOO AMESTHESI OLCOY       7       7       12       0       0       53.         54.00       OSAOO RADIOLOROP PIO KANOSTI C       2,168       2,157       3,711       13,738       638       54.         56.00       OSAOO RADIOLOSTOPE       195       194       335       1,021       0       56.         60.00       OGAOO LABORATORY       2,981       2,966       5,103       7,362       32       60.         63.00       OSAOO INTRAVENDUS THERAPY       64       64       110       819       0       63.         64.00       OSAOO INTRAVENDUS THERAPY       1,190       1,184       2,038       6,094       43       66.         65.00       OSOO REST THERAPY       1,668       1,660       2,855       9,992       929       66.       66.0       66.00       6600 OPHYSI CAL THERAPY       1,668       2,855       490       1,995       66.       66.       66.00       6600 OPHYSI CAL THERAPY       13       13       32       2,577       07.0       0.       0.0       0       0       0       0.0       0.0       0.0       72.       73.       0.0       70.0       70.0       70.0       70.0       70.0       70.0       <							-	
54.00       05400       RADIOLOGY-DIAGNOSTIC       2, 168       2, 157       3, 711       13, 738       638       54.4         56.01       05600       RADIOLOGY-DIAGNOSTIC       2, 961       3, 711       13, 738       638       54.4         56.00       05600       RADIOLSOTOPE       195       104       335       1, 021       0       56.6         60.00       06000       LABORATORY       2, 981       2, 966       5, 103       7, 342       32       60.6         63.00       06300       BLOOD STORING, PROCESSING & TRANS.       85       84       145       442       0       63.6         65.00       06500 RESPIRATORY THERAPY       64       64       110       819       0       64.6         66.00       06000 RESPIRATORAL THERAPY       1, 960       1, 660       2, 855       9, 992       929       66.6       66.0       6600       67.00       0       0       0       67.0       67.00       67.00       67.00       67.00       67.00       67.0       68.6       67.01       67.0       67.00       67.00       67.00       67.00       67.0       67.0       67.0       67.0       67.0       67.00       67.0       67.0       67			40	40				
54.01       US401       ULTRASDUND       424       422       726       626       0       54.00         56.00       05600       RADI 0IS TOPE       195       194       335       1,021       0       56.00         63.00       06300       LABORATORY       2,981       2,966       5,103       7,362       32       60.0         64.00       06400       INTRAVENUS       THERAPY       64       411       819       0       64.0         65.00       00500       INTRAVENUS       THERAPY       1,190       1,184       2,038       6,094       43       65.0         66.01       066000       PMSTS THERAPY       16.66       1,660       2,855       9,992       929       66.0       67.00       67.00       60.00       0       0       0       67.00       67.00       66.00       6800       SPEECH PATHOLOGY       156       155       266       440       68.0       68.0       68.0       68.0       69.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0			2 168	7 2 157				54.00
66.00         05600         RADIO I SOTOPE         195         194         335         1,021         0         56.0           60.00         06000         LABORATORY         2,981         2,966         5,103         7,362         32         60.0           60.00         06000         LABORATORY         2,981         2,966         5,103         7,362         32         60.0           63.00         06300         BLODD STORI NG, PROCESSI NG & TRANS.         85         84         1145         642         0         63.0           65.00         06500         RESPI RATORY THERAPY         1,190         1,184         2,038         6,094         43         65.           66.01         06600         PSPIS TAL THERAPY         1,668         1,660         2,855         9,992         929         66.           67.00         06700         OCCUPATI ONAL THERAPY         286         285         490         1,995         0         67.0           0.00         0         0         0         0         0         0         0         0         70.0         70.0         70.0         70.0         70.0         70.0         70.0         70.0         70.0         70.0         70.0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>54.00</td>								54.00
60.00         IABORATORY         2,981         2,966         5,103         7,362         32         60.03           63.00         06300         BLOOD STORING, PROCESSING & TRANS.         85         84         145         462         0         63.00           64.00         06400         INTRAVENOUS THERAPY         1,190         1,184         2,038         6,094         43         65.00           66.00         06600         PNSTCAL THERAPY         1,190         1,184         2,038         6,094         43         65.00           66.01         06600         PNSTCAL THERAPY         0         0         0         0         0         66.01         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.01         57.01         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         70.01         70.01         70.01         70.01         70.01         70.01								56.00
64.00       06400       INTRAVENOUS THERAPY       64       64       110       819       0       64.0         65.00       06500       RESPI RATORY THERAPY       1,668       1,660       2,855       9,992       292       66.0         66.01       06600       PHYSI CAL THERAPY       0							32	60.00
65.00       06500       RESPIRATORY THERAPY       1,190       1,184       2.038       6,094       43       65.1         66.00       06600       PHYSICAL THERAPY       1,668       1,660       2,855       9,992       929       66.0         66.01       06601       SPORTS THERAPY       0       0       0       0       66.01         66.01       06601       SPORTS THERAPY       286       285       490       1,995       67.0       67.0         68.00       ORGON SPECEN PATHOLOGY       156       155       266       440       0       68.0         70.00       07000       ELECTROENCEPHALOGRAPHY       13       13       22       537       0       70.0         71.00       07100       MELCAL SUPPLIES CHARGED TO PATIENTS       660       657       1,131       0       0       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       0       0       0       0       0       0       73.0         73.00       07300       RUSA CHARGED TO PATIENTS       0       0       0       0       0       0       0       0       0       0       73.0       73.00	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	85	84	14	5 462	0	63.00
66.00         06600         PHYSICAL THERAPY         1,668         1,660         2,855         9,992         929         66.0           66.01         06001         SPORTS THERAPY         0	64.00		64	64	11	0 819	0	64.00
66.01         06.01         SPORTS THERAPY         0         0         0         0         0         0         0         66.01           67.00         06700         0CCUPATI 0NAL THERAPY         286         285         490         1,995         0         67.00           68.00         05600         SPECIAL DATIONAL THERAPY         136         135         266         440         0         68.0           70.01         07000         LECTROENCEPHALOGRAPHY         133         133         22         537         0         70.0           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         660         657         1, 131         0         0         71.0           73.00         07300         DRUSS CHARGED TO PATI ENTS         0         0         0         0         73.0           00.01         OBSOO RURAL HEALTH CLINIC         0								65.00
67.00       0CCUPATIONAL THERAPY       286       285       490       1,995       0       67.0         68.00       06800       SPEECH PATHOLOGY       156       155       266       440       0       68.0         70.00       07001       CARDIOPULMONARY       13       13       22       537       0       70.0         71.00       70010       MEDICAL SUPPLIES CHARGED TO PATIENTS       660       657       1,131       0       0       72.0         72.00       07200 IMPL. DEV. CHARGED TO PATIENT       263       262       451       0       0       72.0         73.00       DRUGS CHARGED TO PATIENTS       0       0       0       0       73.0         00       0000       0       0       0       0       0       73.0         017001 KEDICAL SUPPLIES CHARGED TO PATIENTS       0       0       0       0       73.0         00000 0200 RURAL HEALTH CLINIC       0       0       0       0       0       0       90.0         90.01       090101 JV CLINIC       708       704       1,212       4,797       148       90.0         91.00       OPHOE MERGENCY       1,093       0       1,758       0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>66.00</td>								66.00
68.00       06800       SPEECH PATHOLOGY       156       155       266       440       0       68.00         70.00       07000       ELECTROENCEPHALOGRAPHY       13       13       22       537       0       70.0         70.00       07000       MEDI CAL <supplies charged="" patients<="" td="" to="">       660       657       1,131       0       0       71.00         71.00       07100       MEDI CAL<supplies charged="" patients<="" td="" to="">       660       657       1,131       0       0       71.00         73.00       07300       DRUCS CHARGED TO PATIENTS       0       0       0       0       72.0         00000       CLINIC       0       0       0       0       0       0       90.00       9000       90.00       9000       90.00       9000       90.00</supplies></supplies>			-	0				66.01
70.00       07000       ELECTROENCEPHALOGRAPHY       13       13       22       537       0       70.0         70.01       07001       CARDI OPULMONARY       153       153       263       2,799       0       70.0         71.00       70.01       MEDIAL SUPPLIES CHARGED TO PATIENTS       660       657       1.131       0       0       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       263       262       451       0       0       72.0         00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       72.0       73.0         00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       73.0         00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       0       73.0         00       000000       DRUGS CHARGED TO PATIENTS       0       0       0       0       90.0       90001       0       0       0       0       90.0       90.0       90.0       0       0       91.00       90.0       1.90901       JV CLINIC       70.8       90.0       1.758       0       0       11.00       9								
70. 01       07001       CARDI OPULMONARY       153       153       263       2,799       0       70. 0         71. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       660       657       1, 131       0       0       71. 0         72. 00       07200       IMPL. DEV. CHARGED TO PATI ENT       263       262       451       0       0       73. 0         007300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       0       0       73. 0         001701       EXENTIAL REALTH CLINIC       0								
71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       660       657       1,131       0       0       71.00         72.00       07300       DRUGS CHARGED TO PATIENT       263       262       451       0       0       72.0         73.00       DRUGS CHARGED TO PATIENTS       0       0       0       0       0       0       0       73.0         00179ATIENT SERVICE COST CENTERS       0       1       0       1       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td< td=""><td></td><td></td><td></td><td></td><td>1</td><td></td><td></td><td>70.00</td></td<>					1			70.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENT       263       262       451       0       0       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>-</td><td>71.00</td></t<>							-	71.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0							0	72.00
88.00         08800         RURAL HEALTH CLINIC         0<	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	)	o c	0	73.00
00.00       09000       CLINIC       0					1	-		
90.01       09001       JV CLINIC       708       704       1,212       4,797       148       90.0         91.00       09100       EMERGENCY       3,196       3,196       3,180       5,471       14,467       2,064       91.0         92.00       OBSERVATION BEDS (NON-DISTINCT PART)       0       1,758       0       010       0       0       14,467       2,064       91.0       92.0         00000       DISERVATION BEDS (NON-DISTINCT PART)       0       1,758       0       0       101.0       0       14,467       2,064       91.0       92.0         00000       DISERVATION BEDS (NON-DISTINCT PART)       0       1,758       0       0       101.0       0       101.0       0       17.58       0       0       101.0       0       101.0       0       1.093       0       1,758       0       0       101.0       0 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td></td></td<>			0	0		0 0	0	
91.00       09100       EMERGENCY       3, 196       3, 180       5, 471       14, 467       2, 064       91.0         92.00       0BSERVATI ON BEDS (NON-DI STI NCT PART)       0       14, 467       2, 064       92.0         0THER REI MBURSABLE COST CENTERS       0       1, 758       0       0       101.00         SPECIAL PURPOSE COST CENTERS         118.00       SUBTOTALS (SUM OF LINES 1-117)       38, 713       35, 129       57, 695       178, 915       10, 954         18.00       SUBTOTALS (SUM OF LINES 1-117)       38, 713       35, 129       57, 695       178, 915       10, 954         190.00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       23       1, 281       0       192.0         192.01       19200       PHYSI CI ANS' PRI VATE OFFICES       0       0       0       0       192.0         192.03       19203       FPA       0       0       0       0       192.0         192.03       19203       FPA       0       0       0       0       0       192.0         194.00       07950       MEALS ON WHEELS       0       0       0       0       194.0         194.02			-	0	1.01	0 0		
92.00       OBSERVATION BEDS (NON-DISTINCT PART)       92.0         OTHER REIMBURSABLE COST CENTERS       0       1,093       0       1,758       0       0         101.00       10100       HOME HEALTH AGENCY       1,093       0       1,758       0       0       101.0         SPECIAL PURPOSE COST CENTERS         118.00       SUBTOTALS (SUM OF LINES 1-117)       38,713       35,129       57,695       178,915       10,954       118.0         NONREI MBURSABLE COST CENTERS         190.00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       23       1,281       0       192.0         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       0       0       0       192.0         192.01       19201       MSO CLI NI CS       0       0       0       0       192.0         192.03       19203       FPA       0       0       0       0       192.0         194.00       07950       MEALS ON WHEELS       0       0       0       0       0       194.0         194.02       07950       MARKETI NG       333       331       570       685       0       1								1
OTHER REIMBURSABLE COST CENTERS           101.00         10100         HOME HEALTH AGENCY         1,093         0         1,758         0         0         101.0           SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1-117)         38,713         35,129         57,695         178,915         10,954         118.0           NONREI MBURSABLE COST CENTERS           190.00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         23         1,281         0         190.0           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         0         0         0         192.0           192.01         19201         MSO CLI NI CS         0         0         0         0         192.0           192.03         19203         FPA         0         0         0         0         192.0           194.00         07950         MEALS ON WHEELS         0         0         0         0         194.0           194.02         07950         MARKETI NG         333         331         570         685         0         194.0           194.02         O7952         <			3, 196	3, 180	5,47	14,467	2, 064	
101.00         10100         HOME         HEALTH         AGENCY         1,093         0         1,758         0         0         101.0           SPECI AL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1-117)         38,713         35,129         57,695         178,915         10,954         118.0           NONREI MBURSABLE COST CENTERS           190.00         I9000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         23         1,281         0         190.0         192.0         192.00         192.00         192.01         MSO CLI NI CS         0         0         0         192.0         192.03         192.03         FPA         0         0         0         192.0         192.03         192.03         FPA         0         0         0         192.0         192.03         192.03         FPA         0         0         0         0         192.0         192.01         192.03         192.03         192.04         192.04         192.05         192.04         192.04         192.04         192.05         192.04         192.04         192.04         192.04         192.04         192.04         192.04         192.04         192.04         192.04	92.00							92.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1-117)         38,713         35,129         57,695         178,915         10,954           190.00         19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         23         1,281         0         190.00           192.00         19200 PHYSI CI ANS' PRI VATE OFFI CES         0         0         0         192.0           192.01         19201 MSO CLI NI CS         0         0         0         0         192.0           192.03         19203 FPA         0         0         0         0         0         192.0           194.00         07950 MEALS ON WHEELS         0         0         0         0         0         192.0           194.01         07951 GUEST MEALS         0         0         0         0         0         194.0           194.02         07952 MARKETI NG         333         331         570         685         0         194.0           200.00         Cross Foot Adj ustments         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	101 00		1 093	0	1 75	8 0	0	101 00
Image: Nonce i mean state i and			.,		.,		-	
NONREI MBURSABLE         COST         CENTERS           190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         23         1, 281         0         190.0           192.00         19200         PHYSI CLANS'         PRI VATE OFFICES         0         0         503         0         0         192.0           192.01         19201         MSO CLINICS         0         0         0         0         192.0           192.03         19203         FPA         0         0         0         0         192.0           194.00         07950         MEALS ON WHEELS         0         0         0         0         192.0           194.01         07951         GUEST MEALS         0         0         0         0         194.0           194.02         07952         MARKETI NG         333         331         570         685         0         194.0           194.02         07952         MARKETI NG         333         331         570         685         0         194.0           200.00         Cross Foot Adjustments         0         0         0         0         200.0           201.00         Negati ve Co	118.00		38, 713	35, 129	57, 69	5 178, 915	10, 954	118.00
192.00       19200       PHYSICIANS' PRIVATE OFFICES       0       0       503       0       192.0         192.01       19201       MSO CLINICS       0       0       0       0       192.0         192.03       19203       FPA       0       0       0       0       192.0         194.00       07950       MEALS ON WHEELS       0       0       0       0       194.0         194.01       07951       GUEST MEALS       0       0       0       0       194.0         194.02       07952       MARKETI NG       333       331       570       685       0       194.0         194.02       07952       MARKETI NG       333       331       570       685       0       194.0         200.00       Cross Foot Adj ustments       0       0       0       0       0       200.0         201.00       Negati ve Cost Centers       0       0       0       0       0       0       0       200.0		NONREI MBURSABLE COST CENTERS						
192.01       MSO CLINICS       0       0       0       192.01         192.03       19203       FPA       0       0       0       0       192.02         194.00       07950       MEALS ON WHEELS       0       0       0       0       194.02         194.01       07951       GUEST MEALS       0       0       0       0       194.02         194.02       07952       MARKETI NG       333       331       570       685       0       194.02         200.00       Cross Foot Adjustments       0       0       0       0       200.02         201.00       Negative Cost Centers       0			-					190. 00
192.03       FPA       0       0       0       192.0			-	0				192.00
194.00       07950       MEALS ON WHEELS       0       0       0       194.01         194.01       07951       GUEST MEALS       0       0       0       0       194.01         194.02       07952       MARKETI NG       333       331       570       685       0       194.02         200.00       Cross Foot Adjustments       0       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       0       201.00			0	0		0 0		
194.01       07951       GUEST MEALS       0       0       0       194.01         194.02       07952       MARKETI NG       333       331       570       685       0       194.02         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       0			0	0				
194.02       07952       MARKETI NG       333       331       570       685       0       194.02         200.00       Cross Foot Adjustments       201.00       0       0       0       0       0       201.00			0	0				
200.00         Cross Foot Adjustments         200.00			333	221				
201.00         Negative Cost Centers         0 </td <td></td> <td></td> <td>333</td> <td>551</td> <td>57</td> <td>005</td> <td>0</td> <td>200.00</td>			333	551	57	005	0	200.00
			0	0		o o	0	201.00
202.00 TOTAL (sum lines 118-201) 39,046 35,460 58,791 180,881 10,954 202.0			39, 046	35, 460	58, 79	1 180, 881		

	Financial Systems SUL TION OF CAPITAL RELATED COSTS	LIVAN COUNTY COM	Provider CCI		In Lie Period:	u of Form CMS-2 Worksheet B	2552-10
	TTON OF CAPITAL RELATED COSTS			1	rom 01/01/2016	Part II Date/Time Pre 5/26/2017 2:2	
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
	OFNERAL CERTICO	9.00	10.00	11.00	13.00	14.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00	00200 NEW CAP REL COSTS -MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 I S/ACCOUNTI NG/MARKETI NG 00540 BUSI NESS OFFICE & ADMITTI NG 00560 OTHER ADMINI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVICE 00900 HOUSEKEEPI NG 01000 DI ETARY	27, 751 964	52, 790				2.00 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00
11.00	01100 CAFETERI A	351	32, 369	39, 892			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	216	0	1, 13		17 100	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	900 547	0	86		47, 109	
15.00 16.00	01600 MEDICAL RECORDS & LIBRARY	1, 139	0	1, 17: 2, 364		939 5	15.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	2, 30		0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			-	-1 -1		
30.00	03000 ADULTS & PEDI ATRI CS	6, 012	11, 849	10, 573		3, 627	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 589	684	2,06		238	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	127	0	38!	5 253	214	43.00
50.00	05000 OPERATING ROOM	5, 137	403	3, 189	2,076	4, 500	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	179	0	40		48	52.00
53.00	05300 ANESTHESI OLOGY	0	0	(		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 161	0	2, 552		809	54.00
54.01	05401 ULTRASOUND	130	0		0 0	0	54.01
56.00 60.00	05600 RADI OI SOTOPE 06000 LABORATORY	161 1, 158	0	( 4, 01		0 4, 607	56.00 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	73	0			4,007	63.00
64.00	06400 I NTRAVENOUS THERAPY	129	0	(	0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	959	0	2, 04		2, 160	65.00
66.00	06600 PHYSI CAL THERAPY	1, 572	0	2, 832		277	66.00
66.01	06601 SPORTS THERAPY	0	0	(	-	0	66.01
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	314 69	0	35 <sup>-</sup> 260		6 13	67.00 68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	84	0	200		0	70.00
70.01	07001 CARDI OPULMONARY	440	0	208		0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0 0	19, 671	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT						
72.00		0	0	(	-	7, 820	
72.00 73.00	07300 DRUGS CHARGED TO PATIENTS	0	0 0			7, 820 0	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	-	0	(	-	0	73.00
73.00 88.00	07300 DRUGS CHARGED TO PATIENTS	0	- 1	(	0 0	0	73.00 88.00
73.00 88.00 90.00 90.01	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09001 JV CLINIC	0 0 0 755	- 1	( ( ( ( 1, 23	0 0 0 0 0 0 9 811	0 0 0 0 0	73.00 88.00 90.00 90.01
73.00 88.00 90.00 90.01 91.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09001 JV CLINIC 09100 EMERGENCY		- 1	(	0 0 0 0 0 0 9 811	0 0 0	73.00 88.00 90.00 90.01 91.00
73.00 88.00 90.00 90.01 91.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09001 JV CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 755	- 1	( ( ( ( 1, 23	0 0 0 0 0 0 9 811	0 0 0 0 0	73.00 88.00 90.00 90.01
<ul> <li>73.00</li> <li>88.00</li> <li>90.00</li> <li>90.01</li> <li>91.00</li> <li>92.00</li> </ul>	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09001 JV CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0 0 755 2, 276	0 0 0 0	( ( ( 1, 23' 4, 30	0 0 0 0 7 811 8 2, 815	0 0 0 2, 082	73.00 88.00 90.00 90.01 91.00 92.00
<ul> <li>73.00</li> <li>88.00</li> <li>90.00</li> <li>90.01</li> <li>91.00</li> <li>92.00</li> </ul>	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0 0 0 755	- 1	( ( ( 1, 23' 4, 30	0 0 0 0 0 0 9 811	0 0 0 2, 082	73.00 88.00 90.00 90.01 91.00
<ul> <li>73.00</li> <li>88.00</li> <li>90.00</li> <li>90.01</li> <li>91.00</li> <li>92.00</li> </ul>	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 0 755 2, 276	0 0 0 0	( ( ( 1, 23' 4, 30	0         0           0         0           0         0           0         0           1         2, 815           0         1, 309	0 0 0 2, 082	73.00 88.00 90.00 90.01 91.00 92.00
73.00 88.00 90.00 90.01 91.00 92.00 101.00 118.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NORREIMBURSABLE COST CENTERS	0 0 755 2,276 0 27,442	0 0 0 0	( ( ( 1, 23 4, 30 ( ( 39, 60	0         0           0         0           0         0           0         0           1         2, 815           0         1, 309           7         15, 705	0 0 0 2, 082 93 47, 109	73.00 88.00 90.01 91.00 92.00 101.00 118.00
73.00 88.00 90.00 90.01 91.00 92.00 101.00 118.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09001 JV CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NORREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 0 755 2,276 0 27,442	0 0 0 0	( ( ( ( ( ( ( ( 39, 60 <sup>-</sup> ) (	O         O           O         O           O         O           O         O           O         O           O         O           O         O           O         O           O         1, 309           7         15, 705           O         O	0 0 0 2, 082 93 47, 109 0	73.00 88.00 90.00 90.01 91.00 92.00 101.00 118.00
73.00 88.00 90.01 91.00 92.00 101.00 118.00 190.00 192.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09001 JV CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 0 755 2,276 0 27,442	0 0 0 0	( ( ( ( ( ( ( ( 39, 60 <sup>-</sup> ) (	0         0           0         0           0         0           0         0           1         2, 815           0         1, 309           7         15, 705	0 0 0 2,082 93 47,109 0 0	73.00 88.00 90.01 91.00 92.00 101.00 118.00 190.00 192.00
73.00 88.00 90.01 91.00 92.00 101.00 118.00 192.00 192.01 192.01	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09001 JV CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 MSO CLINICS	0 0 755 2,276 0 27,442	0 0 0 0	( ( ( ( ( ( ( ( 39, 60 <sup>-</sup> ) (	O         O           O         O           O         O           O         O           O         O           O         O           O         O           O         O           O         1, 309           7         15, 705           O         O	0 0 0 2,082 93 47,109 0 0 0 0	73.00 88.00 90.00 90.01 91.00 92.00 101.00 118.00 190.00 192.01
73.00 88.00 90.00 91.00 92.00 101.00 118.00 192.00 192.01 192.01 192.03	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09001 JV CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 0 755 2,276 0 27,442	0 0 0 0	( ( ( ( ( ( ( ( 39, 60 <sup>-</sup> ) (	O         O           O         O           O         O           O         O           O         O           O         O           O         O           O         O           O         1, 309           7         15, 705           O         O	0 0 0 2,082 93 47,109 0 0 0 0 0 0	73.00 88.00 90.01 91.00 92.00 101.00 118.00 190.00 192.00
73.00 88.00 90.01 91.00 92.00 101.00 118.00 192.00 192.01 192.02 194.01	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09001 JV CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NORREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 MSO CLINICS 19203 FPA 077950 MEALS ON WHEELS 07951 GUEST MEALS	0 0 755 2, 276 0 27, 442 201 0 0 0 0 0 0 0 0 0 0	0 0 0 0 45, 305 0 0 0 0 0 0 0	( ( 1, 23 4, 30 ( ( 39, 60 ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	0         0           0         0           0         0           9         811           3         2,815           0         1,309           7         15,705           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0	0 0 0 2, 082 93 47, 109 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73.00 88.00 90.00 90.01 91.00 92.00 101.00 118.00 192.00 192.01 192.01 194.00 194.01
73.00 88.00 90.00 90.01 91.00 92.00 101.00 118.00 192.00 192.00 192.01 192.03 194.02 194.01	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09001 JV CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NORREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 MSO CLINICS 19203 FPA 07950 MEALS ON WHEELS 07951 GUEST MEALS	0 0 755 2,276 0 27,442	0 0 0 0 45, 305 0 0 0 0 0 0 0	( ( ( ( ( ( ( ( 39, 60 <sup>-</sup> ) (	0         0           0         0           0         0           9         811           3         2,815           0         1,309           7         15,705           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0	0 0 0 2, 082 93 47, 109 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73.00 88.00 90.00 90.01 91.00 92.00 101.00 118.00 192.00 192.01 192.01 192.03 194.01 194.02
73.00 88.00 90.01 91.00 92.00 101.00 118.00 192.00 192.00 192.01 192.03 194.01 194.01 194.02 200.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09001 JV CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 MSO CLINICS 19203 FPA 07950 MEALS ON WHEELS 07951 GUEST MEALS 07952 MARKETING Cross Foot Adjustments	0 0 755 2, 276 0 27, 442 201 0 0 0 0 0 0 0 0 0 0	0 0 0 0 45, 305 0 0 0 0 0 0 0	( ( ( ( 1, 23 4, 30 ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	0         0           0         0           0         0           0         0           1         2, 815           0         1, 309           7         15, 705           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0	0 0 0 2, 082 93 47, 109 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73.00 88.00 90.01 91.00 92.00 101.00 118.00 192.00 192.01 192.03 194.01 194.02 200.00
73.00 88.00 90.00 90.01 91.00 92.00 101.00 118.00 192.00 192.00 192.01 192.03 194.02 194.01	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 09000 CLINIC 09001 JV CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 MSO CLINICS 19203 FPA 07950 MEALS ON WHEELS 07951 GUEST MEALS 07952 MARKETING Cross Foot Adjustments Negative Cost Centers	0 0 755 2, 276 0 27, 442 201 0 0 0 0 0 0 0 0 0 0	0 0 0 0 45, 305 0 0 0 0 0 0 0	( ( 1, 23 4, 30 ( ( 39, 60 ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	0         0           0         0           0         0           0         0           1         2, 815           0         1, 309           7         15, 705           0         0	0 0 0 2, 082 93 47, 109 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73.00 88.00 90.01 91.00 92.00 101.00 118.00 192.00 192.01 192.03 194.01 194.02 200.00 201.00

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ALL 00A	TLON			DEL	ATED	

Heal th	Financial Systems SUL	LIVAN COUNTY COM	MUNITY HOSPIT	AL	In Lie	u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C	F	Period: From 01/01/2016 To 12/31/2016		
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	GENERAL SERVICE COST CENTERS	15.00	16.00	19.00	24.00	25.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550 I S/ACCOUNTI NG/MARKETI NG						5.01
5.02 5.03	00540 BUSINESS OFFICE & ADMITTING 00560 OTHER ADMINISTRATIVE AND GENERAL						5.02 5.03
7.00	00700 OPERATI ON OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY	39, 475					15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	62, 785				16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	0	) (		<u> </u>	19.00
30.00	03000 ADULTS & PEDIATRICS	0	5, 754	l I	363, 112	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	424		88, 917	0	31.00
43.00	04300 NURSERY	0	180		8, 503	0	43.00
E0 00	ANCI LLARY SERVI CE COST CENTERS	0	E 095	:	280, 884	0	50.00
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	0	5, 085 40		280, 884 9, 260	0	52.00
53.00	05300 ANESTHESI OLOGY	0	768		794	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	11, 739		131, 684	0	54.00
54.01	05401 ULTRASOUND	0	2, 126		10, 159	0	54.01
56.00 60.00	05600 RADI OI SOTOPE 06000 LABORATORY	0	420 11, 615		9, 127 89, 389	0	56.00 60.00
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	720		4, 645	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	442		7, 085	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	2, 636		59, 309	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 581		90, 474	0	66.00
66. 01 67. 00	06601 SPORTS THERAPY 06700 OCCUPATI ONAL THERAPY	0	0 330		17, 442	0	66. 01 67. 00
68.00	06800 SPEECH PATHOLOGY	0	72		4, 419	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	45	5	4, 292	0	70.00
70.01	07001 CARDI OPULMONARY	0	306		23, 150	0	70.01
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	5, 242 400		27, 361 9, 196	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	39, 475	2, 951		42, 426		73.00
/0/00	OUTPATIENT SERVICE COST CENTERS		2,701		12,120		
88.00	08800 RURAL HEALTH CLINIC	0	0		0	0	88.00
90.00		0	0		0	0	
90. 01 91. 00	09001 JV CLINIC 09100 EMERGENCY	0	980 8, 329		24, 697 145, 273	0	
		0	0, 527		143, 273	0	
	OTHER REIMBURSABLE COST CENTERS	· ·					
101.00	0 10100 HOME HEALTH AGENCY	0	600	)	5, 194	0	101.00
118.00	SPECIAL PURPOSE COST CENTERS           SUBTOTALS (SUM OF LINES 1-117)	39, 475	62, 785	i c	1, 456, 792	0	118.00
116.00	NONREIMBURSABLE COST CENTERS	39,473	02,703		1,430,792	0	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	)	10, 038	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	)	503		192.00
	1 19201 MSO CLINICS	0	0		0		192.01
	3 19203 FPA D 07950 MEALS ON WHEELS	0	0		7 405		192.03 194.00
	107950 MEALS ON WHEELS	0	0		7,485		194.00
	207952 MARKETI NG	0	0		6, 935		194.02
200.00	Cross Foot Adjustments			0	0 0	0	200. 00
201.00		0	0				201.00
202.00	)  TOTAL (sum lines 118-201)	39, 475	62, 785	i c	1, 491, 712	0	202.00

In Lieu of Form CMS-2552-10 Worksheet B

Cost Center Description         Total         26.00           GENERAL SERVICE COST CENTERS         26.00           000100 NEW CAP REL COSTS-BLDG & FIXT         2000           000200 NEW CAP REL COSTS-WBLE EQUIP         4.00           4.00         00400 EMPLOYEE BENEFITS DEPARMMENT           5.01         00550 IS/ACCOUNTING/MARKETING           5.02         00560 OTHER ADMINISTRATIVE AND GENERAL           7.00         00700 OPERATION OF PLANT           8.00         00600 LAUNDRY & LINEN SERVICE           9.00         00900 HOUSEKEPING           11.00         01100 CAFETERIA           13.00         01300 NURSI NG ADMI NI STRATI ON           14.00         01400 CENTRAL SERVICES & SUPPLY           15.00         10500 PHARMACY           16.00         01500 PHARMACY           17.00         01400 CONTHY S LIAN ANESTHETISTS           18.00         03000 NONPHYSI CI AN ANESTHETISTS           19.00         03000 NONPHYSI CI AN ANESTHETI STS           10.00         03000 NURSERY           30.00         03000 NURSERY           30.00         04300 NURSERY           30.00         04300 NURSERY           30.00         05400 RAU OLGAY           31.00         03000 ADULTS & PEDIATRICS	<u>26/2017 2:23 pm</u>
GENERAL         SERVI CE         COST         CENTERS           1.00         00100         NEW         CAP         REL         COSTS-MUGLE         COST           2.00         00200         NEW         CAP         REL         COSTS-MUGLE         COST           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT         5           5.01         005500         DISACCOUNTI No/MARKETI NG         5         5         CO         00540         BUSINESS OFFICE         ADMITTING           5.02         00540         DUSINEST OFFICE         ADMITTING         5         3         00560         OTHER ADMINI STRATIVE AND GENERAL         7         00         00700         OPERATION OF         PLANT         8         0         00800         LAUNRY & LINEN SERVICE         9         00         00900         HOUSEKEEPI NG         10         10         100         CAPTERIA         13.00         01300         NURSI NG ADMINI STRATION         14.00         1100         CAPTERIA         13.00         01500         PHARMACY         16.00         01500         PHARMACY         16.00         01500         PHARMACY         18.917           19.00         03000         ADULTS & PEDI ATRICS         363, 112         <	
1.00       00100       NEW CAP REL COSTS-BLDG & FLXT         2.00       00200       NEW CAP REL COSTS-NUBLE EQUIP         4.00       00400       EMPLOYPE BENEFITS DEPARTMENT         5.01       00550       IS/ACCOUNTING/MARKETI NG         5.02       00540       BUSI NESS OFFICE & ADMITTI NG         5.03       00560       OTHER ADMINI STRATI VE AND GENERAL         7.00       00700       OPERATION OF PLANT         8.00       00800       LAUNDRY & LI NEN SERVI CE         9.00       00900       HOUSEKEEPI NG         11.00       01100       CAPTERI A         13.00       01300       NURSI NG ADMI NI STRATI ON         14.00       01400       CENTRAL SERVI CES & SUPPLY         15.00       10500       PHARMACY         16.00       01600       MEDI CAL RECORDS & LI BRARY         19.00       01900       NOPHYSI CI AN ANESTHETI STS         10.00       O14000       NOPHYSI CI AN ANESTHETI STS         10.00       014001       NOPHYSI CI AN ANESTHETI STS         10.00       00500       ADUIT NE SERVI CE COST CENTERS         30.00       03000       ADULTS & PEDI ATRICS       363, 112         31.00       03000       INTENSI VE CARE UNIT       8	
2.00         00200         NEW CAP REL COSTS-NVBLE EQUIP           4.00         00400         EMPLOYEE BENEFITS DEPARTMENT           5.01         00550         IS/ACCOUNTIN G/MARKETI NG           5.02         00540         BUSI NESS OFFICE & ADMI TTI NG           5.03         00560         OTHER ADMI NI STRATI VE AND GENERAL           7.00         00700         OPERATI ON OF PLANT           8.00         00800         LAUNDRY & LI NEN SERVI CE           9.00         00900         HOJEKEEPI NG           11.00         01100         CAFETERI A           13.00         01300         NURSI NG ADMI NI STRATI ON           14.00         10400         CENTRAK           15.00         01500         PHARMACY           15.00         01500         PHARMACY           16.00         01600         MEDI CAL RECORDS & LI BRARY           19.00         10900         NOPHYNICI CAN ANESTHETI STS           100         03000         ADULT & SERVI CE COST CENTERS           30.00         03000         NURSI NG ADMI NI STRATI ON           43.00         04300         NURSERY           43.00         04300         NURSERY           43.00         04300         NURSERY	1.00
4.00       00400       EMPLOYEE BENEFITS DEPARTMENT	1.00
5.01       00550       I S/ACCOUNTI NG/MARKETI NG         5.02       00540       BUSI NESS OFFICE & ADMI NI STRATI VE AND GENERAL         7.00       00700       OPERATI ON OF PLANT         8.00       00800       LAUNDRY & LINEN SERVICE         9.00       00900       HOUSEKEEPI NG         10.00       01000       DI ETARY         11.00       01100       CAFETERI A         13.00       01400       CAFETERI A         13.00       01400       CENTRAL SERVI CES & SUPPLY         15.00       01500       PHARMACY         16.00       01600       MDI CAL RECORDS & LI BRARY         19.00       01900       NONPHYSI CI AN ANESTHETI STS         INPATI ENT ROUTI NE SERVI CE COST CENTERS       363, 112         30.00       03100       NURSERY       88, 917         43.00       04300       NURSERY       8503         ANCI LLARY SERVI CE COST CENTERS       363, 112         31.00       03500       DELI VERY ROOM       280, 884         52.00       DELI VERY ROOM & LABOR ROOM       9, 260         53.00       05400       RAICI LLARY SERVICE       794         54.01       05401       ULIGGNOSTI C       131, 684         5	4.00
5.02       00540       BUSI NESS OFFI CE & ADMI TTI NG         5.03       00560       OTHER ADMI NI STRATI VE AND GENERAL         7.00       00700       OPERATI ON OF PLANT         8.00       00800       LAUNDRY & LI NEN SERVI CE         9.00       00900       HOUSEKEEPI NG         10.00       01000       DETARY         11.00       01100       CAFETERI A         13.00       01300       NURSI NG ADMI NI STRATI ON         14.00       01400       CENTRAL SERVI CES & SUPPLY         15.00       01500       PHARMACY         16.00       01600       MEDI CAL RECORDS & LI BRARY         19.00       03000       ADULTS & PEDI ATRI CS         30.00       03000       ADULTS & PEDI ATRI CS         31.00       03100       INTENSI VE CARE UNI T         31.00       03100       INTENSI VE CARE UNI T         31.00       04300       NURSERY         31.00       05500       DELI VERY ROM & LABOR ROM         31.00       05500       DELI VERY ROM & LABOR ROM         31.00       05500       DELI VERY ROM & LABOR ROM         31.00       05400       DELI VERY ROM & LABOR ROM         31.00       05400       RADI LLARY SERVICE <td>5. 01</td>	5. 01
5.03       00560       OTHER ADMI NI STRATI VE AND GENERAL	5.02
7.00       00700       OPERATI ON OF PLANT	5.03
8.00         00800         LAUNDRY & LINEN SERVICE	7.00
9.00         00900         HOUSEKEEPING	8.00
10.00       01000       DIETARY       II.00         11.00       01000       CAFETERIA       II.01         13.00       01300       NURSI NG ADMI NI STRATI ON       II.01         14.00       01400       CENTRAL SERVI CES & SUPPLY       II.01         15.00       01500       PHARMACY       II.01         16.00       01600       MEDI CAL RECORDS & LI BRARY       II.01         19.00       01900       NONPHYSI CI AN ANESTHETI STS       II.02         30.00       03000       ADULTS & PEDI ATRI CS       363, 112         31.00       03100       INTENSI VE CARE UNIT       88, 917         43.00       04300       NURSERY       8, 503         ANCI LLARY SERVI CE COST CENTERS       363, 112         50.00       05000       OPERATI NG ROOM       280, 884         52.00       05200       DELI VERY ROOM & LABOR ROOM       9, 260         53.00       05300       ANESTHESI OLOGY       794         54.00       05400       RADI OLOGY-DI AGNOSTI C       131, 684         54.01       ULTRASOUND       10, 159         56.00       GAOI OLOGY-DI AGNOSTI C       131, 684         54.01       ULTRASOUND       10, 159         5	9.00
13.00       01300       NURSI NG ADMI NI STRATI ON	10.00
14.00       01400       CENTRAL SERVICES & SUPPLY       Image: services and s	11.00
15.00       01500       PHARMACY       Image: Constraint of the second	13.00
16.00       01600       MEDI CAL RECORDS & LI BRARY         19.00       01900       NONPHYSI CI AN ANESTHETI STS         1NPATI ENT ROUTI NE SERVI CE COST CENTERS         30.00       03000       ADULTS & PEDI ATRI CS         31.00       03100       INTENSI VE CARE UNI T         30.00       04300       NURSERY         43.00       04300       NURSERY         43.00       05000       OPERATI NG ROOM         50.00       05000       OPERATI NG ROOM         52.00       05200       DELI VERY ROOM & LABOR ROOM         53.00       05300       ANESTHESI OLOGY         54.00       05400       RADI OLOGY-DI AGNOSTI C         55.00       05400       RADI OLOGY-DI AGNOSTI C         56.00       05600       RADI OLOGY-DI AGNOSTI C         50.00       06000       LABORATORY         63.00       06000       LABORATORY       89, 389	14.00
19.00         O1900         NONPHYSICIAN ANESTHETISTS           INPATI ENT ROUTINE SERVICE COST CENTERS           30.00         03000         ADULTS & PEDIATRICS         363, 112           31.00         03100         INTENSIVE CARE UNIT         88, 917           43.00         04300         NURSERY         8, 503           ANCILLARY SERVICE COST CENTERS         363, 112           50.00         05000         OPERATING ROOM         280, 884           52.00         05200         DELIVERY ROOM & LABOR ROOM         9, 260           53.00         05300         ANESTHESI OLOGY         794           54.00         05400         RADI OLOGY-DI AGNOSTI C         131, 684           54.01         05401         ULTRASOUND         10, 159           56.00         05600         RADI OLOGY-DI AGNOSTI C         9, 127           60.00         06000         LABORATORY         89, 389           63.00         06300         BLODD STORING, PROCESSI NG & TRANS.         4, 645	15.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         O3000 ADULTS & PEDI ATRI CS         363, 112           31.00         INTENSI VE CARE UNI T         88, 917           43.00         O4300 NURSERY         8, 503           ANCI LLARY SERVI CE COST CENTERS         80, 884           50.00         O5000 OPERATI NG ROOM         9, 260           53.00         O5200 DELI VERY ROOM & LABOR ROOM         9, 260           53.00         O5300 ANESTHESI OLOGY         794           54.01         O5400 RADI OLOGY-DI AGNOSTI C         131, 684           54.01         O5400 RADI OLOGY-DI AGNOSTI C         131, 684           54.01         O5400 RADI OLOGY-DI AGNOSTI C         10, 159           56.00         O5600 RADI OL SOTOPE         9, 127           60.00         O6000 LABORATORY         89, 389           63.00         O6300 BLOD STORI NG, PROCESSI NG & TRANS.         4, 645	16.00
30.00       O3000       ADULTS & PEDIATRICS       363, 112         31.00       INTENSI VE CARE UNIT       88, 917         43.00       O4300       NURSERY       8, 503         ANCILLARY SERVICE COST CENTERS         50.00       O5000       OPERATI NG ROOM       9, 260         53.00       O5200       DELIVERY ROOM & LABOR ROOM       9, 260         53.00       O5300       ANESTHESI OLOGY       794         54.01       O5400 RADI OLOGY-DI AGNOSTI C       131, 684         54.01       O5400 RADI OLOGY-DI AGNOSTI C       131, 684         56.00       O5600 RADI OLOGY-DI AGNOSTI C       9, 127         60.00       O6000 LABORATORY       89, 389         63.00       06300 BLODD STORI NG, PROCESSI NG & TRANS.       4, 645	19.00
31.00       03100       INTENSI VE CARE UNIT       88, 917         43.00       NURSERY       8, 503         ANCILLARY SERVICE COST CENTERS         50.00       05000       OPERATI NG ROOM       280, 884         52.00       05200       DELI VERY ROOM & LABOR ROOM       9, 260         53.00       05300       ANESTHESI OLOGY       794         54.00       05400       RADI OLOGY-DI AGNOSTI C       131, 684         54.01       05401       ULTRASOUND       10, 159         56.00       05600       RADI OL SOTOPE       9, 127         60.00       06000       LABORATORY       89, 389         63.00       06300       BLODD STORI NG, PROCESSI NG & TRANS.       4, 645	
43. 00         04300         NURSERY         8, 503           ANCI LLARY SERVICE COST CENTERS	30.00
ANCILLARY SERVICE COST CENTERS           50.00         05000         0PERATING ROOM         280,884           52.00         05200         DELIVERY ROOM & LABOR ROOM         9,260           53.00         05300         ANESTHESI OLOGY         794           54.00         05400         RADI OLOGY-DI AGNOSTI C         131,684           54.01         05401         ULTRASOUND         10,159           56.00         06600         LABORATORY         9,127           60.00         06000         LABORATORY         89,389           63.00         06300         BLOOD STORING, PROCESSING & TRANS.         4,645	31.00
50.00         05000         0PERATI NG ROOM         280, 884           52.00         05200         DELI VERY ROOM & LABOR ROOM         9, 260           53.00         05300         ANESTHESI OLOGY         794           54.00         05400         RADI OLOGY-DI AGNOSTI C         131, 684           54.01         05401         ULTRASOUND         10, 159           56.00         05600         RADI OL STOPE         9, 127           60.00         06000         LABORATORY         89, 389           63.00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.         4, 645	43.00
52.00         05200         DELI VERY ROOM & LABOR ROOM         9, 260           53.00         05300         ANESTHESI OLOGY         794           54.00         05400         RADI OLOGY-DI AGNOSTI C         131, 684           54.01         05401         ULTRASOUND         10, 159           56.00         05600         RADI OI SOTOPE         9, 127           60.00         06000         LABORATORY         89, 389           63.00         06300         BLOOD STORING, PROCESSI NG & TRANS.         4, 645	
53.00       05300       ANESTHESI OLOGY       794         54.00       05400       RADI OLOGY-DI AGNOSTI C       131, 684         54.01       05401       ULTRASOUND       10, 159         56.00       05600       RADI OI SOTOPE       9, 127         60.00       06000       LABORATORY       89, 389         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       4, 645	50.00
54.00       05400       RADI OLOGY-DI AGNOSTI C       131, 684         54.01       05401       ULTRASOUND       10, 159         56.00       05600       RADI OI SOTOPE       9, 127         60.00       06000       LABORATORY       89, 389         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       4, 645	52.00
54. 01       05401       ULTRASOUND       10, 159         56. 00       05600       RADI 0I SOTOPE       9, 127         60. 00       06000       LABORATORY       89, 389         63. 00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       4, 645	53.00
56.00         05600         RADI OI SOTOPE         9, 127           60.00         06000         LABORATORY         89, 389           63.00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.         4, 645	54.00 54.01
60. 00         06000         LABORATORY         89, 389           63. 00         06300         BLOOD STORING, PROCESSING & TRANS.         4, 645	56.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 4, 645	60.00
	63.00
	64.00
65. 00 06500 RESPI RATORY THERAPY 59, 309	65.00
66. 00 06600 PHYSI CAL THERAPY 90, 474	66.00
66. 01 06601 SPORTS THERAPY 0	66.01
67. 00 06700 OCCUPATI ONAL THERAPY 17, 442	67.00
68.00 06800 SPEECH PATHOLOGY 4,419	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 4, 292	70.00
70. 01 07001 CARDI OPULMONARY 23, 150	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 27,361	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT 9, 196	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 42, 426	73.00
OUTPATIENT SERVICE COST CENTERS	
88.00   08800  RURAL HEALTH CLINIC 0	88.00
90. 00 09000 CLINIC 0	90.00
90.01         09001         JV CLINIC         24,697           91.00         09100         EMERGENCY         145,273	90. 01 91. 00
91. 00 09100 EMERGENCY 145, 273 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	91.00
OTHER REIMBURSABLE COST CENTERS	92.00
101.00 10100 HOME HEALTH AGENCY 5, 194	101.00
SPECIAL PURPOSE COST CENTERS	101.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 1,456,792	118.00
NONREI MBURSABLE COST CENTERS	110.00
190. 00[19000] GI FT, FLOWER, COFFEE SHOP & CANTEEN 10, 038	190. 00
192. OO 19200 PHYSI CI ANS' PRI VATE OFFI CES 503	192.00
192. 01 19201 MSO CLINICS 0	192.01
192. 03 19203 FPA 0	192.03
194.00 07950 MEALS ON WHEELS 7,485	194.00
194. 01 07951 GUEST MEALS 0	194. 01
194. 02 07952 MARKETI NG 6, 935	194. 02
200.00 Cross Foot Adjustments 0	200. 00
201. 00         Negative Cost Centers         9, 959	201.00
202.00   TOTAL (sum Lines 118-201)   1,491,712	202.00

	n Finan	cial Systems SULL	IVAN COUNTY CON	MUNITY HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
COST A	ALLOCAT	ION - STATISTICAL BASIS		Provider CC	CN: 15-1327 P	eriod:	Worksheet B-1	
						rom 01/01/2016 0 12/31/2016	Date/Time Pre	narod
					1	0 12/31/2010	5/26/2017 2:2	
			CAPITAL REL	ATED COSTS				
		Cost Center Description	NEW BLDG &	NEW MVBLE		Reconci I i ati on		
			FLXT	EQUI P	BENEFITS		MARKETING	
			(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
			FEET)	FEET)	(GROSS		COST)	
			1.00	2.00	SALARI ES)	FA 01	F 01	
	CENED	AL SERVICE COST CENTERS	1.00	2.00	4.00	5A. 01	5. 01	
1.00		NEW CAP REL COSTS-BLDG & FIXT	93, 289			1		1.00
2.00		NEW CAP REL COSTS-BEDG & TTXT	73, 207	01 215			1	2.00
			E 4 4	91, 315			1	1
4.00		EMPLOYEE BENEFITS DEPARTMENT	544	544			21 024 276	4.00
5.01		I S/ACCOUNTI NG/MARKETI NG	2,387	2, 387			21, 934, 276	
5.02		BUSINESS OFFICE & ADMITTING	2,012	2,012			1, 297, 528	
5.03		OTHER ADMINISTRATIVE AND GENERAL	3, 299	3, 299			1, 478, 409	
7.00		OPERATION OF PLANT	10, 606	10, 606			1, 336, 003	
8.00		LAUNDRY & LINEN SERVICE	553	553			94, 107	
9.00		HOUSEKEEPING	1, 291	1, 291			519, 891	1
10.00		DIETARY	2, 522	2, 522			691, 320	
11.00			918	918				
13.00		NURSI NG ADMI NI STRATI ON	564	564			537, 919	
14.00		CENTRAL SERVICES & SUPPLY	2, 354	2, 354			212, 738	1
15.00		PHARMACY	1, 431	1, 431			1, 497, 108	
16.00		MEDICAL RECORDS & LIBRARY	2, 980	2, 980			530, 579	
19.00		NONPHYSICIAN ANESTHETISTS	0	0	0	0 0	0	19.00
		ENT ROUTINE SERVICE COST CENTERS				-1		
30.00		ADULTS & PEDIATRICS	15, 729	15, 729			2, 887, 494	
31.00		INTENSIVE CARE UNIT	4, 157	4, 157			668, 446	
43.00		NURSERY	333	333	81, 151	0	120, 468	43.00
		LARY SERVICE COST CENTERS				-1		
50.00		OPERATING ROOM	13, 439	13, 439			1, 250, 639	1
52.00		DELIVERY ROOM & LABOR ROOM	467	467			22, 535	
53.00		ANESTHESI OLOGY	0	0	-	-	3, 826	
54.00		RADI OLOGY-DI AGNOSTI C	5, 654	5, 654			1, 217, 766	
54.01		ULTRASOUND	340	340			238, 105	1
56.00		RADI OI SOTOPE	420	420	0	0 0	109, 789	56.00
60.00		LABORATORY	3, 030	3, 030		0	1, 674, 800	
63.00		BLOOD STORING, PROCESSING & TRANS.	190	190	0	0 0	47, 664	63.00
64.00	06400	INTRAVENOUS THERAPY	337	337	0	0 0	36, 190	64.00
65.00	06500	RESPI RATORY THERAPY	2, 508	2, 508	446, 137	0	668, 750	65.00
66.00	06600	PHYSI CAL THERAPY	4, 112	4, 112	668, 892	0	937, 066	66.00
66. 01		SPORTS THERAPY	0	0	0	0 0	0	66.01
67.00	06700	OCCUPATI ONAL THERAPY	821	821	114, 703	0	160, 653	67.00
68.00		SPEECH PATHOLOGY	181	181	65, 764	0	87, 361	68.00
70.00		ELECTROENCEPHALOGRAPHY	221	221			7, 288	70.00
70. 01	07001	CARDI OPULMONARY	1, 152	1, 152	49, 224	0	86, 230	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0 0	371, 054	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0 0	147, 983	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPA	TIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0 0	0	88.00
90.00	09000	CLINIC	0	0	0	0 0	0	90.00
90.01	09001	JV CLINIC	1, 974	0	221, 871	0	397, 762	90.01
91.00	09100	EMERGENCY	5, 954	5, 954	862, 424	0	1, 795, 402	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					1	92.00
	OTHER	REIMBURSABLE COST CENTERS						
101.00		HOME HEALTH AGENCY	0	0	432, 546	0	614, 277	101.00
	SPECI /	AL PURPOSE COST CENTERS						
118.00	0	SUBTOTALS (SUM OF LINES 1-117)	92, 480	90, 506	11, 084, 964	-1, 207, 762	21, 747, 150	118.00
	NONRE	MBURSABLE COST CENTERS						
190.00	019000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	527	527	0	-8, 533	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	-186, 300	0	192.00
		MSO CLINICS	0	0	0			192.01
	3 19203		o	0	0	o		192.03
		MEALS ON WHEELS	o	0	0	0		194.00
		GUEST MEALS	o	0	0	o		194.01
		MARKETING	282	282		-	187, 126	
200.00		Cross Foot Adjustments			_, 200		,.=0	200.00
201.00		Negative Cost Centers			1			201.00
202.00		Cost to be allocated (per Wkst. B,	622, 301	869, 411	3, 051, 087		1, 314, 108	
		Part I)			.,,,,		, ,	
203.00	b	Unit cost multiplier (Wkst. B, Part I)	6. 670679	9. 521010	0. 273449	,	0. 059911	203.00
		Cost to be allocated (per Wkst. B,			8, 808			204.00
204.00					0,000		27,010	1
204.00		Part II)			1			1
204.00 205.00	D	Part II) Unit cost multiplier (Wkst. B, Part			0. 000789		0. 001780	205.00

COST A	Financial Systems         SUL           JLLOCATION - STATISTICAL BASIS         SUL	LIVAN COUNTY COM	Provider CO	CN: 15-1327 P	eriod:	u of Form CMS-2 Worksheet B-1	
				FI Te	rom 01/01/2016 p 12/31/2016	Date/Time Pre	pared:
	Cost Center Description	Reconciliation	BUSI NESS OFFI CE & ADMI TTI NG (ACCUM. COST)	Reconciliation	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST)	5/26/2017 2:2 OPERATI ON OF PLANT (SQUARE FEET)	<u>3 pm</u>
		5A. 02	5.02	5A. 03	5.03	7.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	1					1.00
$\begin{array}{c} 1.00\\ 2.00\\ 4.00\\ 5.01\\ 5.02\\ 5.03\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 13.00\\ 14.00\\ \end{array}$	00200 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 I S/ACCOUNTI NG/MARKETI NG 00540 BUSI NESS OFFICE & ADMITTI NG 00560 OTHER ADMINISTRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVICE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMINISTRATI ON 01400 CENTRAL SERVICES & SUPPLY	-1, 375, 264 0 0 0 106, 346 0 0	21, 222, 041 1, 566, 982 1, 416, 044 99, 745 551, 038 732, 738 0 570, 146 225, 483	-1, 668, 529 0 0 0 106, 346 0 0 0 0	21, 774, 688 1, 507, 809 106, 209 586, 747 780, 222 0 607, 094 240, 095	74, 441 553 1, 291 2, 522 918 564 2, 354	2.00 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00 11.00 13.00
15.00	01500 PHARMACY	0	1, 586, 801	0	1, 689, 632	1, 431	
16.00 19.00	01600 MEDICAL RECORDS & LIBRARY 01900 NONPHYSICIAN ANESTHETISTS	0	562, 367 0	0	598, 811 0	2, 980 0	1
19.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	17.00
30.00	03000 ADULTS & PEDIATRICS	0	3, 060, 491	0	3, 258, 813	15, 729	
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0	708, 493 127, 685	0	754, 406 135, 959	4, 157 333	•
43.00	ANCI LLARY SERVICE COST CENTERS		127,003	0	133, 737		
50.00	05000 OPERATING ROOM	0	1, 325, 566	0	1, 411, 468	13, 439	
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	23, 885 4, 055	0	25, 433 4, 318	467 0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 290, 724	0	1, 374, 368	5, 654	
54.01	05401 ULTRASOUND	0	252, 370	0	268, 725	340	•
56.00 60.00	05600 RADI OI SOTOPE 06000 LABORATORY	0	116, 367	0	123, 908	420	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1, 775, 139 50, 520	0	1, 890, 175 53, 794	3, 030 190	
64.00	06400 I NTRAVENOUS THERAPY	0	38, 358	0	40, 844	337	64.00
65.00	06500 RESPIRATORY THERAPY	0	708, 815	0	754, 749	2, 508	
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 SPORTS THERAPY	0	993, 207 0	0	1, 057, 571 0	4, 112 0	1
67.00	06700 OCCUPATI ONAL THERAPY	0	170, 278	0	181, 313	821	67.00
68.00	06800 SPEECH PATHOLOGY	0	92, 595	0	98, 596	181	68.00
70. 00 70. 01	07000 ELECTROENCEPHALOGRAPHY 07001 CARDI OPULMONARY	0	7, 725 91, 396	0	8, 226 97, 319	221 1, 152	
70.01	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	393, 284	0	418, 770	1, 152	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	156, 849	0	167, 013	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
90.00	09000 CLINIC	0	0	0	0	0	
	09001 JV CLINIC	0	421, 592	0	448, 913	1, 974	
	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	1, 902, 966	0	2, 026, 286	5, 954	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	-651, 079	0	0	651, 079	0	101.00
110 00	SPECIAL PURPOSE COST CENTERS	1 010 007	21 022 704	1 5(2 102	21 240 445	72 (22	110 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	-1, 919, 997	21, 023, 704	-1, 562, 183	21, 368, 665	/3,032	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-8, 533	0	0	8, 533	527	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	-186, 300	0	0	186, 300		192.00
	19201 MSO CLINICS 19203 FPA	0	0	0	0		192.01 192.03
	07950 MEALS ON WHEELS	0	0	0	0		194.00
	07951 GUEST MEALS	0	0	0	0		194.01
194.02 200.00	O7952 MARKETING Cross Foot Adjustments	0	198, 337	0	211, 190	282	194.02
200.00							200.00 201.00
202.00	Cost to be allocated (per Wkst. B,		1, 375, 264		1, 668, 529	1, 623, 348	
	Part I)		0.044004		0 07//07	21 00717/	202 00
202 02	Unit cost multiplier (Wkst. B, Part I)		0. 064804		0.076627	21.807176	
203.00	Cost to be allocated (per Wkst B		.35 460		58 /01		1204 00
203.00 204.00 205.00	Part II)		35, 460 0. 001671		58, 791 0. 002700	180, 881 2. 429857	

T AL	LLOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2016	Worksheet B-1	
					To 12/31/2016	Date/Time Pre	par
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	5/26/2017 2:2 NURSI NG	<u>3</u> pi
	cost center bescription	LINEN SERVICE		(MEALS		ADMI NI STRATI ON	
		(POUNDS OF	FEET)	SERVED)	. ,		
		LAUNDRY)				(DI RECT	
		8.00	9.00	10.00	11.00	NRSING HRS) 13.00	
	GENERAL SERVICE COST CENTERS	8.00	9.00	10.00	11.00	13.00	
	00100 NEW CAP REL COSTS-BLDG & FIXT						1
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2
	00400 EMPLOYEE BENEFITS DEPARTMENT						4
	00550 I S/ACCOUNTI NG/MARKETI NG						5
	00540 BUSI NESS OFFI CE & ADMI TTI NG 00560 OTHER ADMI NI STRATI VE AND GENERAL						5
	00700 OPERATI ON OF PLANT						
	00800 LAUNDRY & LINEN SERVICE	118, 251					8
0	00900 HOUSEKEEPI NG	0	72, 597				9
	01000 DI ETARY	426		60, 64			10
	01100 CAFETERI A	391	-	37, 18			11
	01300 NURSI NG ADMI NI STRATI ON	0			0 396	174, 528	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	2, 354 1, 431		0 303 0 411	0	14
	01600 MEDICAL RECORDS & LIBRARY	0			0 828	0	16
	01900 NONPHYSI CI AN ANESTHETI STS	0			0 0	0	19
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	52, 329		13, 61		76, 934	30
	03100 INTENSIVE CARE UNIT	4, 083		78		15, 037	31
		3, 091	333		0 135	2, 810	43
	ANCI LLARY SERVI CE COST CENTERS	15, 631	13, 439	46	3 1, 117	23, 069	50
	05200 DELIVERY ROOM & LABOR ROOM	687			0 16	328	
	05300 ANESTHESI OLOGY	0	1		0 0	0	53
	05400 RADI OLOGY-DI AGNOSTI C	6, 882	5, 654		0 894	0	54
01	05401 ULTRASOUND	0	340		0 0	0	54
	05600 RADI OI SOTOPE	0			0 0	0	56
	06000 LABORATORY	350			0 1, 406	0	60
	06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	63
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 467			0 0 0 716	0	64
	06600 PHYSI CAL THERAPY	10, 032			0 992	0	66
	06601 SPORTS THERAPY	0			0 0	0	66
00	06700 OCCUPATI ONAL THERAPY	0	821		0 123	0	67
	06800 SPEECH PATHOLOGY	0	181		0 93	0	68
	07000 ELECTROENCEPHALOGRAPHY	0	221		0 0	0	70
	07001 CARDI OPULMONARY	0	1, 152		0 73	1, 509	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0 0 0	0	71   72
	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS		<u>и ч</u>		0 0	0	1
	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88
	09000 CLINIC	0	0		0 0	0	
	09001 JV CLINIC	1, 602			0 434	9, 010	
	09100 EMERGENCY	22, 280	5, 954		0 1, 509	31, 279	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS	0				14 552	110-
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0	14, 552	
. 00		118, 251	71, 788	52, 04	2 13, 873	174, 528	111
	NONREI MBURSABLE COST CENTERS	110/201	11,700	02,01	10,070	1717020	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	527		0 0	0	190
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192
	19201 MSO CLINICS	0	0		0 0		192
. 03	19203 FPA	0	0				192
	07950 MEALS ON WHEELS 07951 GUEST MEALS	0	0	8, 59			194 194
	07951 GUEST MEALS		282		0 100		194
. 02			202			0	200
. 00							201
. 00		126, 406	659, 861	918, 38	4 485, 551	684, 800	
	Part I)						
. 00				15.14485		3. 923726	
. 00		10, 954	27, 751	52, 79	0 49, 851	15, 705	204
. 00	Part II)	0.002622	0 2022/1		7 2 054025	0. 089986	201
	Unit cost multiplier (Wkst. B, Part	0. 092633	0. 382261	0.87054	7 2.854935		1205

OST A	n Financial Systems ALLOCATION - STATISTICAL BASIS	SULLIVAN COUNTY CO	Provider CC		Peri od:	u of Form CMS-255 Worksheet B-1
					From 01/01/2016 To 12/31/2016	Date/Time Prepar
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S. )	PHARMACY (COSTED REQUI S. )	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	5/26/2017 2:23 p
		14.00	15.00	16.00	19.00	
. 00	GENERAL SERVICE COST CENTERS		[ [			1
. 00 . 00 . 01 . 02 . 03 . 00 . 00 . 00 0. 00 1. 00 3. 00 4. 00 5. 00 6. 00 9. 00	00200 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00550 I S/ACCOUNTI NG/MARKETI NG 00540 BUSI NESS OFFI CE & ADMI TTI NG 00560 OTHER ADMI NI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01900 NONPHYSI CI AN ANESTHETI STS	891, 432 17, 774 89 0	100 0 0	69, 237, 44	12 0 0	2 5 5 5 7 8 7 10 11 13 14 15 14 15 14 15
0. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	68, 625	0	6, 343, 79	0	30
1.00		4, 496	0	467, 99		31
3. 00	04300 NURSERY	4,054	0	198, 36	0 0	43
	ANCI LLARY SERVICE COST CENTERS	05.454		<b>F</b> (0)( 1)		
0.00 2.00		85, 154 901	0	5, 606, 44 44, 09		50
3.00		0	0	846, 87		53
4.00		15, 302	0	12, 956, 87		54
l. 01		0	0	2, 343, 82		54
5.00		0	0	463, 02		56
0.00		87, 173	0	12, 806, 19		60
3.00		0	0	793, 34		63
4.00 5.00		40, 878	0	487, 20 2, 906, 21	-	64
b. 00		5, 237	0	1, 743, 03		66
. 01		0	0	,, .	0 0	66
. 00		118	0	363, 31		67
. 00		243	0	79, 91		68
		0	0	49, 83		70
. 01 . 00		NTS 372, 247	0	337, 33 5, 779, 26		70
		147, 983	0	441, 36		72
	07300 DRUGS CHARGED TO PATIENTS	0				
	OUTPATIENT SERVICE COST CENTERS					
. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	88
		0	0		0 0	90
	09001 JV CLINIC 09100 EMERGENCY	20,202	0	1, 080, 70		90
	09200 OBSERVATION BEDS (NON-DISTINCT PAR	39, 393 2T)	0	9, 183, 40	0	92
. 00	OTHER REIMBURSABLE COST CENTERS					· · · · · · · · · · · · · · · · · · ·
1.00	0 10100 HOME HEALTH AGENCY	1, 765	0	661, 07	0 /2	101
	SPECIAL PURPOSE COST CENTERS		<b>T</b>			
8.00		891, 432	100	69, 237, 44	12 0	118
0 00	NONREIMBURSABLE COST CENTERS	EN O	0		0 0	190
	0 19200 PHYSICIANS' PRIVATE OFFICES		0		0 0	190
	1 19201 MSO CLINICS	0	0		0 0	192
	3 19203 FPA	0	0		0 0	192
	007950 MEALS ON WHEELS	0	0		0 0	194
	1 07951 GUEST MEALS	0	0		0 0	194
	2 07952 MARKETING	0	0		0	194
0.00						200
1. UC 2. OC	0	341, 752	1, 884, 412	765, 57	13 0	202
2.00	Part I)	541,752	1, 004, 412	705, 57		
3. 00		rt I) 0. 383374	18, 844. 120000	0. 01105	0. 000000	203
04. OC	0 Cost to be allocated (per Wkst. B,	-	39, 475	62, 78		204
	Part II)					
)5. OC	0 Unit cost multiplier (Wkst. B, Pa	rt 0. 052846	394. 750000	0.00090	0. 000000	205

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1327		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/26/2017 2:2	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B, Part I, col.	Adj .		Di sal I owance		
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	4, 783, 575		4, 783, 5	75 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1,047,978		1, 047, 9		0	
43. 00 04300 NURSERY	179, 434		179, 4		0	
ANCI LLARY SERVI CE COST CENTERS	177,434		177,4	<u> </u>	0	43.00
50. 00 05000 OPERATING ROOM	2, 182, 532		2, 182, 5	32 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	45, 221		45, 2		0	•
53. 00 05300 ANESTHESI OLOGY	14, 013		14, 0		0	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 841, 939		1, 841, 9		0	•
54. 01 05401 ULTRASOUND	325, 737		325, 7		0	54.01
56. 00 05600 RADI 0I SOTOPE	151, 500		151, 5		0	
60. 00 06000 LABORATORY	2, 352, 879		2, 352, 8		0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	72, 558		72, 5		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	59, 773		59,7		0	
65. 00 06500 RESPI RATORY THERAPY	963, 256				0	•
66.00 06600 PHYSI CAL THERAPY	1, 332, 131				0	66.00
66. 01 06601 SPORTS THERAPY	0	0	,	0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	228, 908	0	228, 9	0 80	0	67.00
68.00 06800 SPEECH PATHOLOGY	115, 952		115, 9		0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	16, 235		16, 2		0	70.00
70. 01 07001 CARDI OPULMONARY	152, 557		152, 5		0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	657, 470		657, 4		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	241, 424		241, 4	24 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 920, 391		1, 920, 3	91 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	88.00
90. 00 09000 CLINIC	0			0 0	0	90.00
90. 01 09001 JV CLINIC	608, 396		608, 3	96 0	0	90.01
91.00 09100 EMERGENCY	2, 681, 138		2, 681, 1	38 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 095, 872		2, 095, 8	72	0	92.00
OTHER REIMBURSABLE COST CENTERS	1	-				
101.00 10100 HOME HEALTH AGENCY	766, 053		766, 0			101.00
200.00 Subtotal (see instructions)	24, 836, 922		,,			200.00
201.00 Less Observation Beds	2, 095, 872		2, 095, 8			201.00
202.00  Total (see instructions)	22, 741, 050	0	22, 741, 0	50 0	0	202.00

Heal th	Fi nan	ci a	ıl Syst	ems		
COMPLIE		OF	DATIO	OF	COSTS	ΤO

COMPUTATION (	DF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/26/2017 2:2	
				XVIII	Hospi tal	Cost	
(	Cost Center Description	I npati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	<u> </u>
I NPATI	ENT ROUTINE SERVICE COST CENTERS						
30.00 03000 /	ADULTS & PEDIATRICS	3, 367, 131		3, 367, 13	1		30.00
31.00 03100	INTENSIVE CARE UNIT	467, 997		467, 99	7		31.00
43.00 04300 1	NURSERY	198, 360		198, 36	0		43.00
ANCI LL	ARY SERVICE COST CENTERS			•			1
50.00 05000 0	OPERATING ROOM	804, 659	4, 801, 787	5, 606, 44	6 0. 389290	0.000000	50.00
52.00 05200 1	DELIVERY ROOM & LABOR ROOM	12, 962	31, 128	44, 09	0 1.025652	0.000000	52.00
53.00 05300	ANESTHESI OLOGY	142, 737	704, 139	846, 87	6 0. 016547	0.000000	53.00
54.00 05400 I	RADI OLOGY-DI AGNOSTI C	258, 563	12, 698, 313	12, 956, 87	6 0. 142159	0.000000	54.00
54.01 05401 0	ULTRASOUND	184, 456	2, 159, 367	2, 343, 82	0. 138977	0.000000	54.0
56.00 05600 I	RADI OI SOTOPE	23, 714	439, 314	463, 02	0. 327194	0.000000	56.0
60. 00 06000 I	LABORATORY	617, 948	12, 188, 245	12, 806, 19	0. 183730	0.000000	60.0
63.00 06300 I	BLOOD STORING, PROCESSING & TRANS.	361, 256	432, 086	793, 34	2 0. 091459	0.000000	63.0
64.00 06400	INTRAVENOUS THERAPY	150, 599	336, 607	487, 20	0. 122685	0.000000	64.0
65.00 06500 I	RESPI RATORY THERAPY	881, 805	2,024,414	2, 906, 21	9 0. 331446	0.000000	65.0
66.00 06600 I	PHYSI CAL THERAPY	117, 597	1, 625, 436	1, 743, 03	0. 764260	0.000000	66.0
	SPORTS THERAPY	0	0		0 0.000000	0.000000	66. 0 <sup>°</sup>
67.00 06700	OCCUPATIONAL THERAPY	3, 146	360, 166	363, 31	2 0.630059	0.000000	67.0
68.00 06800 \$	SPEECH PATHOLOGY	8, 353	71, 558			0.000000	68.0
70.00 07000 1	ELECTROENCEPHALOGRAPHY	1, 902	47, 933	49, 83	0. 325775	0.000000	70.0
70.01 07001	CARDI OPULMONARY	0	337, 338	337, 33	0. 452238	0.000000	
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 909, 228	3, 870, 034	5, 779, 26	0. 113764	0.000000	71.0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	102, 501	338, 859	441, 36	0. 547000	0.000000	72.0
73.00 07300 [	DRUGS CHARGED TO PATIENTS	889, 717	2, 364, 242	3, 253, 95	0. 590171	0.000000	73.00
	IENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC	0	0		0		88.00
90.00 09000	CLINIC	0	0		0 0.000000	0.00000	90.0
	JV CLINIC	0	1, 080, 708			0.000000	
	EMERGENCY	43, 761	9, 139, 644			0.000000	
	OBSERVATION BEDS (NON-DISTINCT PART)	63, 199	2, 913, 461	2, 976, 66	0 0. 704102	0.00000	92.00
	REIMBURSABLE COST CENTERS						
	HOME HEALTH AGENCY	0	661, 072				101.0
	Subtotal (see instructions)	10, 611, 591	58, 625, 851	69, 237, 44	2		200.00
	Less Observation Beds						201.00
202.00	Total (see instructions)	10, 611, 591	58, 625, 851	69, 237, 44	2		202.00

Health Financial Systems SUL	LIVAN COUNTY COMM	IUNI TY HOSPI TAL	In Lieu	u of Form CMS-2	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1327	Peri od:	Worksheet C	
			From 01/01/2016	Part I	
			To 12/31/2016	Date/Time Prep	
		Title XVIII	Hospi tal	5/26/2017 2:23 Cost	рш
Cost Center Description	PPS Inpatient		nospi tui	0031	
cost center bescription	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11100				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS	11				
50.00 05000 OPERATI NG ROOM	0.000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000				52.00
53. 00 05300 ANESTHESI OLOGY	0.000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.000000				54.00
54. 01 05401 ULTRASOUND	0.000000				54.01
56. 00 05600 RADI 0I SOTOPE	0. 000000				56.00
60. 00 06000 LABORATORY	0. 000000				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000				63.00
64.00 06400 INTRAVENOUS THERAPY	0.000000				64.00
65. 00 06500 RESPI RATORY THERAPY	0.000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000				66.00
66.01 06601 SPORTS THERAPY	0.000000				66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0.000000				67.00
68.00 06800 SPEECH PATHOLOGY	0.000000				68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
70. 01 07001 CARDI OPULMONARY	0. 000000				70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88.00
90. 00 09000 CLI NI C	0.000000				90.00
90. 01 09001 JV CLINIC	0.000000				90.01
91.00 09100 EMERGENCY	0.000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					101. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)				:	202.00

#### SULLIVAN COUNTY COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C			Date/Time Pre 5/26/2017 2:2	pared: 3 pm
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	4, 783, 575		4, 783, 57	5 0	4, 783, 575	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1,047,978		1, 047, 97		1, 047, 978	
43. 00 04300 NURSERY	179, 434		179, 43		179, 434	
ANCI LLARY SERVICE COST CENTERS		1		<u> </u>	,	
50. 00 05000 OPERATI NG ROOM	2, 182, 532		2, 182, 53	2 0	2, 182, 532	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	45, 221		45, 22		45, 221	
53. 00 05300 ANESTHESI OLOGY	14, 013		14, 01		14, 013	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 841, 939		1, 841, 93			
54. 01 05401 ULTRASOUND	325, 737		325, 73		325, 737	
56. 00 05600 RADI 0I SOTOPE	151, 500		151, 50		151, 500	
60. 00 06000 LABORATORY	2, 352, 879		2, 352, 87		2, 352, 879	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	72, 558		72, 55		72, 558	
64. 00 06400 I NTRAVENOUS THERAPY	59, 773		59, 77		59, 773	
65. 00 06500 RESPIRATORY THERAPY	963, 256		963, 25		963, 256	
66. 00 06600 PHYSI CAL THERAPY	1, 332, 131		1, 332, 13		1, 332, 131	
66. 01 06601 SPORTS THERAPY	0			0 0	0	1
67. 00 06700 OCCUPATI ONAL THERAPY	228, 908	-	228, 90		228, 908	
68. 00 06800 SPEECH PATHOLOGY	115, 952		115, 95		115, 952	
70. 00 07000 ELECTROENCEPHALOGRAPHY	16, 235		16, 23		16, 235	
70. 01 07001 CARDI OPULMONARY	152, 557		152, 55		152, 557	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	657, 470		657, 47		657, 470	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	241, 424		241, 42		241, 424	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 920, 391		1, 920, 39		1, 920, 391	
OUTPATIENT SERVICE COST CENTERS	1,720,071		1, 720, 07	<u> </u>	1,720,071	/0.00
88. 00 08800 RURAL HEALTH CLINIC	0			0 0	0	88.00
90. 00 09000 CLINIC	0			0 0	0	90.00
90. 01 09001 JV CLINIC	608, 396		608, 39	6 0	608, 396	
91.00 09100 EMERGENCY	2, 681, 138		2, 681, 13		2, 681, 138	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,095,872		2, 095, 87		2, 095, 872	
OTHER REIMBURSABLE COST CENTERS	1 1 1 1 1 1					
101.00 10100 HOME HEALTH AGENCY	766, 053		766, 05	3	766, 053	101.00
200.00 Subtotal (see instructions)	24, 836, 922					
201.00 Less Observation Beds	2,095,872		2, 095, 87		2, 095, 872	
202.00 Total (see instructions)	22, 741, 050					

Heal th	Fi nan	ci a	I Syst	ems		
COMPLIE		OF	DATIO	OF	COSTS	ΤO

Heal th Financia	al Systems SULL	IVAN COUNTY COM	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF	RATIO OF COSTS TO CHARGES		Provider CO		Peri od:	Worksheet C	
					From 01/01/2016	Part I	
					To 12/31/2016	Date/Time Pre 5/26/2017 2:2	
			Ti †I	e XIX	Hospi tal	Cost	<u>.5 pili</u>
			Charges		nospreur	0031	
Cc	ost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
I NPATI EN	NT ROUTINE SERVICE COST CENTERS						
30.00 03000 AE	DULTS & PEDIATRICS	3, 367, 131		3, 367, 13			30.00
31.00 03100 I N	NTENSIVE CARE UNIT	467, 997		467, 99	7		31.00
43.00 04300 NL	JRSERY	198, 360		198, 36	0		43.00
	RY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			1		
	PERATING ROOM	804, 659	4, 801, 787				
	ELIVERY ROOM & LABOR ROOM	12, 962	31, 128			0. 000000	
	NESTHESI OLOGY	142, 737	704, 139			0. 000000	
	ADI OLOGY-DI AGNOSTI C	258, 563	12, 698, 313				•
	TRASOUND	184, 456	2, 159, 367	2, 343, 82		0. 000000	
	ADI OI SOTOPE	23, 714	439, 314				
	ABORATORY	617, 948	12, 188, 245				•
	_OOD STORING, PROCESSING & TRANS.	361, 256	432, 086	793, 34		0. 000000	
	NTRAVENOUS THERAPY	150, 599	336, 607	487, 20		0. 000000	
	ESPI RATORY THERAPY	881, 805	2,024,414				
	HYSI CAL THERAPY	117, 597	1, 625, 436	1, 743, 03		0. 000000	
	PORTS THERAPY	0	0		0 0. 000000		
	CCUPATIONAL THERAPY	3, 146	360, 166	363, 31			
	PEECH PATHOLOGY	8, 353	71, 558				
	LECTROENCEPHALOGRAPHY	1, 902	47, 933				
	ARDI OPULMONARY	0	337, 338	337, 33			
	EDICAL SUPPLIES CHARGED TO PATIENTS	1, 909, 228	3, 870, 034				
	MPL. DEV. CHARGED TO PATIENT	102, 501	338, 859				
	RUGS CHARGED TO PATIENTS	889, 717	2, 364, 242	3, 253, 95	9 0. 590171	0.000000	73.00
	ENT SERVICE COST CENTERS					0.00000	00.00
	JRAL HEALTH CLINIC	0	0		0 0.000000		
90.00 09000 CL		0	•		0 0.00000		
90.01 09001 JV		Ű	1,080,708			0.000000	
91.00 09100 EN		43, 761	9, 139, 644				
	BSERVATION BEDS (NON-DISTINCT PART) EIMBURSABLE COST CENTERS	63, 199	2, 913, 461	2, 976, 66	0 0. 704102	0.000000	92.00
	DME HEALTH AGENCY	0	661, 072	661, 07	2		101.00
	ubtotal (see instructions)	10, 611, 591	58, 625, 851	69, 237, 44		ł	200.00
	ess Observation Beds	10, 011, 591	JO, UZJ, 851	07,237,44	4	ł	200.00
	otal (see instructions)	10, 611, 591	58, 625, 851	69, 237, 44	2	l	201.00
202.00 10		10,011,091	JU, UZJ, OJ I	07,237,44	<u> </u>	1	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1327	Peri od: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/26/2017 2:2	
		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
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS	II				
50. 00 05000 OPERATI NG ROOM	0.000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
54. 01 05401 ULTRASOUND	0. 000000				54.01
56. 00 05600 RADI OI SOTOPE	0. 000000				56.00
60. 00 06000 LABORATORY	0. 000000				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000				64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
66. 01 06601 SPORTS THERAPY	0. 000000				66.01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
70. 01 07001 CARDI OPULMONARY	0. 000000				70.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS	0.000000				/ 0. 00
88. 00 08800 RURAL HEALTH CLINIC	0.000000				88.00
90. 00 09000 CLINIC	0. 000000				90.00
90. 01 09001 JV CLINIC	0. 000000				90.01
91. 00 09100 EMERGENCY	0. 000000				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS	0.000000				12.00
101.00 10100 HOME HEALTH AGENCY					101.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					200.00
202.00 Total (see instructions)					201.00
	1				1202.00

Health Financial Systems SUL	LIVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider C	CN: 15-1327	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II	pared:
	_	Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	280, 884	5, 606, 446	0. 05010	0 299, 900	15, 025	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 260	44, 090	0. 21002	5 0	0	52.00
53.00 05300 ANESTHESI OLOGY	794	846, 876	0.00093	8 58, 846	55	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	131, 684	12, 956, 876	0. 01016	3 225, 154	2, 288	54.00
54. 01 05401 ULTRASOUND	10, 159	2, 343, 823	0.00433	4 114, 182	495	54.01
56. 00 05600 RADI OI SOTOPE	9, 127	463, 028	0. 01971	2 17, 129	338	56.00
60. 00 06000 LABORATORY	89, 389	12, 806, 193	0. 00698	0 496, 816	3, 468	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	4,645	793, 342	0. 00585	5 217, 245	1, 272	63.00
64.00 06400 I NTRAVENOUS THERAPY	7,085	487, 206	0. 01454	2 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	59, 309	2, 906, 219	0. 02040	8 328, 264	6, 699	65.00
66. 00 06600 PHYSI CAL THERAPY	90, 474	1, 743, 033	0. 05190	6 37, 475	1, 945	66.00
66.01 06601 SPORTS THERAPY	0	0	0. 00000	0 0	0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	17, 442	363, 312	0. 04800	8 911	44	67.00
68.00 06800 SPEECH PATHOLOGY	4, 419	79, 911	0. 05529	9 5, 551	307	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 292	49, 835	0. 08612	4 1,902	164	70.00
70. 01 07001 CARDI OPULMONARY	23, 150		0. 06862	6 0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 361	5, 779, 262	0.00473	4 839, 337	3, 973	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	9, 196			6 59, 707	1, 244	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	42, 426					73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88.00
90. 00 09000 CLINIC	0	l o	0. 00000	0 0	0	90.00
90. 01 09001 JV CLINIC	24, 697	1, 080, 708			0	90.01
91. 00 09100 EMERGENCY	145, 273				391	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	159,093					92.00
200.00 Total (lines 50-199)	1, 150, 159			3, 307, 606		

Health Financial Systems SUL	LIVAN COUNTY COM	MUNITY HOSPIT	AL	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Pre 5/26/2017 2:2	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician N	ursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 05401 ULTRASOUND	0	0		0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
66.01 06601 SPORTS THERAPY	0	0		0 0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
70. 01 07001 CARDI OPULMONARY	0	0		0 0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 JV CLINIC	0	0		0 0	0	
91. 00 09100 EMERGENCY	0	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	
200.00   Total (lines 50-199)	0	0		0 0	0	200.00

Health Financial Systems SUL	LIVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C	Provider CCN: 15-1327		Worksheet D	
THROUGH COSTS				From 01/01/2016 To 12/31/2016	Part IV Date/Time Pre	narod
				10 12/31/2010	5/26/2017 2:2	pareu: 3 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Total	Total Charges	Ratio of Cost		Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1		1			
50.00 O5000 OPERATING ROOM	0	0/000/110			299, 900	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	44, 090				52.00
53. 00 05300 ANESTHESI OLOGY	0	846, 876				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	12, 956, 876			225, 154	54.00
54. 01 05401 ULTRASOUND	0	2, 343, 823			114, 182	54.01
56. 00 05600 RADI OI SOTOPE	0	463, 028				56.00
60. 00 06000 LABORATORY	0	12, 806, 193				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	793, 342			217, 245	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	487, 206			0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	2, 906, 219	0.00000	0. 000000	328, 264	65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 743, 033	0.00000	0. 000000	37, 475	66.00
66. 01 06601 SPORTS THERAPY	0	0	0.00000	0. 000000	0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0	363, 312	0.00000	0. 000000	911	67.00
68.00 06800 SPEECH PATHOLOGY	0	79, 911	0.00000	0. 000000	5, 551	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	49, 835	0.00000	0. 000000	1, 902	70.00
70. 01 07001 CARDI OPULMONARY	0	337, 338	0.00000	0. 000000	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 779, 262	0.00000	0. 000000	839, 337	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	441, 360	0.00000	0. 000000	59, 707	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 253, 959	0.00000	0. 000000	576, 181	73.00
OUTPATIENT SERVICE COST CENTERS		•	•			
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0. 000000	0	88.00
90. 00 09000 CLINIC	0	0	0.00000	0. 000000	0	90.00
90. 01 09001 JV CLINIC	0	1, 080, 708	0.00000	0. 000000	0	90.01
91.00 09100 EMERGENCY	0	9, 183, 405	0.00000	0. 000000	24, 714	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 976, 660	0.00000	0. 000000	4, 292	92.00
200.00 Total (lines 50-199)	0	64, 542, 882			3, 307, 606	200. 00

Health Financial Systems SUL	LIVAN COUNTY COM	MUNITY HOSPIT	AL		In Lie	u of Form CMS.	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	VICE OTHER PASS	Provider C	CN: 15-1327		: 1/01/2016 2/31/2016		
		Title	XVIII	Hos	spi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent				
	Program	Program	Program				
	Pass-Through	Charges	Pass-Throug				
	Costs (col. 8		Costs (col.	9			
	x col. 10) 11.00	12.00	x col. 12) 13.00				
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00				-
50. 00 05000 OPERATI NG ROOM	0	0	1	0			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0			52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0			54.00
54. 01 05401 ULTRASOUND	0	0		0			54.01
56. 00 05600 RADI 0I SOTOPE	0	0		0			56.00
60. 00 06000 LABORATORY	0	0		0			60,00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	)	0			63.00
64.00 06400 INTRAVENOUS THERAPY	0	C		0			64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	)	0			65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0			66.00
66. 01 06601 SPORTS THERAPY	0	0		0			66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0			67.00
68.00 06800 SPEECH PATHOLOGY	0	C	)	0			68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0			70.00
70. 01 07001 CARDI OPULMONARY	0	C		0			70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0			73.00
OUTPATIENT SERVICE COST CENTERS			1	-			
88.00 08800 RURAL HEALTH CLINIC	0	C		0			88.00
90. 00 09000 CLINIC	0	0		0			90.00
90. 01 09001 JV CLINIC	0	0		0			90.01
91.00 09100 EMERGENCY	0	0	1	0			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0	1	0			92.00
200.00  Total (lines 50-199)	0	C	1	0			200.00

	LIVAN COUNTY COM	MMUNITY HOSPIT			u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period:	Worksheet D	
				From 01/01/2016 To 12/31/2016		narodi
				10 12/31/2010	5/26/2017 2:2	
		Title	XVIII	Hospi tal	Cost	<u> </u>
			Charges	•	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 389290	0	1, 265, 29	5 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 025652	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 016547	0	208, 40	5 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 142159	0	4, 329, 83	0 0	0	54.00
54. 01 05401 ULTRASOUND	0. 138977	0	512, 32	4 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 327194	0	208, 63	7 0	0	56.00
60. 00 06000 LABORATORY	0. 183730	0	4, 603, 64	1 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 091459	0	137, 15		0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 122685	0	329, 98		0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 331446	0	502, 21		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 764260	0	555, 81		0	66.00
66. 01 06601 SPORTS THERAPY	0. 000000	0		0 0	0	66.01
67.00 06700 OCCUPATI ONAL THERAPY	0. 630059	0	96, 26	8 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1. 451014	0	5, 14		0	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 325775	0	5, 42		0	70.00
70. 01 07001 CARDI OPULMONARY	0. 452238	0	184, 24		0	70.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 113764	0	1, 406, 37		0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 547000	0	91, 23		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 590171	0				73.00
OUTPATIENT SERVICE COST CENTERS	01070171		021727	, 01,100		/0/00
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 JV CLINIC	0. 562961	0	312, 82		0	90.01
91. 00 09100 EMERGENCY	0. 291955	0	2, 914, 71		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 704102	0	1, 210, 96		0	92.00
200.00 Subtotal (see instructions)	0.701102	0	19, 701, 78		Ũ	200.00
201.00 Less PBP Clinic Lab. Services-Program		0		0 0	Ū	201.00
Only Charges				Ĭ		
202.00 Net Charges (line 200 +/- line 201)		0	19, 701, 78	4 51, 108	0	202.00

Health Financial Systems SULL	IVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1327	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pr 5/26/2017 2:	
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	492, 567	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	3, 448	0				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	615, 524	0				54.00
54. 01 05401 ULTRASOUND	71, 201	0				54.01
56. 00 05600 RADI OI SOTOPE	68, 265	0				56.00
60. 00 06000 LABORATORY	845, 827	0				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	12, 544	0				63.00
64.00 06400 I NTRAVENOUS THERAPY	40, 484	0				64.00
65. 00 06500 RESPI RATORY THERAPY	166, 458	0				65.00
66. 00 06600 PHYSI CAL THERAPY	424, 784	0				66.00
66. 01 06601 SPORTS THERAPY	0	0				66.01
67.00 06700 OCCUPATI ONAL THERAPY	60, 655	0				67.00
68.00 06800 SPEECH PATHOLOGY	7,470	0				68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	1, 768	0				70.00
70. 01 07001 CARDI OPULMONARY	83, 324					70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	159, 995					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	49, 903	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	484, 707	30, 162				73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
90. 00 09000 CLINIC	0	0				90.00
90. 01 09001 JV CLINIC	176, 105	0				90.01
91.00 09100 EMERGENCY	850, 964					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	852, 644	0				92.00
200.00 Subtotal (see instructions)	5, 468, 637	30, 162				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	5, 468, 637	30, 162				202.00

Health Financial Systems SUL	LIVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
		Component		From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	nored.
		component	JUN: 15-Z327	To 12/31/2016	5/26/2017 2:2	
		Title	XVIII S	wing Beds - SNF		<u>o p</u>
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 O5000 OPERATING ROOM	0. 389290			0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 025652	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 016547	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 142159	0	(	0 0	0	54.00
54. 01 05401 ULTRASOUND	0. 138977	0	(	0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 327194	0		0 0	0	56.00
60. 00 06000 LABORATORY	0. 183730	0		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 091459	0		0 0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0. 122685	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 331446	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 764260	0		0 0	0	66.00
66. 01 06601 SPORTS THERAPY	0. 000000	0		0 0	0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0. 630059	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1.451014	0		0 0	0	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 325775	0	(	0 0	0	70.00
70. 01 07001 CARDI OPULMONARY	0. 452238	0	(	0 0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 113764	0	(	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 547000	0	(	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 590171	0	(	0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	r			-		
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
90. 00 09000 CLINIC	0. 000000	0	(	0 0	0	90.00
90. 01 09001 JV CLINIC	0. 562961	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0. 291955	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 704102	0		0 0	0	92.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program			(	0 0		201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)		0	(	0 0	0	202.00

Health Financial Systems SULI	LIVAN COUNTY CO	ΜΜΠΝΙΤΥ ΗΟSPIT	AI	Inlie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL. OTHER HEALTH SERVICES AND		Provi der C		Peri od:	Worksheet D	2002 10
				From 01/01/2016	Part V	
		Component	CCN: 15-Z327	To 12/31/2016	Date/Time Pre 5/26/2017 2:2	
		Title	e XVIII	Swing Beds - SNF		s pili
	Cos	sts		Jowning Deuts Jown	0031	
Cost Center Description	Cost	Cost	1			
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATING ROOM	0					50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
53.00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01 05401 ULTRASOUND	0	0				54.01
56. 00 05600 RADI OI SOTOPE	0	0				56.00
60.00 06000 LABORATORY	0	0	)			60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	1			64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY 66. 01 06601 SPORTS THERAPY	0					66.00 66.01
66. 01 06601 SPORTS THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0		•			67.00
68. 00 06800 SPEECH PATHOLOGY	0					68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0					70.00
70. 01 07000 CARDI OPULMONARY	0					70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS						71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	, s				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		•			73.00
OUTPATIENT SERVICE COST CENTERS						/ 0/ 00
88.00 08800 RURAL HEALTH CLINIC	0	C				88.00
90. 00 09000 CLINIC	0		•			90.00
90. 01 09001 JV CLINIC	0	C				90.01
91.00 09100 EMERGENCY	0	C				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	0				202.00

Health Financial Systems SUL	LI VAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/26/2017 2:2	
		Titl	e XIX	Hospi tal	Cost	<u> </u>
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 389290	0			0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 025652	0	3, 04	2 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 016547	0	24, 16	5 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 142159	0	219, 80	6 0	0	54.00
54. 01 05401 ULTRASOUND	0. 138977	0	67, 99	5 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 327194	0	3, 54	0 0	0	56.00
60. 00 06000 LABORATORY	0. 183730	0	194, 51	1 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 091459	0	3, 87	0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 122685	0	5,85	4 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 331446	0	20, 13		0	65,00
66. 00 06600 PHYSI CAL THERAPY	0. 764260	0	12, 33		0	66,00
66. 01 06601 SPORTS THERAPY	0. 000000	0		0 0	0	66.01
67.00 06700 OCCUPATI ONAL THERAPY	0. 630059	0	4, 35	2 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1. 451014	0	4, 38		0	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 325775	0		0 0	0	70.00
70. 01 07001 CARDI OPULMONARY	0. 452238	0	59	4 0	0	70.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 113764	0	98, 34		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 547000	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 590171	0			0	73.00
OUTPATIENT SERVICE COST CENTERS	01070171		20/0/	<u> </u>		10100
88.00 08800 RURAL HEALTH CLINIC	0.000000				0	88.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 JV CLINIC	0. 562961	0	1, 72		0	
91. 00 09100 EMERGENCY	0. 291955	0	59, 78		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 704102	0	59,66		0	
200.00 Subtotal (see instructions)	01.701102	0	867, 41		0	200.00
201.00 Less PBP Clinic Lab. Services-Program		0		0 0	Ŭ	201.00
Only Charges				-		
202.00 Net Charges (line 200 +/- line 201)		0	867, 41	3 0	0	202.00

Health Financial Systems SULI	LIVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider C	CN: 15-1327	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pr 5/26/2017 2:	
		Ti tl	e XIX	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	23, 448	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 120	0	1			52.00
53. 00 05300 ANESTHESI OLOGY	400	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	31, 247	0				54.00
54. 01 05401 ULTRASOUND	9, 450	0				54.01
56. 00 05600 RADI OI SOTOPE	1, 158	0				56.00
60. 00 06000 LABORATORY	35, 738	0				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	354	0				63.00
64.00 06400 INTRAVENOUS THERAPY	718	0				64.00
65. 00 06500 RESPI RATORY THERAPY	6, 673	0				65.00
66. 00 06600 PHYSI CAL THERAPY	9, 427	0				66.00
66. 01 06601 SPORTS THERAPY	0	0				66. 01
67.00 06700 OCCUPATI ONAL THERAPY	2, 742	0				67.00
68.00 06800 SPEECH PATHOLOGY	6, 357	0				68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
70. 01 07001 CARDI OPULMONARY	269	0				70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 188	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	13, 618	0				73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
90. 00 09000 CLINIC	0	0				90.00
90. 01 09001 JV CLINIC	973	0				90.01
91.00 09100 EMERGENCY	17, 453	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	42,013	0				92.00
200.00 Subtotal (see instructions)	216, 346	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	216, 346	0				202.00

SULLI VAN	COUNTY	COMMUNI TY	HOSPI TAL

Health Financial Systems SULLIVAN COUNTY CO	MMUNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1327	Peri od:	Worksheet D-1	
		From 01/01/2016 To 12/31/2016	Date/Time Pre 5/26/2017 2:2	
Cost Conton Description	Title XVIII	Hospi tal	Cost	
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS			1.00	
I NPATI ENT DAYS				
1.00 Inpatient days (including private room days and swing-bed o			4, 494	
2.00 Inpatient days (including private room days, excluding swir			4, 028	
3.00 Private room days (excluding swing-bed and observation bed do not complete this line.	days). It you have only pr	rivate room days,	0	3.00
4.00 Semi-private room days (excluding swing-bed and observation	bed davs)		2, 096	4.00
5.00 Total swing-bed SNF type inpatient days (including private		er 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	0	6.00
<ul> <li>reporting period (if calendar year, enter 0 on this line)</li> <li>7.00 Total swing-bed NF type inpatient days (including private r</li> </ul>	coom days) through December	- 31 of the cost	105	7.00
reporting period	through becember	ST OF THE COST	105	7.00
8.00 Total swing-bed NF type inpatient days (including private r	oom days) after December 3	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	e to the Program (excluding	g swing-bed and	1, 261	9.00
newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII	only (including private )	(ave)	361	10.00
through December 31 of the cost reporting period (see instr		Uulii uays)	501	10.00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII	only (including private i	room days) after	0	11.00
December 31 of the cost reporting period (if calendar year,				
12.00 Swing-bed NF type inpatient days applicable to titles V or	XIX only (including privat	te room days)	0	12.00
through December 31 of the cost reporting period 13.00 Swing-bed NF type inpatient days applicable to titles V or	XIX only (including privat	te room dave)	0	13.00
after December 31 of the cost reporting period (if calendar			0	13.00
14.00 Medically necessary private room days applicable to the Pro			0	14.00
15.00 Total nursery days (title V or XIX only)			0	
16.00 Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT           17.00         Medicare rate for swing-bed SNF services applicable to services	icos through December 21	f the cost		17.00
reporting period	Tes thiodgn becember 31 t	JI THE COST		17.00
18.00 Medicare rate for swing-bed SNF services applicable to serv	vices after December 31 of	the cost		18.00
reporting period		S + L +	212 54	10.00
19.00 Medicaid rate for swing-bed NF services applicable to servi reporting period	ces through December 31 of	the cost	212.56	19.00
20.00 Medicaid rate for swing-bed NF services applicable to servi	ces after December 31 of t	the cost	0.00	20.00
reporting period				
21.00 Total general inpatient routine service cost (see instructi			4, 783, 575	
22.00 Swing-bed cost applicable to SNF type services through Dece 5 x line 17)	ember 31 of the cost report	ting period (line	0	22.00
23.00 Swing-bed cost applicable to SNF type services after Decemb	per 31 of the cost reportion	na period (line 6	0	23.00
x line 18)			0	20.00
24.00 Swing-bed cost applicable to NF type services through Decem	nber 31 of the cost reporti	ng period (line	22, 319	24.00
7 x line 19)			-	05 05
25.00 Swing-bed cost applicable to NF type services after December	er 31 OT THE COST REPORTING	j perioa (line 8	0	25.00
x line 20) 26.00 Total swing-bed cost (see instructions)			413, 939	26.00
27.00 General inpatient routine service cost net of swing-bed cos	st (line 21 minus line 26)		4, 369, 636	
PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				
28.00 General inpatient routine service charges (excluding swing-	bed and observation bed ch	narges)	0	
29.00 Private room charges (excluding swing-bed charges)			0	
<ul> <li>30.00 Semi-private room charges (excluding swing-bed charges)</li> <li>31.00 General inpatient routine service cost/charge ratio (line 2)</li> </ul>	27 ÷ line 28)		0 0. 000000	
32.00 Average private room per diem charge (line 29 ÷ line 3)			0.000000	
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		ctions)	0.00	
35.00 Average per diem private room cost differential (line 34 x			0.00	
36.00 Private room cost differential adjustment (line 3 x line 35		fforontial (line	0	
37.00 General inpatient routine service cost net of swing-bed cos 27 minus line 36)	anu private room cost di	inerential (IINe	4, 369, 636	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST A	DJUSTMENTS			1
38.00 Adjusted general inpatient routine service cost per diem (s	see instructions)		1, 084. 82	
39.00 Program general inpatient routine service cost (line 9 x li	-		1, 367, 958	
40.00 Medically necessary private room cost applicable to the Pro			0 1, 367, 958	
41.00  Total Program general inpatient routine service cost (line	57 T THE 40)		1, 307, 938	41.00

	2	LIVAN COUNTY CO				u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC		eriod: rom 01/01/2016	Worksheet D-1	
					o 12/31/2016		
			Title	XVIII	Hospi tal	5/26/2017 2:23 Cost	3 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days			(col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
42.00	NURSERY (title V & XIX only)	0					42.00
42.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1 0 47 070	205	F 110 00	10/	( 4 4 . 1 2 2	42.00
	CORONARY CARE UNIT	1, 047, 978	205	5, 112. 09	126	644, 123	43.00 44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
						1.00	
	Program inpatient ancillary service cost (Wk			、 、		907, 473	
49.00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instructio	ns)		2, 919, 554	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	0	50.00
51.00	) Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, su	m of Parts II	0	51.00
F2 00	and IV) Tatal Dragnam evoludable cast (our of lines	EQ and E1)				0	F2 00
52.00 53.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated, non-phy	sician anesthe	tist, and	0	52.00 53.00
	medical education costs (line 49 minus line						
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operation	ing cost and ta	rget amount (I	ine 56 minus I	ine 53)	0	57.00
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endina 1996. u	pdated and com	pounded by the	0.00	58.00 59.00
	market basket		0				
	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line:				he amount by	0.00	60.00 61.00
01.00	which operating costs (line 53) are less than					0	01.00
	amount (line 56), otherwise enter zero (see			<i>,</i> .	3	_	
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymu	ent (see instru	ictions)			0	62.00 63.00
05.00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	03.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reportin	g period (See	391, 620	64.00
65 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	neriod (See	0	65.00
	instructions)(title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVIII	only). For	391, 620	66.00
67.00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 o	f the cost rep	orting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repor	ting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + line	68)		0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU		•				70.00
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	3					70.00 71.00
72.00	Program routine service cost (line 9 x line	71)					72.00
	Medically necessary private room cost applica Total Program general inpatient routine serv			ne 35)			73.00 74.00
75.00	0 0	•		orksheet B, Pa	rt II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
	Program capital-related costs (line 9 x line	· · · ·					77.00
78.00 79.00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for exces	,	rovi der record	c)			78.00 79.00
	Total Program routine service costs for comp	• •			s line 79)		80.00
	Inpatient routine service cost per diem limi						81.00
	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (						82.00 83.00
	Program inpatient ancillary services (see ins		- /				84.00
	Utilization review - physician compensation	•					85.00
80. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)				86.00
	Total observation bed days (see instructions)	)					87.00
88.00	Adjusted general inpatient routine cost per (	•	,			1, 084. 82 2, 095, 872	
07.00	Observation bed cost (line 87 x line 88) (see	e instructions)				2,093,8/2	09.00

Health Financial Systems SUL	LIVAN COUNTY CO	MMUNITY HOSPITA	AL	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		pared: 3 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	363, 112	4, 783, 575	0. 075908	3 2, 095, 872	159, 093	90.00
91.00 Nursing School cost	0	4, 783, 575	0.00000	2, 095, 872	0	91.00
92.00 Allied health cost	0	4, 783, 575	0.00000	2, 095, 872	0	92.00
93.00 All other Medical Education	0	4, 783, 575	0.00000	2, 095, 872	0	93.00

SULLI VAN	COUNTY	COMMUNI TY	HOSPI TAL

2.00       Injestient days (including private room days, excluding swing-bed and newborn days).       4.028       2.00         00       Derivate room days (excluding swing-bed and observation bed days).       15 you have only private room days.       3.0         0.00       Derivate room days (excluding swing-bed and observation bed days).       2.096       4.00         0.00       Derivate room days (excluding private room days).       10 room days.       0.00         0.01       Total swing-bed K type inpatient days (including private room days).       11 room days.       0.00         0.01       Total swing-bed K type inpatient days (including private room days).       11 room days.       0.00         0.00       Total swing-bed K type inpatient days (including private room days.)       11 room days.       0.00         0.00       Total swing-bed K type inpatient days (including private room days.)       11 room days.       0.00         0.00       Total swing-bed SK type inpatient days applicable to title XVIII only (including private room days.)       0       0.00         0.00       Swing-bed SK type inpatient days applicable to title SVIII only (including private room days.)       0       10.00         0.00       Swing-bed SK type inpatient days applicable to title SVIII only (including private room days.)       0       10.00         0.01       Swing-bed SK type inpatient days applicable to title SVII		Financial Systems SULLIVAN COUNTY COMM			u of Form CMS-2	
Cost Center Description         Title XX         Hospital         Cost           IMMAILINE MAYS         1.00	COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1327	From 01/01/2016	Date/Time Pre	pared:
Cost Center Rescription         1.00           PMAT Let MAN         1.00           PMAT Let MAN         PMAT Let MAN           1.00         Imposite days (including private room days, excluding samp-bed and newtonen)         4.424         1.0           1.00         Imposite days (including private room days, excluding samp-bed and newtonen)         4.028         2.00           0.00         Frivate room days (excluding samp-bed and observation bed days)         Frou have only private room days         0.0           0.01         Total samp-bed SR type inpatient days (including private room days) through becenter 31 of the cost         0.6         0.0           1.00         Total samp-bed SR type inpatient days (including private room days) after Decenter 31 of the cost         0.0         0.0           0.00         Samp-bed SR type inpatient days and (including private room days) after Decenter 31 of the cost         0.0         1.00           0.01         Samp-bed SR type inpatient days applicable to the WNII only (including private room days) after Decenter 31 of the cost         0.0         1.00           0.01         Samp-bed NR type inpatient days applicable to strike WNII only (including private room days) after Decenter 31 of the cost         0.0         1.00           0.01         Samp-bed NR type inpatient days applicable to strike WNII only (including private room days) after December 31 of the cost reporting period (incluster room days) anderecost			Title XIX	Hospi tal		3 pm
PART 1 - ALL PROVIDER CONFORMS           IMPART INFORMS         Institut durys (including private room days and swing-bed days, excluding needorm)         4,494           1.00         Inpattent durys (including private room days and swing-bed days, excluding needorm)         4,093           0.01         Inpattent durys (including private room days and swing-bed and needorm days)         5,00           0.02         Completer this line, and nay-bed and observation bed days)         7,00           0.03         Seen-private room days (excluding swing-bed and observation bed days)         100           0.04         Completer this line, and the private room days) after December 31 of the cost         5,00           0.05         Total swing-bed K type inpattent days (including private room days) after December 31 of the cost         0           0.05         Total swing-bed K type inpattent days (including private room days) after December 31 of the cost         0           0.00         Total swing-bed K type inpattent days (including private room days) after December 31 of the cost         0           0.00         Swing-bed SK type inpattent days applicable to title XVIII only (including private room days) after         0           0.00         Swing-bed SK type inpattent days applicable to title XVIII only (including private room days) after         0           0.00         Swing-bed SK type inpattent days applicable to title XVIII only (including private room days) after		Cost Center Description				
1.00       Inpatient days (including private room days. excluding newborn)       4,494       1.00         0.01       Inpatient days (including private room days. excluding swing-bed and newborn days)       4,028       2.00         3.00       Private room days (excluding swing-bed and observation bed days).       17 you have only private room days.       0					1.00	
2.00       Injuitent days (including private room days, excluding swing-bed and newborn days)       4.08       2.00         00       Derivate room days, excluding swing-bed and observation bed days).       4.00       3.0         01       Samig-trained structures (excluding swing-bed and observation bed days).       5.00       5.00       5.00         02       Samig-bed SK type inpatient days, (including private room days) structures days, after becember 31 of the cost       0.0         03       100       101       100	1 00		s excluding newborn)		4 494	1.00
4.00       Semi-private room days (excluding swing-bed and observation bed days)       2.006       4.00         5.00       Total swing-bed SK type inpatient days (including private room days) strough December 31 of the cost       5.00         7.00       Total swing-bed SK type inpatient days (including private room days) strough December 31 of the cost       0.00         7.00       Total swing-bed KF type inpatient days (including private room days) strough December 31 of the cost       0.00         7.00       Total swing-bed KF type inpatient days (including private room days) strough December 31 of the cost       0.00         7.00       Total swing-bed KF type inpatient days (including private room days) strough December 31 of the cost       0.00         7.00       Total swing-bed KF type inpatient days applicable to the Visit only (including private room days)       0.00         0.00       Sang-bed SK type inpatient days applicable to thit s XVII only (including private room days)       0.10.00         10.00       Sang-bed KF type inpatient days applicable to thits XVII only (including private room days)       0.10.00         11.00       Sang-bed KF type inpatient days applicable to thits XVII only (including swing-bed days)       0.10.00         12.00       Sang-bed KF type inpatient days applicable to the Program (excluding swing-bed days)       0.11.00         12.00       Sang-bed KF type inpatient days applicable to the Program (excluding swing-bed days)       0.11.00	2.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	bed and newborn days)	rivate room days,	4, 028	2.00 3.00
6.00       Total swing-bed SNF type inpatient days (including private room days) after becember 31 of the cost       0       6.00         7.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost       0       7.00         8.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost       0       8.00         9.00       Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)       0       0       0       0       10       0<	4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		4. 00 5. 00
7.00       Total sering-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         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)       8.00         9.00       Total inpatient days including private room days applicable to the Program (excluding swing-bed and through December 31 of the cost reporting period (see instructions)       9.00         10.0       Swing-bed SWF type inpatient days applicable to the Vite XVI In 100 (including private room days)       01.00         11.00       Swing-bed SWF type inpatient days applicable to the Vite XVI and V (including private room days)       01.00         12.00       Swing-bed NF type inpatient days applicable to the Vite XV AIX only (including private room days)       01.00         13.00       Swing-bed NF type inpatient days applicable to the Vite XV AIX only (including private room days)       01.00         14.00       Medi care rate for swing-bed SWF services applicable to the Program (excluding swing-bed days)       01.00         15.00       Total reporting period       11.00       11.00         16.00       Medi care rate for swing-bed SWF services applicable to services after December 31 of the cost       12.25         16.00       Near year year year year year year year y	6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00
8.00       Total swingbed NF type Inpatient days (including private room days) after December 31 of the cost reporting period (ir calendar year, enter 0 on this line) 10.00       Swingbed SW type Inpatient days applicable to the Program (excluding swingbed and newborn days)       0       0         10.00       Swingbed SW type Inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)       0       0         11.00       Swingbed SW type Inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period       0       10.00         0.00       Swingbed SW type Inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period       0       10.00         10.00       Swingbed SW type Inpatient days applicable to title XVIII only (including private room days)       0       10.00         10.00       Swingbed SW type Inpatient days applicable to title XVIII only (including private room days)       0       11.00         10.00       Swingbed SW type Inpatient days applicable to services through December 31 of the cost       0       14.00         11.00       Wedicaid rate for swingbed SW services applicable to services through December 31 of the cost       0.00       20.00         11.00       Wedicaid rate for swingbed SW services applicable to services after December 31 of the cost       0.00       20.00         12.00 </td <td>7.00</td> <td>Total swing-bed NF type inpatient days (including private roo</td> <td>m days) through Decembe</td> <td>r 31 of the cost</td> <td>105</td> <td>7.00</td>	7.00	Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	105	7.00
9.00       Total inplatient days including private room days applicable to the Program (excluding swing-bed and newborn days)       70       9.00         10.00       Swing-bed SMF type inplatient days applicable to title XVIII only (including private room days) after becomber 31 of the cost reporting period (ical endar year, enter 0 on this line)       0       0.00         11.00       Swing-bed SMF type inplatient days applicable to title XVIII only (including private room days) after becomber 31 of the cost reporting period (ical endar year, enter 0 on this line)       11.00         12.00       Swing-bed WF type inplatient days applicable to title V VXIX only (including private room days)       0       12.00         13.00       Swing-bed WF type inpatient days applicable to title V VXIX only (including private room days)       0       13.00         14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Iotal nursery days (title V or XIX only)       1500       16.00       10.00       10.00         10.00       Medicaler rate for swing-bed SMF services applicable to services after December 31 of the cost       212.56       10.00       20.00         10.00       Medicaler rate for swing-bed NF services applicable to services after December 31 of the cost       212.56       10.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00	8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8.00
10.00       Swing-bed Swif type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (incleading reprivate room days) after December 31 of the cost reporting period (incleading reprivate room days) after December 31 of the cost reporting period (incleading reprivate room days) after December 31 of the cost reporting period (incleading reprivate room days) (including private room days) after December 31 of the cost reporting period (incleading reprivate room days) (including private room days) (incleading reprivate room days) (incleading reprivate room days) (incleading swing-bed swing-bed SWF services applicable to services after December 31 of the cost reporting period (incleading to services after December 31 of the cost (incer arte for swing-bed SWF services applicable to services after December 31 of the cost (incer appending period) (in	9.00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	70	9.00
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       0       11:0         12:00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period       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       0       13:00         14:00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14:00         15:00       Total nursery days (title V or XIX only)       150       16:00	10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00
12:00       Swing-bed NF type inpatient days applicable to itles 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       12:00         13:00       Swing-bed NF type inpatient days applicable to itles 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       Medical reserved asy (title V or XIX only)       150       16:00	11.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private i	room days) after	0	11.00
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 called ray ear, enter 0 on this line)       0       13.00         14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Total nursery days (title V or XIX only)       150       16.00         15.00       Nursery days (title V or XIX only)       150         17.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       17.00         18.00       Medical care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       17.00         19.00       Medical care for swing-bed NF services applicable to services after December 31 of the cost reporting period       10.00         10.01       Madical arate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         20.01       Madical arate for swing-bed NF services after December 31 of the cost reporting period (line 5 x line 17)       4.783.575         21.00       Total general inpatient routine service after December 31 of the cost reporting period (line 7 x line 18)       4.783.575         22.01       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18)       2.00 <td< td=""><td>12.00</td><td>Swing-bed NF type inpatient days applicable to titles V or XI</td><td></td><td>te room days)</td><td>0</td><td>12.00</td></td<>	12.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.00
14.00       Nedically 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)       222       15.00         16.00       Nursery days (title V or XIX only)       150         17.00       Hedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         19.00       Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         20.00       Medical general inpatient routine service cost (see instructions)       4.783,575       21.00         21.00       Total general inpatient routine services after December 31 of the cost reporting period (line 5 x line 13)       4.783,575       21.00         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       22.00       23.00         24.00       Swing-bed cost (see instructions)       4.783,575       21.00       22.00         25.00       Swing-bed cost (see instructions)       413,993       26.00       23.00         26.00       Total swing-bed cost (see instructions)       413,993       26.00       26.00	13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
16:00       Nursery days (title V or XIX only)       150       16:0         SWING BED ADJUSTION       150       16:0         17:00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       17:00         10:00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       11:00         10:00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         10:00       Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)       4.783,575         21:00       Total general inpatient routine service cost (see instructions)       4.783,575       21:00         22:00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)       23:00         24:00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)       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)       24:00         26:00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       24:00         20:00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	14.00	Medically necessary private room days applicable to the Progr	-			
17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         19.00       Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       20.00         20.00       Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17)       0.00         21.00       Total general inpatient routine service cost (see instructions)       4.783,575       21.00         22.00       Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18)       0       22.00         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 18)       0       23.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       4.389,636       27.00         25.00       Swing-bed cost (see instructions)       413,939       26.00       27.00       4.369,636       27.00         26.00       Totate swing-bed cost (see instructions)       4.369,636       27.00       28.00       60       29.00       29.00       29.00       29.00		Nursery days (title V or XIX only)				
18. 00       Medicare are farte for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18. 00         19. 00       Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period       21.0         20. 00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         21. 00       Total general inpatient routine service cost (see instructions)       4, 783, 575       21.0         22. 00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)       0.00       22.00         23. 00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)       0.20.00         24. 00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0.20.00         25. 00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0.20.00         26. 00       Total swing-bed cost (see instructions)       413,939       26.00         27. 00       General inpatient routine service cost net of swing-bed and observation bed charges)       0.20.00       0.20.00         27. 00       General inpatient routine service charges (excluding swing-bed and observation bed charges)       0.00.000       0.000 </td <td>17.00</td> <td></td> <td>es through December 31 (</td> <td>of the cost</td> <td></td> <td>17.00</td>	17.00		es through December 31 (	of the cost		17.00
19.00       Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period       212.56       19.00         20.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       20.00         21.00       Total general inpatient routine service cost (see instructions)       4,783,575       21.00         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)       0       22.01         23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       0       22.01         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       24.00       413,939       26.00         25.00       Swing-bed cost (see instructions)       413,939       26.00       27.00         26.00       Total swing-bed cost (see instructions)       413,939       26.00         27.00       General inpatient routine service cost net of swing-bed charges)       0       29.00         29.00       Private room charges (excluding swing-bed charges)       0       00.00         29.00       Private room charges (excluding swing-bed charges)       0       0.00       0       0.00       32.00       32.00	18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18.00
20.00       Medical Grate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       20.00         21.00       Total general inpatient routine service cost (see instructions)       4, 783,575       21.00         22.00       Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18)       0.00       22.00         23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 19)       22.00       23.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0.00       24.00       24.00       24.00       24.00       24.00       25.00       24.00       25.00       26.00       26.00       26.00       26.00       26.00       26.00       27.00       26.00       27.00       26.00       27.00       26.00       27.00       27.00       26.00       27.00       27.00       27.00       27.00       27.00       28.00       28.00       28.00       28.00       29.00       28.00       29.00       29.00       29.00       29.00       29.00       29.00       29.00       29.00       29.00       29.00       29.00       29.00       29.00       29.00       29.00       29.00       29.0	19.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	f the cost	212. 56	19.00
21.00Total general inpatient routine service cost (see instructions)4, 783, 57521.0022.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line x line 18)022.0023.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)0023.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)0024.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 20)00026.00Total swing-bed cost (see instructions)413,93926.0026.00Total inpatient routine service cost net of swing-bed cost (line 21 minus line 26)4,369,63627.0027.00General inpatient routine service cost charges (excluding swing-bed charges)028.0028.00Semi-private room charges (excluding swing-bed charges)0020.00Semi-private room charges (excluding swing-bed charges)0020.00Average private room per diem charge (line 29 + line 3)0.000020.00Average per diem private room per diem charge (line 32 minus line 33)(see instructions)0.0021.00Average per diem private room cost differential (line 34 x line 31)0.0020.01Average per diem private room cost differential (line 3 x line 35)021.02Average per diem private room cost differential sing-bed cost applicable to the Program (line 14 x line 35)1,064,82	20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0.00	20.00
23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       0       23.00         24.00       Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 29)       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         26.00       Total swing-bed cost (see instructions)       413,939         26.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       4,369,636         27.00       General inpatient routine service charges (excluding swing-bed and observation bed charges)       0         28.00       General inpatient routine service cost/charge ratio (line 27 + line 28)       0.000000         29.00       Private room charges (excluding swing-bed charges)       0.000000         31.00       General inpatient routine service cost/charge ratio (line 27 + line 28)       0.000000         32.00       Average per diem private room charge differential (line 32 minus line 33)(see instructions)       0.00         33.00       Average per diem private room cost differential (line 34 x line 31)       0.00       36.00         34.00       Average per diem private room cost differential (line 34 x line 31)       0.00       36.00         35.00       Average per diem private room cost diffe		Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line		21.00 22.00
24.00Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)22, 31924.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)00026.00Total swing-bed cost (see instructions)413,93926.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)4,369,63627.00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT0028.0029.00Private room charges (excluding swing-bed charges)028.0030.00Semi-private room charges (excluding swing-bed charges)029.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.000000031.0032.00Average peri diem private room per diem charge (line 30 + line 4)0.0033.0033.00Average peri diem private room cost differential (line 32 minus line 33) (see instructions)0.0035.0035.00Average peri diem private room cost differential (line 3 x line 35)0.30.0036.0037.00PART I1 - HOSPITAL AND SUBPROVIDERS ONLY4,369,63637.0027.01PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1,084.8238.00Adjusted general inpatient routine service cost per diem (see instructions)1,084.8239.00Program general inpatient routine service cost per diem (see instructions)75,93739.00Adjusted general inpatient routine service cost per diem (see instructions)75,937<	23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	ng period (line 6	0	23.00
25. 00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)025. 0026. 00Total swing-bed cost (see instructions)413, 93926. 0027. 00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)4, 369, 63628. 00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT29. 0029. 00Private room charges (excluding swing-bed charges)020. 00Semi-private room charges (excluding swing-bed charges)030. 00Semi-private room charges (excluding swing-bed charges)031. 00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031. 00Average private room per diem charge (line 30 + line 3)0.0032. 00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0033. 00Average per diem private room cost differential (line 3 x line 35)037. 00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)077. minus line 300.0035. 0078. 00Adjusted general inpatient routine service cost per diem (see instructions)1,084.8278. 00Adjusted general inpatient routine service cost (line 9 x line 38)75,937.9079. 00Program general inpatient routine service cost (line 9 x line 38)75,937.9070. 00Medically necessary private room cost applicable to the Program (line 14 x line 35)0	24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	22, 319	24.00
26.00Total swing-bed cost (see instructions)413,93926.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)4,369,63627.0028.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 30 + line 3)0.0032.0034.00Average per diem private room cost differential (line 34 x line 31)0.0033.0035.00Private room cost differential djustment (line 3 x line 35)0.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35)37.0037.00General inpatient routine service cost per diem (see instructions)1,084.8238.00Adjusted general inpatient routine service cost per diem (see instructions)1,084.8238.00Adjusted general inpatient routine service cost per diem (see instructions)1,084.8238.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0	25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.00
PRI VATE       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       29.00         30.00       Semi-private room charges (excluding swing-bed charges)       0       29.00         31.00       General inpatient routine service cost/charge ratio (line 27 ÷ line 28)       0.000000       31.00         32.00       Average private room per diem charge (line 29 ÷ line 3)       0.000       32.00         33.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.000       33.00         34.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00       0.00       35.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 369, 636       37.00       36.00       7 minus line 36)       0.00       36.00         PART 11       HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1,084.82       38.00       1,084.82       38.00       75,937       39.00       75,937       39.00       75,937       39.00       75,937       39.00		Total swing-bed cost (see instructions)				
29.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average per diem private room per diem charge (line 30 ÷ line 4)0.0033.004.00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.0035.005.00Average per diem private room cost differential (line 3 x line 35)0.0035.006.00Private room cost differential adjustment (line 3 x line 35)036.007.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 369, 63637.007.01PART 11 - HOSPI TAL AND SUBPROVI DERS ONLYPROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 084.8238.00Adjusted general inpatient routine service cost per diem (see instructions)1, 084.8238.009.00Program general inpatient routine service cost (line 9 x line 38)75, 93739.009.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	27.00		(line 21 minus line 26)		4, 369, 636	27.00
30.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0032.0034.00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.0034.0035.00Average per diem private room cost differential (line 3 x line 31)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)0.0036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 369, 63637.0027. minus line 36)PRRT 11 - HOSPI TAL AND SUBPROVI DERS ONLY1, 084.82PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 084.8238.0039.00Program general inpatient routine service cost per diem (see instructions)1, 084.8239.0090.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	28.00		d and observation bed cl	narges)		
31.00       General inpatient routine service cost/charge ratio (line 27 ÷ line 28)       0.000000       31.00         32.00       Average private room per diem charge (line 29 ÷ line 3)       0.00       32.00         33.00       Average semi-private room per diem charge (line 30 ÷ line 4)       0.00       33.00         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       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       0.00       35.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 369, 636       37.00         27 minus line 36)       PRAT 11 - HOSPITAL AND SUBPROVI DERS ONLY       0       38.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1, 084.82       38.00         39.00       Program general inpatient routine service cost per diem (see instructions)       1, 084.82       39.00         97.00       Program general inpatient routine service cost (line 9 x line 38)       75, 937       39.00         90.00       Program general inpatient routine service cost (line 9 x line 38)       0       40.00          1,					-	
32.00       Average private room per diem charge (line 29 ÷ line 3)       0.00       32.00         33.00       Average semi-private room per diem charge (line 30 ÷ line 4)       0.00       33.00         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       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0.00       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 369, 636       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       38.00         Adjusted general inpatient routine service cost per diem (see instructions)       1, 084.82       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       75, 937       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00			÷line 28)			
33.00       Average semi-private room per diem charge (line 30 ÷ line 4)       0.00       33.00         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       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0.00       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 369, 636       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       38.00         Adjusted general inpatient routine service cost per diem (see instructions)       1, 084.82         39.00       Program general inpatient routine service cost (line 9 x line 38)       75, 937         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0						1
35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 369, 636)       37.00         27 minus line 36)       PART 11 - HOSPI TAL AND SUBPROVIDERS ONLY       4, 369, 636       37.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1, 084.82       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       75, 937       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00						
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 2.7 minus line 36)       0       36.00         PART 11 - HOSPI TAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       0       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1,084.82       38.00         9.00       Program general inpatient routine service cost (line 9 x line 38)       75,937       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00				ctions)		
37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 369, 636 27 minus line 36)       37.00         PART 11 - 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)       1,084.82       38.00         9.00       Program general inpatient routine service cost (line 9 x line 38)       75,937       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	35.00		ne 31)			
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)       1,084.82       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       75,937       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00		General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	-	36.00 37.00
38.00Adjusted general inpatient routine service cost per diem (see instructions)1,084.8238.0039.00Program general inpatient routine service cost (line 9 x line 38)75,93739.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
39.00Program general inpatient routine service cost (line 9 x line 38)75,93739.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	20 00				1 004 00	20.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			-			
						40.00

	N OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2016	Worksheet D-1	I
					To 12/31/2016		
			Ti tl	e XIX	Hospi tal	Cost	20 pii
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00 NURS	SERY (title V & XIX only) ensive Care Type Inpatient Hospital U	179, 434	232	773. 4	2 150	116, 013	3 42
	ENSIVE CARE UNIT	1, 047, 978	205	5, 112. 0	9 15	76, 681	43
	DNARY CARE UNIT	1,047,770	200	3, 112.0	/	/0,001	44
	I INTENSIVE CARE UNIT						45
	GICAL INTENSIVE CARE UNIT						46
OO OTHE	R SPECIAL CARE (SPECIFY)			L			47
	Cost Center Description					1.00	
00 Prog	gram inpatient ancillary service cost	: (Wkst. D-3, col. 3,	line 200)			67, 338	3 48
00 Tota	al Program inpatient costs (sum of li			ns)		335, 969	9 49
	THROUGH COST ADJUSTMENTS s through costs applicable to Program	innationt routing of	orvione (from	Wkct D cum	of Darte L and	0	50
		i inpatrent routine s	Services (110	WKSL. D, SUM	OF PAILS F ANU		50
	s through costs applicable to Program	n inpatient ancillary	/ services (fr	om Wkst. D, s	um of Parts II	0	51
and	,	poc EO and E1					
	al Program excludable cost (sum of li al Program inpatient operating cost e		ated non-nby	sician anesth	etist and		
medi	cal education costs (line 49 minus I						
	ET AMOUNT AND LIMIT COMPUTATION						
	gram discharges					0	
	get amount per discharge					0.00	
	get amount (line 54 x line 55) Ference between adjusted inpatient op	vorating cost and tar	ant amount (1	ino 56 minus	(ino 52)	0	
	us payment (see instructions)	erating cost and tar	get allount (i	The so minus i	The 53)		
	ser of lines 53/54 or 55 from the cos	st reporting period e	endina 1996, u	pdated and co	mpounded by the		
	ket basket	511 511	5		, <b>.</b>		
	ser of lines 53/54 or 55 from prior y					0.00	
	ine 53/54 is less than the lower of ch operating costs (line 53) are less					0	) 61
	unt (line 56), otherwise enter zero (		s (THES 54 X	00), 01 1/8 01	the target		
	ef payment (see instructions)					0	62
	wable Inpatient cost plus incentive		ctions)			0	) 63
	RAM INPATIENT ROUTINE SWING BED COST care swing-bed SNF inpatient routine		ber 31 of the	cost reporti	na period (See	0	64
	tructions) (title XVIII only)			0001 i opoi i i	ig poir ou (oco		
	care swing-bed SNF inpatient routine	e costs after Decembe	er 31 of the c	ost reporting	period (See	0	65
	tructions)(title XVIII only) al Medicare swing-bed SNF inpatient r	soutino coste (lino 4	4 plus line 4			0	) 66
	(see instructions)	outille costs (The d	54 prus rine o	5)(title xvii	OIIIY). FUI		
.00 Titl	e V or XIX swing-bed NF inpatient ro	outine costs through	December 31 o	f the cost re	porting period	0	67
	ne 12 x line 19)	uting gosta after Da	acombar 21 of	the east rang	nting pariod		
	e V or XIX swing-bed NF inpatient ro ne 13 x line 20)	outine costs after De	cember 31 01	the cost repo	ting period		68
	al title V or XIX swing-bed NF inpati	ent routine costs (I	ine 67 + line	68)		0	) 69
	III - SKILLED NURSING FACILITY, OTH					1	
	led nursing facility/other nursing f usted general inpatient routine servi	3		• •			70
	gram routine service cost (line 9 x l		ne /0 ÷ inne	2)			72
	cally necessary private room cost ap	-	(line 14 x li	ne 35)			73
	al Program general inpatient routine	5	•	,			74
	tal-related cost allocated to inpati	ent routine service	costs (from W	orksheet B, Pa	art II, column		75
1	line 45)	÷ line 2)					76
	diem capital-related costs (line 75 gram capital-related costs (line 9 x	-					77
	atient routine service cost (line 74						78
	regate charges to beneficiaries for e		rovi der record	s)			79
	al Program routine service costs for	•	ost limitation	(line 78 min <sup>,</sup>	us line 79)		80
	atient routine service cost per diem						81
	atient routine service cost limitatio	• • • •					82
1	sonable inpatient routine service cos gram inpatient ancillary services (se	•	<i>)</i>				83
	gram inpatient ancillary services (se ization review – physician compensat		is)				84
	al Program inpatient operating costs						86
	IV - COMPUTATION OF OBSERVATION BED		<u> </u>				
PART							
PART 00 Tota	al observation bed days (see instruct usted general inpatient routine cost	i ons)	11			1, 932 1, 084. 82	

Health Financial Systems SUL	LIVAN COUNTY CO	OMMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		pared: 3 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	363, 112	2 4, 783, 575	0.075908	3 2, 095, 872	159, 093	90.00
91.00 Nursing School cost	(	4, 783, 575	0.00000	2, 095, 872	0	91.00
92.00 Allied health cost	(	4, 783, 575	0.00000	2, 095, 872	0	92.00
93.00 All other Medical Education	(	4, 783, 575	0.00000	2, 095, 872	0	93.00

Health Financial Systems SULLIVAN COUNTY (	COMMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1327	Period:	Worksheet D-3	
			From 01/01/2016 To 12/31/2016		
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS		1	1 770 577		20.00
			1, 773, 577 288, 070		30.00 31.00
31. 00  03100  I NTENSI VE CARE UNI T 43. 00  04300  NURSERY			200, 070		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM		0. 3892	299, 900	116, 748	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		1. 0256		0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 0165			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1421			
54. 01 05401 ULTRASOUND		0. 1389			54.01
56. 00 05600 RADI 0I SOTOPE		0. 3271	94 17, 129	5, 605	56.00
60. 00 06000 LABORATORY		0. 1837	496, 816	91, 280	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 0914	59 217, 245	19, 869	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 1226	35 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 3314	46 328, 264	108, 802	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 7642		28, 641	66.00
66. 01 06601 SPORTS THERAPY		0.0000			66. 01
67. 00 06700 OCCUPATI ONAL THERAPY		0. 6300		574	67.00
68.00 06800 SPEECH PATHOLOGY		1.4510		8, 055	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 3257		620	70.00
70. 01 07001 CARDI OPULMONARY		0. 4522		0	70.01
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 1137		95, 486	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT		0.5470			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 5901	71 576, 181	340, 045	73.00
0UTPATI ENT_SERVICE_COST_CENTERS 88. 00 08800 RURAL_HEALTH_CLINIC		0.0000		0	88.00
90. 00 09000 CLINIC		0.0000		0	90.00
90. 01 09001 JV CLINIC		0.5629		0	90.00
91. 00 09100 EMERGENCY		0. 2919		-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7041			
200.00 Total (sum of lines 50-94 and 96-98)		0.7041	3, 307, 606		
201.00 Less PBP Clinic Laboratory Services-Program only cha	raes (line 61)		0,007,000		201.00
202.00 Net Charges (line 200 minus line 201)	3 · · · (· · · · · · · · · · · · · · · ·		3, 307, 606		202.00

Health Financial Systems SULLIVAN COUNTY COMMUN	NITY HOSPIT	AL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1327	Per		Worksheet D-3	
		001 45 3003		m 01/01/2016		
	Component	CCN: 15-Z327	То	12/31/2016	Date/Time Pre 5/26/2017 2:2	
	Title	× XVIII	Swi r	ng Beds - SNF		
Cost Center Description		Ratio of Cos		Inpatient	Inpatient	
		To Charges			Program Costs	
				Charges	(col. 1 x col.	
					2)	
		1.00		2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	_			
30. 00 03000 ADULTS & PEDIATRICS				0		30.00
31. 00 03100 I NTENSI VE CARE UNI T				0		31.00
43. 00 04300 NURSERY						43.00
		0.2002	00	0	0	
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0.3892		0	-	50.00
52. 00  05200  DELI VERY ROOM & LABOR ROOM 53. 00  05300  ANESTHESI OLOGY		1. 0256 0. 0165	-	0	0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0165		15, 088	2, 145	
54. 01 05400 KADI OLOGI -DI AGNOSTI C 54. 01 05401 ULTRASOUND		0. 1421		1, 421	2, 145	54.00
56. 00 05600 RADI 0I SOTOPE		0. 3271		1, 421	0	56.00
60. 00 06000 LABORATORY		0. 1837		56, 833	10, 442	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 0914		4, 874	446	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 1226		0	0	64.00
65. 00 06500 RESPIRATORY THERAPY		0. 3314		53, 648	17, 781	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 7642		47,021	35, 936	66,00
66. 01 06601 SPORTS THERAPY		0.0000		0	0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY		0.6300		1, 989	1, 253	67.00
68. 00 06800 SPEECH PATHOLOGY		1. 4510	14	434	630	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 3257	75	0	0	70.00
70. 01 07001 CARDI OPULMONARY		0. 4522	38	0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1137	64	62, 560	7, 117	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 5470	00	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 5901	71	120, 073	70, 864	73.00
OUTPATIENT SERVICE COST CENTERS		1		1		
88.00 08800 RURAL HEALTH CLINIC		0.0000			0	88.00
90. 00 09000 CLINIC		0.0000		0	0	90.00
90. 01 09001 JV CLINIC		0.5629		0	0	90.01
		0. 2919		0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)		0. 7041	02	0	0	92.00
200.00 Total (sum of lines 50-94 and 96-98)	(Lino (1)			363, 941	146, 811	
201.00Less PBP Clinic Laboratory Services-Program only charges202.00Net Charges (line 200 minus line 201)	(THE OI)			0 363, 941		201.00 202.00
202.00 Inter charges (The 200 millios The 201)		I	I	303, 941		202.00

Health Financial Systems SU	JLLIVAN COUNTY COMMUNITY HOSPIT.	AL	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC	CN: 15-1327	Peri od: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
				5/26/2017 2:2	3 pm
	litl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program Charges	Program Costs (col. 1 x col.	
			charges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			2100	0100	
30. 00 03000 ADULTS & PEDI ATRI CS			69, 871		30.00
31. 00 03100 I NTENSI VE CARE UNI T			8, 314		31.00
43.00 04300 NURSERY			23, 085		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 38929	90 33, 465	13, 028	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		1. 0256	52 912	935	52.00
53. 00 05300 ANESTHESI OLOGY		0. 01654	47 32, 502	538	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 1421			54.00
54.01 05401 ULTRASOUND		0. 1389	6, 940	965	54.01
56. 00 05600 RADI OI SOTOPE		0. 32719			56.00
60. 00 06000 LABORATORY		0. 1837:			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 09145			63.00
64.00 06400 INTRAVENOUS THERAPY		0. 12268			
65. 00 06500 RESPI RATORY THERAPY		0. 33144			65.00
66. 00 06600 PHYSI CAL THERAPY		0. 76420			
66.01 06601 SPORTS THERAPY		0.0000		0	66. 01
67.00 06700 OCCUPATIONAL THERAPY		0. 6300		0	67.00
68.00 06800 SPEECH PATHOLOGY		1.4510		409	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 3257		0	70.00
70. 01 07001 CARDI OPULMONARY		0. 45223		0	70.01
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 11370		10, 427	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0.54700		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		0. 5901	71 25, 361	14, 967	73.00
88.00 08800 RURAL HEALTH CLINIC		0.0000	0 00	0	88.00
90. 00 09000 CLINIC		0.00000		0	90.00
90. 01 09001 JV CLINIC		0. 56296		0	90.00
91. 00 09100 EMERGENCY		0. 2919			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2919		5, 063	
200.00 Total (sum of lines 50-94 and 96-98)		0.70410	294, 690		
201.00 Less PBP Clinic Laboratory Services-P	Program only charges (line 61)		274,070	57, 550	201.00
202.00 Net Charges (line 200 minus line 201)			294, 690		202.00
		1			

ALCOL	ATION OF REIMBURSEMENT SETTLEMENT Prov	vider CCN: 15-1327	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Pre 5/26/2017 2:2	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
00	Medical and other services (see instructions)	、 、		5, 498, 799	
00	Medical and other services reimbursed under OPPS (see instructions PPS payments	)		0	
00	Outlier payment (see instructions)			0	
00	Enter the hospital specific payment to cost ratio (see instruction	s)		0.000	
00	Line 2 times line 5	,		0	6.0
00	Sum of line 3 plus line 4 divided by line 6			0.00	1
00	Transitional corridor payment (see instructions)	ol 12 lino 200		0	
00 0.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, c Organ acquisitions	51. 13, TThe 200		0	
1.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 498, 799	1
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
2.00 3.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 6	0)		0	
	Total reasonable charges (sum of lines 12 and 13)	9)		0	
	Customary charges				1
5.00	Aggregate amount actually collected from patients liable for payme		5	0	
5.00	Amounts that would have been realized from patients liable for pay	ment for services	on a chargebasis	0	16.0
7.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17 0
3.00	Total customary charges (see instructions)			0.000000	
9.00	Excess of customary charges over reasonable cost (complete only if	line 18 exceeds	ine 11) (see	0	1
	instructions)				
0. 00	Excess of reasonable cost over customary charges (complete only if	line 11 exceeds l	ine 18) (see	0	20.0
1.00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see ins	tructions)		5, 553, 787	21 0
2.00	Interns and residents (see instructions)			0	
3.00	Cost of physicians' services in a teaching hospital (see instructi	ons)		0	23.0
4. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24.0
5.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			33, 078	25.0
5.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH	, see instruction	5)	2, 998, 840	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus	the sum of lines :	22 and 23] (see	2, 521, 869	27.0
	instructions)	~		0	
3.00 7.00	Direct graduate medical education payments (from Wkst. E-4, line 5 ESRD direct medical education costs (from Wkst. E-4, line 36)	0)		0	
). 00 ). 00	Subtotal (sum of lines 27 through 29)			2, 521, 869	1
1.00	Primary payer payments			3, 637	1
2.00	Subtotal (line 30 minus line 31)			2, 518, 232	32.0
3. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. 1-5, line 11)			0	33.0
	Allowable bad debts (see instructions)			834, 084	
5.00	Adjusted reimbursable bad debts (see instructions)			542, 155	
5.00	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)		693, 597	
7.00	Subtotal (see instructions)			3, 060, 387	1
3.00 9.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
7.00 7.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
9. 98	Partial or full credits received from manufacturers for replaced d	evices (see instru	uctions)	0	
9. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
D. 00	Subtotal (see instructions)			3, 060, 387	1
D. 01 1. 00	Sequestration adjustment (see instructions) Interim payments			61, 208 3, 064, 025	
2.00	Tentative settlement (for contractors use only)			3, 004, 025	
3.00	Balance due provider/program (see instructions)			-64, 846	
4.00	Protested amounts (nonallowable cost report items) in accordance w	ith CMS Pub. 15-2	chapter 1,	0	44.0
	§115.2 TO BE COMPLETED BY CONTRACTOR				-
D. 00	Original outlier amount (see instructions)			0	90. (
1.00	Outlier reconciliation adjustment amount (see instructions)			0	
				0.00	92.0
2.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)				93.0

- 93.00Time Value of Money (see instructions)94.00Total (sum of lines 91 and 93)

NALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		!		Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	•
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2, 420, 78	0	3, 064, 025 0	1.00 2.00 3.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3.02				0	0	3. 02
3.03 3.04				0	0	3.03 3.04
3.04				0	0	3.02
0.00	Provider to Program					0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52 3.53				0	0	3.5 3.5
3.53				0	0	3.54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.99
1.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 420, 78	31	3, 064, 025	4.0
. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.0
. 00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5. 0
5. 01	TENTATI VE TO PROVIDER			0	0	5. 0 <sup>.</sup>
5.02				0	0	5.02
. 03				0	0	5.0
	Provider to Program					
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.5 5.5
5.52				0	0	5.5
. 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.9
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 0
. 01	SETTLEMENT TO PROVIDER		223, 84	4	0	6.0
0. 02 . 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		2, 644, 62	0	64, 846 2, 999, 179	6. 0 7. 0
. 00	Total meancare program trabitity (see fistructions)		2, 044, 02	Contractor Number	NPR Date (Mo/Day/Yr)	7.0
			)			

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider C	CN: 15-1327		riod: om 01/01/2016	Worksheet E-1 Part I	1
		Component (	CCN: 15-Z327	To			
		Title	XVIII	Swi	ng Beds - SNF	Cost	
		I npati en	t Part A		Par	tВ	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
00	Total interim payments paid to provider		498, 4	19		C	) 1.
00	Interim payments payable on individual bills, either			0		C	) 2.
	submitted or to be submitted to the contractor for						
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero						
00	List separately each retroactive lump sum adjustment						3.
00	amount based on subsequent revision of the interim rate						J 3.
	for the cost reporting period. Also show date of each						
	payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider						
01	ADJUSTMENTS TO PROVIDER			0		C	
02				0		C	
03 04				0		C	
04 05				0		C	
05	Provider to Program			0			1 3
50	ADJUSTMENTS TO PROGRAM			0		C	) 3
51				0		C	) 3
52				0		C	
53				0		C	
54				0		C	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0		C	3.
00	Total interim payments (sum of lines 1, 2, and 3.99)		498, 4	19		C	4.
00	(transfer to Wkst. E or Wkst. E-3, line and column as						1
	appropri ate)						
	TO BE COMPLETED BY CONTRACTOR						
00	List separately each tentative settlement payment after						5.
	desk review. Also show date of each payment. If none,						
	write "NONE" or enter a zero. (1) Program to Provider						-
D1	TENTATI VE TO PROVI DER			0		C	5
02				0		C	
03				0		C	) 5
	Provider to Program						÷
50	TENTATI VE TO PROGRAM			0		C	
51 52				0		C	
92 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0		0	
77	5. 50-5. 98)			0		C	/  <sup>3</sup>
00	Determined net settlement amount (balance due) based on						6
	the cost report. (1)						
D1	SETTLEMENT TO PROVIDER		33, 4	15		C	
02	SETTLEMENT TO PROGRAM			0		C	
00	Total Medicare program liability (see instructions)		531, 8	34	0	C	) 7
					Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)		1,00	2.00	
	Name of Contractor			_		2.00	8

Health Financial Systems SULLIVAN COUNTY COMMUNITY HOSPITAL In Lieu of Form CMS-255					
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1327 Period:			Worksheet E-1	
			From 01/01/2016 To 12/31/2016		narod:
			10 12/31/2010	5/26/2017 2:23	
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14	763	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	8-12		1, 387	2.00
3.00	.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			159	3.00
4.00	00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			2, 301	4.00
5.00	00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200			69, 237, 442	5.00
6.00	0 Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6, 909, 767	6.00
7.00				0	7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00
9.00	Sequestration adjustment amount (see instructions)			0	9.00
10.00				0	10.00
	I NPATI ENT HOSPI TAL SERVICES UNDER THE I PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	is)	0	32.00

Heal th	Financial Systems SULLIVAN COUNTY COMMU	JNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1327	Peri od:	Worksheet E-2	
			From 01/01/2016	D . (T) D	
		Component CCN: 15-Z327	To 12/31/2016	Date/Time Pre 5/26/2017 2:2	
		Title XVIII	Swing Beds - SNF		5 piii
			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)		395, 536	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A, and sum of Wkst. D,	148, 279	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see in:				
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		361	0	
6.00	Interns and residents not in approved teaching program (see in			0	0.00
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)		543, 815	0	
9.00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		543, 815	0	10.00
11.00	Deductibles billed to program patients (exclude amounts appli- professional services)	cable to physician	0	0	11.00
12.00	Subtotal (line 10 minus line 11)		543, 815	0	12.00
13.00	Coinsurance billed to program patients (from provider records) for physician professional services)	) (excl ude coi nsurance	1, 127	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line	14)	542, 688	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instruction	s)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	18.00
19.00	Total (see instructions)		542, 688	0	19.00
19.01	Sequestration adjustment (see instructions)		10, 854	0	19.01
20.00	Interim payments		498, 419	0	
21.00	Tentative settlement (for contractor use only)		0	0	
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, a		33, 415	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2				

	Financial Systems SULLIVAN COUN ATION OF REIMBURSEMENT SETTLEMENT	TY COMMUNITY HOSPITAL Provider CCN: 15-1327	Peri od:	u of Form CMS-2 Worksheet E-3	
ALCUI	ATTON OF REIMBURSEMENT SETTLEMENT	Provider CCN. 15-1327	From 01/01/2016	Part V	
			To 12/31/2016	Date/Time Pre 5/26/2017 2:2	
		Title XVIII	Hospi tal	Cost	5 pin
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR M	EDICARE PART A SERVICES - COS	T REIMBURSEMENT		
. 00	Inpatient services			2, 919, 554	
. 00	Nursing and Allied Health Managed Care payment (see in	istructions)		0	
. 00 . 00	Organ acquisition			0 2, 919, 554	
. 00	Subtotal (sum of lines 1 through 3) Primary payer payments			2, 919, 554 1, 176	
. 00	Total cost (line 4 less line 5). For CAH (see instruct	i ons)		2, 947, 574	
. 00	COMPUTATION OF LESSER OF COST OR CHARGES			2, 747, 374	0.
	Reasonable charges				
. 00	Routine service charges			0	7.
.00	Ancillary service charges			0	8.
00	Organ acquisition charges, net of revenue			0	
0. 00	Total reasonable charges			0	10.
	Customary charges				
1.00	33 3 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4			0	11.
2.00		1 5	on a charge basis	0	12
	had such payment been made in accordance with 42 CFR 4	13.13(e)			
3. 00				0.00000	
	Total customary charges (see instructions)			0	
5.00		olete only if line 14 exceeds l	ine 6) (see	0	15
5. 00	instructions) Excess of reasonable cost over customary charges (comp	lata anly if line 6 avcords li	$n_{0}$ 14) (coo	0	16
5.00	instructions)	fete only if the o exceeds if	110 14) (See	0	10
7 00	Cost of physicians' services in a teaching hospital (s	ee instructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
B. 00		heet E-4, line 49)		0	18
9.00				2, 947, 574	19
0. 00	Deductibles (exclude professional component)			399, 224	
. 00	Excess reasonable cost (from line 16)			0	21
2. 00				2, 548, 350	22
	Coinsurance			2, 254	
. 00				2, 546, 096	
	Allowable bad debts (exclude bad debts for professiona	I services) (see instructions)		234, 617	
5.00				152, 501	
7.00		see instructions)		38, 315	
	Subtotal (sum of lines 24 and 25, or line 26)			2, 698, 597	
0.00		rusti ana)		0	
9.50 9.99		ructions)		0	
). 00				2, 698, 597	
). 00 ). 01				2, 698, 597 53, 972	
	Interim payments			2, 420, 781	
	Tentative settlement (for contractor use only)			2, 420, 781	
	Balance due provider/program (line 30 minus lines 30.0	1. 31. and 32)		223, 844	
4.00			chapter 1.	223, 044	
	§115. 2		e	-	1

	Financial Systems SULLIVAN COUNTY ATION OF REIMBURSEMENT SETTLEMENT	COMMUNITY HOSPITAL Provider CCN: 15-1327	Peri od:	u of Form CMS-2 Worksheet E-3	
LCOL		110010er 00N. 13-1327	From 01/01/2016 To 12/31/2016	Part VII	par
		Title XIX	Hospi tal	Cost	<u> </u>
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALT	TH SERVICES FOR TITLES V OR	XIX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES		005.0/0		
00	Inpatient hospital/SNF/NF services		335, 969	217 247	
00	Medical and other services		0	216, 346	
00 00	Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)		335, 969	216, 346	
00	Inpatient primary payer payments		0	210, 340	1
00	Outpatient primary payer payments		0	0	l
00	Subtotal (line 4 less sum of lines 5 and 6)		335, 969	216, 346	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
00	Routine service charges		0		8
00	Ancillary service charges		294, 690	867, 413	
	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation		0	0/7 //0	1
. 00	Total reasonable charges (sum of lines 8 through 11)		294, 690	867, 413	12
. 00	CUSTOMARY CHARGES Amount actually collected from patients liable for paymer	at for sorvices on a charge	0	0	1:
. 00	basi s	The for services on a charge	0	0	'`
. 00	Amounts that would have been realized from patients liabl	e for payment for services	on 0	0	14
	a charge basis had such payment been made in accordance w			-	
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	,	0. 000000	0. 000000	1!
	Total customary charges (see instructions)		294, 690	867, 413	10
. 00	Excess of customary charges over reasonable cost (complet	te only if line 16 exceeds	0	651, 067	1
	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (completed)	te only if line 4 exceeds li	ne 41, 279	0	1
00	16) (see instructions)		0	0	1
	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see	instructions)	0	0	20
	Cost of covered services (enter the lesser of line 4 or l		335, 969	216, 346	
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must onl			210, 340	12
. 00	Other than outlier payments		0	0	2
	Outlier payments		0	0	
	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		2
. 00	Routine and Ancillary service other pass through costs		0	0	2
	Subtotal (sum of lines 22 through 26)		0	0	2
	Customary charges (title V or XIX PPS covered services or	nl y)	0	0	28
. 00	Titles V or XIX (sum of lines 21 and 27)		335, 969	216, 346	20
~~	COMPUTATION OF REIMBURSEMENT SETTLEMENT		41.070	0	
	Excess of reasonable cost (from line 18)		41, 279 335, 969	0	
. 00 . 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 a Deductibles	anu 6)	335, 969	216, 346 0	
	Coi nsurance		0	0	3
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	0	35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 3	32 and 33)	335, 969	216, 346	
	OTHER	/	-335, 969		
	Subtotal (line 36 ± line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-	-4)	0		30
. 00	Total amount payable to the provider (sum of lines 38 and	d 39)	0	0	40
	Interim payments		0	0	4
	Balance due provider/program (line 40 minus line 41)		0	0	42
. 00	barance ade provider, program (inne to minus inne tr)				

LANCE	Financial Systems SULLIVAN COUNTY CO SHEET (If you are nonproprietary and do not maintain pe accounting records, complete the General Fund column	Provider C	CN: 15-1327	Period: From 01/01/2016	wof Form CMS-2 Worksheet G	
ıl y)				To 12/31/2016	Date/Time Pre 5/26/2017 2:2	pare 3 pm
		General Fund	Specific Purpose Fund		Plant Fund	
C	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
-	Cash on hand in banks	3, 821, 218		0 0	0	1.
	Temporary investments	11, 091, 706		0 0	0	2
00 0	Notes receivable	0		0 0	0	3
00 4	Accounts receivable	7, 713, 977		0 0	0	4
	Other receivable	1, 114, 943		0 0	0	
	Allowances for uncollectible notes and accounts receivable	-4, 745, 005		0 0	0	
	Inventory	543, 563		0 0	0	
	Prepaid expenses Other current assets	409, 238		0 0	0	
	Due from other funds			0 0	0	
	Total current assets (sum of lines 1-10)	19, 949, 640		0 0	0	
	TXED ASSETS	17, 747, 040	1	0 0		1
	Land	1, 042, 227		0 0	0	12
	Land improvements	345, 187		0 0	0	
1	Accumulated depreciation	0		0 0	0	14
. OO   E	Buildings	18, 140, 589		0 0	0	15
	Accumulated depreciation	-24, 530, 335		0 0	0	16
. 00   l	Leasehold improvements	0		0 0	0	17
1	Accumulated depreciation	0		0 0	0	
	Fixed equipment	1, 104, 418		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Automobiles and trucks			0 0	0	
	Accumulated depreciation Major movable equipment	17, 604, 289		0 0	0	
	Accumul ated depreciation	17,004,289			0	
	Minor equipment depreciable			0 0	0	
	Accumul ated depreciation			0 0	0	
	HIT designated Assets			0 0	0	
	Accumul ated depreciation	C		0 0	0	
	Mi nor equi pment-nondepreci abl e	C		0 0	0	29
. 00   1	Total fixed assets (sum of lines 12-29)	13, 706, 375		0 0	0	30
C	OTHER ASSETS					
	Investments	C		0 0	0	
	Deposits on Leases	0		0 0	0	
	Due from owners/officers	0		0 0	0	
	Other assets Tatal ather apparts (sum of lines 21.24)			0 0	0	
	Total other assets (sum of lines 31-34)	33, 656, 015		0 0 0 0	0	
	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	53, 000, 010		0 0	0	1 30
	Accounts payable	1, 203, 640		0 0	0	37
	Salaries, wages, and fees payable	312, 920		0 0	0	
	Payroll taxes payable	595, 239		0 0	0	
	Notes and loans payable (short term)	C		0 0	0	
	Deferred income	0		0 0	0	
. 00	Accelerated payments	0				42
1	Due to other funds	0		0 0	0	
	Other current liabilities	1, 495, 159		0 0	0	
	Total current liabilities (sum of lines 37 thru 44)	3, 606, 958		0 0	0	45
	ONG TERM LIABILITIES					1.
	Mortgage payable Notes payable			0 0	0	
	Unsecured Loans			0 0	0	
	Other long term liabilities			0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)			0 0	0	
	Total liabilities (sum of lines 45 and 50)	3, 606, 958		0 0	0	
	CAPITAL ACCOUNTS	0,000,700	1	<u> </u>		10.
	General fund balance	30, 049, 057				52
	Specific purpose fund			0		53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
. 00 0	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion				-	
	Total fund balances (sum of lines 52 thru 58)	30, 049, 057		0 0	0	
	Total liabilities and fund balances (sum of lines 51 and	33, 656, 015	1	0 0	0	60

		IVAN COUNTY COM				eu of Form CMS-2	
STATEN	IENT OF CHANGES IN FUND BALANCES		Provider CC	N: 15-1327	Period: From 01/01/2016 To 12/31/2016		pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) LOSS PROFIT/LOSS CLEARING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	1, 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 30 30, 281, 018 1, 038, 106 31, 319, 124 0 31, 319, 124 1, 270, 067 30, 049, 057	3.00			$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
		Endowment Fund	PI ant	Fund			
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) LOSS PROFIT/LOSS CLEARING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

				From 01/01/2016 To 12/31/2016		
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	<u> </u>
	PART I - PATIENT REVENUES					4
. 00	General Inpatient Routine Services Hospital		3, 201, 7	25	3, 201, 705	1.0
. 00	SUBPROVIDER - IPF		3, 201, 7	5	3, 201, 703	2.0
. 00	SUBPROVIDER - IRF					3.0
. 00	SUBPROVIDER					4.0
. 00	Swing bed - SNF		354, 6	26	354, 626	
. 00	Swing bed - NF			0	0	
. 00	SKILLED NURSING FACILITY					7.
. 00	NURSING FACILITY					8.0
. 00	OTHER LONG TERM CARE					9.
0.00	Total general inpatient care services (sum of lines 1-9)		3, 556, 3	31	3, 556, 331	10.
	Intensive Care Type Inpatient Hospital Services			T.		
1.00	INTENSIVE CARE UNIT		542, 2	01	542, 201	
2.00	CORONARY CARE UNI T					12.
3.00	BURN INTENSIVE CARE UNIT					13.
4.00	SURGI CAL I NTENSI VE CARE UNI T					14.
5.00	OTHER SPECIAL CARE (SPECIFY)		F 4 0 0	24	F 40, 001	15.
6.00	Total intensive care type inpatient hospital services (sum of 11-15)	lines	542, 2	JI	542, 201	16.
7.00	Total inpatient routine care services (sum of lines 10 and 16)		4, 098, 5	22	4, 098, 532	17.
8.00	Ancillary services		7, 111, 1			
9.00	Outpatient services		,,,,,,,	0 0	00, 300, 307	1
	RURAL HEALTH CLINIC			0 0	-	
1.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
2.00	HOME HEALTH AGENCY			698, 847	698, 847	22.
3.00	AMBULANCE SERVICES					23.
4.00	СМНС					24.
5.00	AMBULATORY SURGICAL CENTER (D. P.)					25.
6.00	HOSPICE					26.
7.00	OTHER REVENUE			0 -37, 775		
8.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	11, 209, 6	48 59, 918, 265	71, 127, 913	28.
	G-3, line 1)				Ĺ	-
0 00	PART II - OPERATING EXPENSES			25 (70 504		1
9.00 0.00	Operating expenses (per Wkst. A, column 3, line 200) EXPENSES NOT INCLUDED ON WORKSHEET A		1, 926, 5	25, 679, 594		29.
1.00	LAFLINGLO INVLUDED UN WUKNOMEELA		1, 720, 5	0		30.
2.00				0		31.
2.00				0		33.
4.00				0		34.
5.00				0		35.
6.00	Total additions (sum of lines 30-35)			1, 926, 586		36.
7.00	DEDUCT (SPECIFY)			0		37.
8.00				0		38.
9.00				0		39.
0. 00				0		40.
1.00				0		41.
2.00	Total deductions (sum of lines 37-41)			0		42.
3.00	Total operating expenses (sum of lines 29 and 36 minus line 42 to Wkst. G-3, line 4)	2)(transfer		27, 606, 180		43.

Heal th	Financial Systems SULLIVAN COUNTY COMM	IUNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1327	Peri od:	Worksheet G-3	
			From 01/01/2016 To 12/31/2016	Date/Time Pre 5/26/2017 2:2:	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir			71, 127, 913	1.00
2.00	Less contractual allowances and discounts on patients' accour	nts		42, 640, 956	2.00
3.00	Net patient revenues (line 1 minus line 2)			28, 486, 957	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		27, 606, 180	
5.00	Net income from service to patients (line 3 minus line 4)			880, 777	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			55	6.00
7.00	Income from investments			52, 262	7.00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			139, 592	
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		1, 193	16.00
17.00	Revenue from sale of drugs to other than patients			301	17.00
18.00	Revenue from sale of medical records and abstracts			6, 966	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			-107	21.00
22.00	Rental of hospital space			750	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER			-43, 683	24.00
25.00	Total other income (sum of lines 6-24)			157, 329	25.00
26.00	Total (line 5 plus line 25)			1, 038, 106	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			1, 038, 106	29.00

	Financial Systems SIS OF HOSPITAL-BASED HOME HEALT			MMUNITY HOSPIT Provider C	CN: 15-1327	Period:	u of Form CMS-2 Worksheet H	2002-
				HHA CCN:		From 01/01/2016 To 12/31/2016	Date/Time Pre	pare
						Home Health	5/26/2017 2:2 PPS	3 pm
						Agency I	PP5	
		Sal ari es	Employee Benefits	Transportati on	Contracted/Pu chased	r Other Costs	Total (sum of cols. 1 thru	
			Denerrus	(see instructions)			5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &			C		0	0	1.
00	Fixtures					0	0	1 .
00	Capital Related - Movable			C		0	0	2.
00	Equipment Plant Operation & Maintenance	0	0	C		0 0	0	3.
00	Transportation	0	0			0 0	0	
00	Administrative and General HHA REIMBURSABLE SERVICES	103, 657	0	5, 921		0 38, 745	148, 323	5.
00	Skilled Nursing Care	129, 212	0	7, 381		0 0	136, 593	6.
00	Physical Therapy	135, 123	0	7, 718		0 0	142, 841	
00	Occupational Therapy	36, 807	0	2, 102		0 0 0 0	38, 909	
00 . 00	Speech Pathology Medical Social Services	2, 832 0	0	162 0		0 0	2, 994 0	
. 00	Home Health Aide	24, 915	0	1, 423		0 0	26, 338	
. 00	Supplies (see instructions)	0	0	0		0 0	0	
. 00 . 00	Drugs DME	0	0			0 0 0 0	0	
	HHA NONREI MBURSABLE SERVI CES					-		1
. 00	Home Dialysis Aide Services	0	0				0	
. 00 . 00	Respiratory Therapy Private Duty Nursing	0	0			0 0	0	
. 00	Clinic	0	0	C		0 0	0	
. 00	Health Promotion Activities	0	0	0		0 0	0	
. 00 . 00	Day Care Program Home Delivered Meals Program	0	0				0	20.
. 00	Homemaker Service	0	0	0		0 0	0	
. 00	All Others (specify)	0	0	C		0 0	0	
. 50 . 00	Telemedicine Total (sum of lines 1–23)	0 432, 546	0	24, 707		0 0 0 38, 745	0 495, 998	
		Recl assi fi cati		Adjustments	Net Expenses		,	
		on	Trial Balance (col. 6 +		for Allocation (col. 8 + col			
			col.7)		9)			
	OFNEDAL OFDILLOF ODOT OFNITEDO	7.00	8.00	9.00	10.00			
					•			
00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0	C		0		1.
	Capital Related - Bldg. & Fixtures	0	0	C		-		
00 00	Capital Related - Bldg. & Fixtures Capital Related - Movable	0	0	C C		0		
	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment	0 0 0	0 0 0	c c c		-		1. 2. 3.
00 00 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation	0	0 0 0	C C C				2. 3. 4.
00 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General	0	0	C C C				2. 3. 4.
00 00 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation	0	0 0 0	0 0 0 0	148, 32	0 0 0 3		2. 3. 4. 5.
00 00 00 00 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy	0 0 0 0	0 0 148, 323 136, 593 142, 841		148, 32 136, 59 142, 84	0 0 0 3 1		2. 3. 4. 5. 6. 7.
00 00 00 00 00 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy	0 0 0 0	0 0 148, 323 136, 593 142, 841 38, 909		148, 32 136, 59 142, 84 38, 90	0 0 3 3 1 9		2. 3. 4. 5. 6. 7. 8.
00 00 00 00 00 00 00 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0 0 0 0	0 0 148, 323 136, 593 142, 841		148, 32 136, 59 142, 84 38, 90 2, 99	0 0 3 3 1 9		2. 3. 4. 5. 6. 7. 8. 9.
00 00 00 00 00 00 00 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	0 0 0 0	0 0 148, 323 136, 593 142, 841 38, 909 2, 994		148, 32 136, 59 142, 84 38, 90 2, 99 26, 33	0 0 0 3 3 1 9 4 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11.
00 00 00 00 00 00 00 00 . 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)		0 0 148, 323 136, 593 142, 841 38, 909 2, 994 0 26, 338 0		148, 32 136, 59 142, 84 38, 90 2, 99 26, 33	0 0 3 3 1 9 4 0 8 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.
00 00 00 00 00 00 00 00 . 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs		0 0 148, 323 136, 593 142, 841 38, 909 2, 994 0 26, 338 0 0 0		148, 32 136, 59 142, 84 38, 90 2, 99 26, 33	0 0 0 3 3 1 9 4 0 8 8 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13.
00 00 00 00 00 00 00 00 . 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES		0 0 148, 323 136, 593 142, 841 38, 909 2, 994 0 26, 338 0		148, 32 136, 59 142, 84 38, 90 2, 99 26, 33	0 0 3 3 1 9 4 0 8 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13.
00 00 00 00 00 00 00 00 00 00 00 00 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONRELMBURSABLE SERVICES Home Dialysis Aide Services		0 0 148, 323 136, 593 142, 841 38, 909 2, 994 0 26, 338 0 0 0 0 0 0		148, 32 136, 59 142, 84 38, 90 2, 99 26, 33	0 0 3 3 3 4 4 0 8 0 0 0 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15.
000 000 000 000 000 000 000 000 000 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy		0 0 148, 323 136, 593 142, 841 38, 909 2, 994 0 26, 338 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		148, 32 136, 59 142, 84 38, 90 2, 99 26, 33	0 0 3 3 1 9 4 4 0 8 0 0 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16.
00 00 00 00 00 00 00 00 00 00 00 00 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONRELMBURSABLE SERVICES Home Dialysis Aide Services		0 0 148, 323 136, 593 142, 841 38, 909 2, 994 0 26, 338 0 0 0 0 0 0		148, 32 136, 59 142, 84 38, 90 2, 99 26, 33	0 0 3 3 3 4 4 0 8 0 0 0 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17.
000 000 000 000 000 000 000 000 000 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities		0 0 148, 323 136, 593 142, 841 38, 909 2, 994 0 26, 338 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		148, 32 136, 59 142, 84 38, 90 2, 99 26, 33	0 0 0 3 3 1 9 4 4 0 8 8 0 0 0 0 0 0 0 0 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19.
000 000 000 000 000 000 000 000 000 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program		0 0 148, 323 136, 593 142, 841 38, 909 2, 994 0 26, 338 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		148, 32 136, 59 142, 84 38, 90 2, 99 26, 33	0 0 0 3 3 1 9 9 4 4 0 0 8 0 0 0 0 0 0 0 0 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 15. 17. 18. 19. 20.
000 000 000 000 000 000 000 000 000 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities		0 0 148, 323 136, 593 142, 841 38, 909 2, 994 0 26, 338 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		148, 32 136, 59 142, 84 38, 90 2, 99 26, 33	0 0 0 3 3 1 9 4 4 0 8 8 0 0 0 0 0 0 0 0 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 14. 19. 20. 21.
000 000 000 000 000 000 000 000 000 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program		0 0 148, 323 136, 593 142, 841 38, 909 2, 994 0 26, 338 0 0 0 26, 338 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		148, 32 136, 59 142, 84 38, 90 2, 99 26, 33	0 0 3 3 3 4 4 0 8 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12.

UST A	LLOCATION - HHA GENERAL SERVICE	COST		Provider CO		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared
						Home Health	5/26/2017 2:2 PPS	<u>3 pm</u>
			Capital Rela	ated Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H,	BI dgs & Fixtures	Movable Equipment	Plant Operation & Maintenance		Subtotal (cols. 0-4)	-
	T	col. 10) 0	1.00	2.00	3.00	4.00	4A. 00	
00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0				0	1.(
00	Fixtures	0	Ŭ				0	
00	Capital Related - Movable	0		0			0	2.
00	Equipment Plant Operation & Maintenance	0	0	0		0	0	3.
00	Transportation	0	0	0		0 0		4.
00	Administrative and General	148, 323	0	0		0 0	148, 323	5.
00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	136, 593	0	0		0 0	136, 593	6.
00	Physical Therapy	142, 841	0	0		0 0	142, 841	
00	Occupational Therapy	38, 909	0	0		0 0	38, 909	8.
00	Speech Pathology	2, 994	0	0		0 0	2, 994	
00 . 00 .	Medical Social Services Home Health Aide	0 26, 338	0	0			0 26, 338	
2.00	Supplies (see instructions)	20, 330	0	0		0 0	20, 330	
8. 00	Drugs	0	О	0		0	0	13.
1.00		0	0	0		0 0	0	14.
5. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0 0	0	15.
b. 00	Respiratory Therapy	0	0	0		0 0	0	
. 00	Private Duty Nursing	0	О	0		0 0	0	
3.00	Clinic	0	0	0		0 0	0	
9.00 ).00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	
1.00	Home Delivered Meals Program	0	0	0		0 0	0	
2.00	Homemaker Service	0	О	0		0 0	0	1
3.00	All Others (specify)	0	0	0		0 0	0	
3.50 4.00	Telemedicine Total (sum of lines 1-23)	495, 998	0	0		0 0	0 495, 998	
		Admi ni strati ve				-		
		& General	4A + 5)					-
	GENERAL SERVICE COST CENTERS	5.00	6.00					
00	Capital Related - Bldg. &							1.
	Fixtures							
00	Capital Related - Movable Equipment							2.
00	Plant Operation & Maintenance							3.
00	Transportation							4.
00	Administrative and General HHA REIMBURSABLE SERVICES	148, 323						5.
00	Skilled Nursing Care	58, 272	194, 865					6.
00	Physical Therapy	60, 939	203, 780					7.
00	Occupational Therapy	16, 599	55, 508					8.
00 ). 00	Speech Pathology Medical Social Services	1, 277	4, 271					9. 10.
. 00	Home Heal th Ai de	11, 236	37, 574					11.
2.00	Supplies (see instructions)	0	0					12.
3.00 1.00	Drugs	0	0					13. 14.
+. UU	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.
5.00	Home Dialysis Aide Services	0	0					15.
6.00	Respiratory Therapy	0	0					16.
7.00 3.00	Private Duty Nursing Clinic	0	0					17. 18.
3.00 9.00	Health Promotion Activities	0	0					18.
). 00	Day Care Program	0	0					20.
1.00	Home Delivered Meals Program	0	О					21.
	Homemaker Service	0	0					22.
3.00	All Others (specify) Telemedicine							23. 23.

In Lieu of Form CMS-2552-10 Worksheet H-1

COST A	ST ALLOCATION - HHA STATISTICAL BASIS			Provider C		Period: Worksheet H From 01/01/2016 Part II To 12/31/2016 Date/Time F		norod.
				HHA CCN:	15-7542	10 12/31/2010	5/26/2017 2:2	areu: 3 pm
						Home Health Agency I	PPS	-
		Capital Rel	ated Costs					
		BI dgs & Fi xtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Pl ant Operation & Maintenance (SQUARE FEET)	Transportati (MI LEAGE)	onReconciliation	Administrative & General (ACCUM. COST)	
	T	1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS	1		<b>F</b>	1		<b>F</b>	
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	C		0		3.00
4.00	Transportation (see	0	0	C		0		4.00
5.00	instructions) Administrative and General	0	0	C		0 -148, 323	347, 675	5.00
5.00	HHA REI MBURSABLE SERVI CES	0	0		1	- 140, 323	347,075	5.00
6.00	Skilled Nursing Care	0	0	0		0 0	136, 593	6.00
7.00	Physical Therapy	0	0	0		0 0	142, 841	7.00
8.00	Occupational Therapy	0	0	0		0 0	38, 909	
9.00	Speech Pathology	0	0	0	)	0 0	2, 994	
10.00	Medical Social Services	0	0	C	)	0 0	0	
11.00	Home Health Aide	0	0	C		0 0	26, 338	11.00
12.00	Supplies (see instructions)	0	0	C		0 0	0	12.00
13.00	Drugs	0	0	C		0	0	13.00
14.00	DME	0	0	C		0 0	0	14.00
	HHA NONREI MBURSABLE SERVI CES	-			1		-	
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	1 101 00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0			0 0	0	16.00 17.00
17.00	Clinic	0	0			0 0	0	17.00
19.00	Health Promotion Activities	0	0			0 0	0	19.00
20.00	Day Care Program		0			0 0	0	20.00
21.00	Home Delivered Meals Program	0	0	0		0 0	0	21.00
22.00	Homemaker Service	0	0	0		0 0	0	22.00
23.00	All Others (specify)	0	0	C C		0 0	0	23.00
23.50	Tel emedi ci ne	0	0	C		0 0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	C	)	0 -148, 323	347, 675	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	C		0	148, 323	25.00
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.0000	00	0. 426614	26.00

	Financial Systems ATION OF GENERAL SERVICE COSTS T		IVAN COUNTY COM	MUNITY HOSPIT		In Lie Period:	u of Form CMS-2 Worksheet H-2	
	TTON OF GENERAL SERVICE COSTS T			HHA CCN:		From 01/01/2016 To 12/31/2016	Part I Date/Time Pre 5/26/2017 2:2	pared:
						Home Health Agency I	PPS	
			CAPITAL REL	ATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	I S/ACCOUNTI NG/ MARKETI NG	
		0	1.00	2.00	4.00	4A	5. 01	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.	0 194, 865 203, 780 55, 508 4, 271 0 37, 574 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				$ \begin{smallmatrix} 0 & 194, 865 \\ 0 & 203, 780 \\ 0 & 55, 508 \\ 0 & 4, 271 \\ 0 & 0 \\ 0 & 37, 574 \\ 0 & 0 \\ 0 $	11, 675 12, 208 3, 326 0 2, 251 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ \end{array}$
	Cost Center Description	Subtotal	BUSI NESS OFFI CE & ADMI TTI NG	Subtotal	OTHER ADMI NI STRATI V AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5A. 01	5.02	5A. 02	5.03	7.00	8.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.	125, 365 206, 540 215, 988 58, 834 4, 527 0 39, 825 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		125, 365 206, 540 215, 988 58, 834 4, 527 0 39, 825 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15, 82 16, 55 4, 50 34 3, 05	7       0         10       0         10       0         10       0         17       0         17       0         10       0         12       0         12       0         10       0         10       0         10       0         10       0         10       0         10       0         10       0         10       0         10       0         10       0         10       0         11       0         12       0         13       0         14       0         15       0         16       0         17       0         18       0         19       0         10       0         10       0         10       0         10       0         10       0         10       0         10       0         10       0         10	0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ \end{array}$

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

	Financial Systems TION OF GENERAL SERVICE COSTS T		<u>LIVAN COUNTY CON</u> TERS		CN: 15-1327 15-7542	Period: From 01/01/2016 To 12/31/2016		pared:
						Home Health	PPS	- F
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI	Agency I CENTRAL ON SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
19.50	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				98     677       0     0		2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 18.0 19.0 19.0 19.5
	of column 26, line 20 minus column 26, line 1, rounded to <u>6 decimal places.</u> Cost Center Description	MEDI CAL RECORDS & LI BRARY	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Co & Post Stepdown		Allocated HHA A&G (see Part II)	
		16.00	19.00	24 00	Adjustments		27.00	
1.00 2.00 3.00 4.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1, rounded to	16.00 7,309 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		24.00 200,055 222,367 232,538 63,342 4,874 0 42,877 0 0 0 0 0 0 0 0 0 0 0 0 0		26.00           0         200,055           0         222,367           0         232,538           0         63,342           0         4,874           0         42,877           0         60           0         42,877           0         60	78, 597 82, 191 22, 389 1, 723 0 15, 155 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. C 4. C 5. C 7. C 9. C 10. C 11. C 12. C 13. C 14. C 15. C 16. C 17. C 18. C 19. S 19. C 19. S 20. C

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

Heal th	Financial Systems	SULL	I VAN COUNTY COMM	JNI TY HOSPI	In Lie	eu of Form CMS-2552-10		
ALLOCA	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provi der	CCN: 15-1327	Peri od:	Worksheet H-2	
					15 7540	From 01/01/2016		nored.
				HHA CCN:	15-7542	To 12/31/2016	Date/Time Pre 5/26/2017 2:2	
-						Home Health	PPS	•
						Agency I		
	Cost Center Description	Total HHA						
		Costs						-
	1	28.00						
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	300, 964						2.00
3.00	Physical Therapy	314, 729						3.00
4.00	Occupational Therapy	85, 731						4.00
5.00	Speech Pathology	6, 597						5.00
6.00	Medical Social Services	0						6.00
7.00	Home Health Aide	58, 032						7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10.00
11.00	Home Dialysis Aide Services	0						11.00
12.00	Respiratory Therapy	0						12.00
13.00	Private Duty Nursing	0						13.00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17.00	Home Delivered Meals Program	0						17.00
18.00	Homemaker Service	0						18.00
19.00	All Others (specify)	0						19.00
19.50	Tel emedi ci ne	0						19.50
20.00	Total (sum of lines 1-19) (2)	766, 053						20.00
21.00	Unit Cost Multiplier: column							21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	•							

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

	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATISTIC	AL Provider CC	CN: 15-1327		riod: om 01/01/2016	Worksheet H-2 Part II	
ASI S				HHA CCN:	15-7542	То			
							Home Health Agency I	PPS	
		CAPI TAL REI	ATED COSTS				Agency 1		
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliati	onl	S/ACCOUNTING/	Reconciliation	
		FLXT	EQUI P	BENEFI TS			MARKETI NG		
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS			(ACCUM. COST)		
				SALARI ES)			0001)		
. 00	Administrative and General	1.00	2.00	4.00 432,546	5A. 01	0	<u>5. 01</u> 118, 279	5A. 02 -125, 365	1.0
. 00	Skilled Nursing Care	0	-	432, 546		0	194, 865		
. 00	Physical Therapy	0	0	0		0	203, 780	-215, 988	3. C
. 00	Occupational Therapy	0	0	0		0	55, 508	-58, 834	
. 00 . 00	Speech Pathology Medical Social Services	0		0		0	4, 271	-4, 527 0	5. C
. 00	Home Heal th Aide	0	0	0		0	37, 574	-39,825	7.0
. 00	Supplies (see instructions)	0	0	0		0	0	0	8.0
. 00	Drugs	0	0	0		0	0	0	9. (
D. 00 1. 00	DME Home Dialysis Aide Services	0	0	0		0 0	0	0	10. 0 11. 0
2.00	Respiratory Therapy	0		0		0	0	0	12. (
8.00	Private Duty Nursing	0	0	0		0	0	0	13.
4.00	Clinic	0	0	0		0	0	0	14.
5.00	Health Promotion Activities Day Care Program	0	0	0		0	0	0	15.
5.00 7.00	Home Delivered Meals Program	0		0		0	0	0	16. 17.
3.00	Homemaker Service	0	0	0		0	0	0	18.
9.00	All Others (specify)	0	0	0		0	0	0	19. (
9.50	Telemedicine	0	0	0		0	0	0	19.
0.00 1.00	Total (sum of lines 1–19) Total cost to be allocated	0		432, 546 118, 279			614, 277 36, 802		20. ( 21. (
2.00	Unit cost multiplier	0. 000000	0. 000000				0. 059911		22.0
	Cost Center Description	BUSI NESS	Reconciliation		OPERATION O		LAUNDRY &	HOUSEKEEPI NG	
		OFFICE & ADMITTING		ADMI NI STRATI VE AND GENERAL	PLANT (SQUARE		LINEN SERVICE (POUNDS OF	(SQUARE FEET)	
		(ACCUM.		(ACCUM.	FEET)		LAUNDRY)		
		COST)	51.00	COST)	7.00				
00	Administrative and General	5.02	5A. 03	5.03 125,365	7.00	0	8.00	9.00	1.0
00	Skilled Nursing Care	0	-	206, 540		0	0	Ő	2.
00	Physical Therapy	0	0	215, 988		0	0	0	3.
00 00	Occupational Therapy Speech Pathology	0	0	58, 834 4, 527		0 0	0	0	4. 5.
00	Medical Social Services	0		4, 527		0	0	0	6.
00	Home Heal th Aide	0	0	39, 825		0	0	0	7.
00	Supplies (see instructions)	0	0	0		0	0	0	
00	Drugs	0	-	-		0	0	0	
. 00 . 00	DME Home Dialysis Aide Services	0	0	0		0	0	0	10. 11.
. 00	Respiratory Therapy	0	0	0		0	0	0	12.
. 00	Private Duty Nursing	0	0	0		0	0	0	13.
. 00	Clinic	0	0	0		0	0	0	14.
5.00 5.00	Health Promotion Activities Day Care Program	0		0		0	0	0	15. 16.
. 00 . 00	Home Delivered Meals Program	0		0		0	0	0	17.
3. 00	Homemaker Service	0	0	Ő		0	0	0	18.
. 00	All Others (specify)	0	0	0		0	0	0	19.
	Tel emedi ci ne	0	0	0		0	0	0	19.
9.50	llotal (cum of linee 1 10)								
<ul><li>7. 50</li><li>7. 00</li><li>1. 00</li></ul>	Total (sum of lines 1-19) Total cost to be allocated	0		651, 079 49, 890		0	0	0	20. 21.

Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS T			MMUNITY HOSPITA AL Provider CC		Peri od:	u of Form CMS-2 Worksheet H-2	
BASI S			HHA CCN:	15-7542	From 01/01/2016 To 12/31/2016	Part II Date/Time Pre 5/26/2017 2:23	pared: 3 pm
					Home Health Agency I	PPS	
Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	
	10.00	11.00	13.00	14.00	15.00	16.00	
<ol> <li>Administrative and General</li> <li>Administrative and General</li> <li>Skilled Nursing Care</li> <li>O Skilled Nursing Care</li> <li>O Occupational Therapy</li> <li>O Occupational Therapy</li> <li>O Ospeech Pathology</li> <li>O Medical Social Services</li> <li>O Home Health Aide</li> <li>O Supplies (see instructions)</li> <li>O Drugs</li> <li>O DME</li> <li>O Respiratory Therapy</li> <li>O Respiratory Therapy</li> <li>O Health Promotion Activities</li> <li>O Day Care Program</li> <li>O Home Belivered Meals Program</li> <li>O Home Belivered Service</li> <li>O Home Belivered Meals Program</li> <li>O Total (sum of lines 1-19)</li> <li>O Utal cost to be allocated</li> </ol>			14, 552 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 76 1, 76 0 2925	0       0         0       0	661, 072 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 20.\ 00\\ 20.\ 00\\ 21.\ 00\end{array}$
22.00 Unit cost multiplier Cost Center Description	0. 000000 NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME) 19. 00	0. 000000	3. 923722	0. 38356	<u>9</u> 0.000000	0. 011056	22.00
<ol> <li>Administrative and General</li> <li>Administrative and General</li> <li>Skilled Nursing Care</li> <li>O Skilled Nursing Care</li> <li>O Occupational Therapy</li> <li>O Occupational Therapy</li> <li>Sou Speech Pathology</li> <li>O Medical Social Services</li> <li>O Home Health Aide</li> <li>Supplies (see instructions)</li> <li>O Drugs</li> <li>O DME</li> <li>O Home Dialysis Aide Services</li> <li>O Respiratory Therapy</li> <li>O Private Duty Nursing</li> <li>O Day Care Program</li> <li>O Home Delivered Meals Program</li> <li>O Home Delivered Meals Program</li> <li>O Home Service</li> <li>O All Others (specify)</li> <li>Sou Telemedicine</li> <li>O Total (sum of lines 1-19)</li> <li>O Unit cost multiplier</li> </ol>							$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$

	Financial Systems		I VAN COUNTY CO				u of Form CMS-2	
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet H-3 Part I Date/Time Prep	
							5/26/2017 2:2	3 pm
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (col s.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION		· · · · · · · · · · · · · · · · · · ·			· ·		
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	300, 964		300, 96			
2.00	Physical Therapy	3.00	314, 729	0			227.57	2.00
3.00	Occupational Therapy	4.00	85, 731	0			168.10	
4.00	Speech Pathol ogy	5.00	6, 597	C	6, 59		160. 90	
5.00	Medical Social Services Home Health Aide	6. 00 7. 00	0 59 022		58, 03		0. 00 64. 55	
6.00 7.00	Total (sum of lines 1-6)	7.00	58, 032 766, 053	0			04. 00	6.00 7.00
7.00			700,055		Program Visit			7.00
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t			
					Deductibles			
					Coi nsurance			
		0	1.00	2.00	3.00	4.00	5.00	
0.00	Limitation Cost Computation		45440					0.00
8.00	Skilled Nursing Care		45460 99915	0				8.00
8.01 9.00	Skilled Nursing Care Physical Therapy		45460	0	) 18 83			8. 01 9. 00
9.00 9.01	Physical Therapy		45460 99915	0				9.00
10.00	Occupational Therapy		45460	0	31			10.00
10.00	Occupational Therapy		99915	0		2		10.00
11.00	Speech Pathol ogy		45460	0		0		11.00
11.01	Speech Pathol ogy		99915	0		0		11.01
12.00	Medical Social Services		45460	0		0		12.00
12.01	Medical Social Services		99915	C		0		12.01
13.00	Home Health Aide		45460	0	64	8		13.00
13.01	Home Health Aide		99915	C	11	6		13.01
14.00	Total (sum of lines 8-13)			0	3, 12			14.00
	Cost Center Description	From Wkst. H-2		Shared	Total HHA	Total Charges	Ratio (col. 3	
		Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from Part II)	+ 2)	Records)		
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computa	-	1.00	2.00	3.00	4.00	5.00	
15.00	Cost of Medical Supplies	8.00	0	0	)	0 0	0. 000000	15.00
16.00	Cost of Drugs	9.00	0	0		0 0	0. 000000	16.00
			Program Visits		Cost of			
					Servi ces			
			Par			Part B		
				Subject to	Part A	Not Subject to	Subject to	
	Cost Center Description	Part A	Not Subject to	2	i di c n			
	Cost Center Description	Part A	Deductibles &	Deductibles &		Deductibles &	Deductibles &	
	Cost Center Description		Deductibles & Coinsurance	Deductibles & Coinsurance		Coi nsurance	Coi nsurance	
		6.00	Deductibles & Coinsurance 7.00	Deductibles & Coinsurance 8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
	Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	6.00	Deductibles & Coinsurance 7.00	Deductibles & Coinsurance 8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
	PART I - COMPUTATION OF LESSER	6.00	Deductibles & Coinsurance 7.00	Deductibles & Coinsurance 8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
1.00	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	6.00	Deductibles & Coinsurance 7.00	Deductibles & Coinsurance 8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	1.00
1.00 2.00	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	6.00 OF AGGREGATE F	Deductibles & Coinsurance 7.00 PROGRAM COST, A 1,033 941	Deductibles & Coinsurance 8.00	9.00	Coinsurance 10.00	Coi nsurance 11.00	
2.00 3.00	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	6.00 OF AGGREGATE F 0 0 0	Deductibles & Coinsurance 7.00 ROGRAM COST, A 1,033 941 359	Deductibles & Coinsurance 8.00	9.00	Coi nsurance           10.00           I TATI ON COST, OF           0           224, 471           0           214, 143           0           60, 348	Coi nsurance 11.00	2. 00 3. 00
2.00 3.00 4.00	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	6.00 OF AGGREGATE F 0 0 0 0 0 0	Deductibles & Coinsurance 7.00 ROGRAM COST, Av 1,033 941 359 30	Deductibles & Coinsurance 8.00	9.00	Coi nsurance 10.00 I TATI ON COST, OF 0 224, 471 0 214, 143 0 60, 348 0 4, 827	Coi nsurance 11.00	2.00 3.00 4.00
2.00 3.00 4.00 5.00	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	6.00 OF AGGREGATE F 0 0 0 0 0 0 0 0 0 0	Deductibles & Coinsurance 7.00 ROGRAM COST, Av 1,033 941 359 30 0	Deductibles & Coinsurance 8.00	9.00	Coi nsurance 10.00 I TATI ON COST, OF 224, 471 0 224, 471 0 214, 143 0 60, 348 0 4, 827 0 0	Coi nsurance 11.00	2.00 3.00 4.00 5.00
2.00 3.00 4.00	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	6.00 OF AGGREGATE F 0 0 0 0 0 0	Deductibles & Coinsurance 7.00 ROGRAM COST, Av 1,033 941 359 30	Deductibles & Coinsurance 8.00	9.00	Coi nsurance 10.00 I TATI ON COST, OF 0 224, 471 0 214, 143 0 60, 348 0 4, 827	Coi nsurance 11.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00

ealth Financial Systems PPORTIONMENT OF PATIENT SERVICE COS	TS		Provider CC	CN: 15-1327	Period:	Worksheet H-3	3
			HHA CCN:	15-7542	From 01/01/2016 To 12/31/2016	Part I Date/Time Pre 5/26/2017 2:2	epareo
			Title	XVIII	Home Health Agency I	PPS	<u> </u>
Cost Center Description	( 00	7.00	0.00	0.00	10.00	11 00	
Limitation Cost Computation	6.00	7.00	8.00	9.00	10.00	11.00	
<ul> <li>Skilled Nursing Care</li> <li>Skilled Nursing Care</li> <li>Skilled Nursing Care</li> <li>Physical Therapy</li> <li>Physical Therapy</li> <li>OCcupational Therapy</li> <li>OCcupational Therapy</li> <li>OCSpeech Pathology</li> <li>OSpeech Pathology</li> <li>OSpeech Pathology</li> <li>OMedical Social Services</li> <li>OMedical Social Services</li> <li>OHome Health Aide</li> <li>OHome Health Aide</li> </ul>							8. 8. 9. 10. 10. 11. 11. 12. 12. 13. 13.
4.00 Total (sum of lines 8-13)							14.
	Progi	ram Covered Cha	rges	Cost of Servi ces			
		Part	t B		Part B		
Cost Center Description	Part A	Not Subject to	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	6.00	7.00	8.00	9.00	10.00	11.00	+
Supplies and Drugs Cost Comput							
5.00 Cost of Medical Supplies	0		0		0 0	(	
6.00 Cost of Drugs	<b>T</b> 1 1 D	0	0		0	(	) 16.
Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00				-		
PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	ROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	!	
Cost Per Visit Computation							-
.00 Skilled Nursing Care	224, 471						1.
. 00 Physical Therapy	214, 143						2.
.00 Occupational Therapy	60, 348						3.
00 Speech Pathology 00 Medical Social Services	4, 827						4.
.00 Medical Social Services .00 Home Health Aide	0 49, 316						5. 6.
.00 Total (sum of lines 1-6)	553, 105						7.
Cost Center Description	333, 103						/.
per on	12.00						1
Limitation Cost Computation							
.00 Skilled Nursing Care							8.
							8.
5.01 Skilled Nursing Care		1					9. 9.
. 00 Physical Therapy		1					
2.00 Physical Therapy 2.01 Physical Therapy							
. 00 Physical Therapy . 01 Physical Therapy 0. 00 Occupational Therapy							
<ul> <li>0.0 Physical Therapy</li> <li>0.1 Physical Therapy</li> <li>0.00 Occupational Therapy</li> <li>0.01 Occupational Therapy</li> </ul>							10.
.00Physical Therapy.01Physical Therapy0.00Occupational Therapy0.01Occupational Therapy1.00Speech Pathology							10. 11.
<ul> <li>0.0 Physical Therapy</li> <li>0.1 Physical Therapy</li> <li>0.00 Occupational Therapy</li> <li>0.01 Occupational Therapy</li> <li>1.00 Speech Pathology</li> </ul>							10. 11. 11. 12.
<ul> <li>Physical Therapy</li> <li>Physical Therapy</li> <li>Physical Therapy</li> <li>Occupational Therapy</li> <li>Occupational Therapy</li> <li>Occupational Therapy</li> <li>Ospeech Pathology</li> <li>Ospeech Pathology</li> <li>OMedical Social Services</li> <li>Medical Social Services</li> </ul>							10. 10. 11. 11. 12. 12.
<ul> <li>0.0 Physical Therapy</li> <li>0.1 Physical Therapy</li> <li>0.00 Occupational Therapy</li> <li>0.01 Occupational Therapy</li> <li>1.00 Speech Pathology</li> <li>1.01 Speech Pathology</li> <li>2.00 Medical Social Services</li> <li>2.01 Medical Social Services</li> <li>3.00 Home Health Aide</li> </ul>							10. 11. 11. 12. 12. 13.
<ul> <li>Physical Therapy</li> <li>Physical Therapy</li> <li>Physical Therapy</li> <li>Occupational Therapy</li> <li>Occupational Therapy</li> <li>Occupational Therapy</li> <li>Ospeech Pathology</li> <li>Ospeech Pathology</li> <li>OMedical Social Services</li> <li>Medical Social Services</li> </ul>							10 11 11 12 12

Heal	th Financial Systems	SULL	IVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
APP	ORTIONMENT OF PATIENT SERVICE COS	rs		Provider C	CN: 15-1327	Period: From 01/01/2016	Worksheet H-3 Part II	
				HHA CCN:	15-7542	To 12/31/2016		
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.0	D Physical Therapy	66.00	0. 764260	0		0 col. 2, line 2	. 00	1.00
1.0	1 Physical Therapy 1	66. 01	0. 000000	0		0 col. 2, line 2	. 01	1.01
2.0	0 Occupational Therapy	67.00	0. 630059	0		0 col. 2, line 3	. 00	2.00
3.0	D Speech Pathology	68.00	1.451014	0		0 col. 2, line 4	. 00	3.00
4.0	Cost of Medical Supplies	71.00	0. 113764	0		0 col. 2, line 1	5.00	4.00
5.0	Cost of Drugs	73.00	0. 590171	0		0col. 2, line 1	6.00	5.00

th Financial Systems         SULLIVAN COUNTY COMMUN           CULATION OF HHA REIMBURSEMENT SETTLEMENT         F	Provider CC		Peri od:	eu of Form CMS-2 Worksheet H-4	
	HA CCN:	15-7542	From 01/01/2016 To 12/31/2016	Part I-II	
'				5/26/2017 2:2	
	Title	XVIII	Home Health Agency I	PPS	
				rt B	
		Part A		Deductibles &	
		1 00	Coinsurance	Coinsurance	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM		1.00	2.00	3.00	-
Reasonable Cost of Part A & Part B Services	ANT CHANCES	·			
0 Reasonable cost of services (see instructions)			0 (	0 0	1
0 Total charges			0 0	0	2
Customary Charges			1	1	
0 Amount actually collected from patients liable for payment for	servi ces		0 0	0 0	3
on a charge basis (from your records)	aumont		0		
0 Amount that would have been realized from patients liable for p for services on a charge basis had such payment been made in ac			0 (	0	4
with 42 CFR §413.13(b)					
0 Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0.000000	5
0 Total customary charges (see instructions)			0 0	0	
0 Excess of total customary charges over total reasonable cost (c	omplete		0 0	0	7
only if line 6 exceeds line 1)	1 E 11				
0 Excess of reasonable cost over customary charges (complete only 1 exceeds line 6)	itine		0	0	8
0 Primary payer amounts			0 (	0	q
			Part A	Part B	
			Servi ces	Servi ces	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	-
00 Total reasonable cost (see instructions)			(	· ·	
00 Total PPS Reimbursement - Full Episodes without Outliers			(	435, 000	
00 Total PPS Reimbursement - Full Episodes with Outliers			(	5, 594	
00 Total PPS Reimbursement - LUPA Episodes				5, 128	
00 Total PPS Reimbursement - PEP Episodes				4, 196	
00  Total PPS Outlier Reimbursement - Full Episodes with Outliers 00  Total PPS Outlier Reimbursement - PEP Episodes				253	
00 Total Other Payments					
00 DME Payments			(	ol o	
00 Oxygen Payments			(	0	
00 Prosthetic and Orthotic Payments			(	0	
00 Part B deductibles billed to Medicare patients (exclude coinsur	ance)			0	
00 Subtotal (sum of lines 10 thru 20 minus line 21)			(	450, 171	
00 Excess reasonable cost (from line 8)				0	
00  Subtotal (line 22 minus line 23) 00  Coinsurance billed to program patients (from your records)				450, 171 0	
00 Net cost (line 24 minus line 25)			(		
00 Reimbursable bad debts (from your records)				430, 171	27
00 Reimbursable bad debts for dual eligible beneficiaries (see ins	tructions)				28
00 Total costs - current cost reporting period (line 26 plus line			(	450, 171	
00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			(	0	
50 Pioneer ACO demonstration payment adjustment (see instructions)			0	0	
00 Subtotal (see instructions)			(	450, 171	
01 Sequestration adjustment (see instructions)				9,004	
00  Interim payments (see instructions) 00  Tentative settlement (for contractor use only)				0 441, 167 0 0	
	d 33)		(		1 2/
00 Balance due provider/program (line 31 minus lines 31.01, 32, an 00 Protested amounts (nonallowable cost report items) in accordanc	,	Pub. 15-2.	(		

	IS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider CC	CN: 15-1327	Period:		Worksheet H-5	
PRO	IGRAM BENEFI CI ARI ES	HHA CCN: 15-7542			rom 01/01/2016 p 12/31/2016		
					Home Health Agency I	PPS	
		I npati en	t Part A			t B	
	-	mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
0	Tatal intenin normate neid to providen	1.00	2.00	0	3.00	4.00	1
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0		441, 167 0	1
0	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3
	Program to Provider						
1 ว				0		0	3
12 13				0		0	
4				0		0	3
5				0		0	1
^	Provider to Program			0		0	
0 1				0		0	
2				0		0	
3				0		0	1
4	Subtatal (sum of lines 2.01.2.40 minus sum of lines			0		0	
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		441, 167	4
	TO BE COMPLETED BY CONTRACTOR						
0	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5
	Program to Provider			0			
1				0		0	5
3				0		0	5
_	Provider to Program						
0 1				0		0 0	5
2				0		0	5
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0		0	5
0	5.50-5.98) Determined net settlement amount (balance due) based on						ė
1	the cost report. (1) SETTLEMENT TO PROVIDER			0		0	6
)2	SETTLEMENT TO PROGRAM			0		0	6
0	Total Medicare program liability (see instructions)			0		441, 167	7
					Contractor Number	NPR Date (Mo/Day/Yr)	
			)		1.00	2.00	