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 HARRISON COUNTY HOSPITAL (15-1331) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si aned)

Officer or Administrator of Provider(s)

In Lieu of Form CMS-2552-10

OMB NO. 0938-0050

Time:

2:22 pm

Δ

Title

			Title	XVIII			
	Cost Center Description		Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	381, 360	-691, 969	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	2, 037	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
200.00	Total	0	383, 397	-691, 969	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

Health Financial Systems	HARRISON COUNTY HOSPITAL	In Lieu of Form CMS-2
This report is required by law (42 USC	395g; 42 CFR 413.20(b)). Failure to report of	can result in all interim FORM APPROVED

AND SETTLEMENT SUMMARY

Provi der

EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1331 Worksheet S Peri od. From 01/01/2017 Parts I-III 12/31/2017 Date/Time Prepared: То 5/22/2018 2:22 pm PART I - COST REPORT STATUS 1. [X] Electronically filed cost report Date: 5/22/2018 Manually submitted cost report] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low.

payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

number of times reopened = 0-9. MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND

	Financial Systems		ON COUNTY H					n Lieu			2552-10
HOSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DA	IA	Provi de	er CCN: 1	15-1331	Period: From 01/01		Workshe Part I		
	1						To 12/31.		Date/Ti 5/22/20		
	1.00 Hospital and Hospital Health Care Co		00		3.00			4.00			
1.00	Street: 245 ATWOOD ST.	P0 Box:									1.00
2.00	City: CORYDON	State: I Component Na		p Code: CCN	: 47112- CBSA	Count Provi der	y: HARRISON Date		nt Syst	om (D	2.00
				umber	Number	Туре	Certified		0, or	N)	-
		1.00	2	2.00	3.00	4.00	5.00	6.00	_	8.00	
3.00	Hospital and Hospital-Based Componen Hospital	t Identification: HARRISON COUNTY		51331	31140	1	12/15/2005	N	0	0	3.00
3.00		HOSPITAL		51551	51140		12/15/2003				3.00
4.00 5.00 6.00 7.00	Subprovi der – IPF Subprovi der – IRF Subprovi der – (Other) Swi ng Beds – SNF	HARRISON COUNTY : BEDS	SWING 15	5Z331	15999		08/14/2011	N	0	0	4.00 5.00 6.00 7.00
11.00 12.00 13.00 14.00 15.00 16.00 17.00	Swing Beds - NF Hospital-Based SNF Hospital-Based NF Hospital-Based OLTC Hospital-Based HHA Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FOHC Hospital-Based (CMHC) I Renal Dialysis Other	HARRI SON COUNTY	HHA 15	57242	15999		12/23/1992		Ρ	N	8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
							From 1.00		Tc 2. (-
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/2		12/31		20.00
	Inpatient PPS Information Does this facility qualify and is it	currently receiv	/ing paymen	ts for	di sprop	ortionate	N		Ν	1	22.00
22100	share hospital adjustment, in accord for yes or "N" for no. Is this facil amendment hospital?) In column 2, en	ance with 42 CFR ity subject to 42	§412.106? 2 CFR Secti	In col on §412	umn 1,	enter "Y"					
22. 01	Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions)	es or "N" for no October 1. Enter	for the po in column	rtion o 2, "Y"	of the c for yes	ost or "N"	N		N	I	22.01
22. 02	Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1.	? (see instruction e cost reporting	ons) Enter period pri	in colu or to C	ımn 1, " October	Y" for ye 1. Enter			Ν	I	22.02
22. 03	Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on o hospital contain at least 100 but no	statistical area no for the portic 2, "Y" for yes or r after October 1	as adopted on of the c ⁻ "N" for n 1. (see ins	by CMS ost rep o for t tructio	in FY20 porting the port ons) Doe	15? Enter period ion of th s this	e		Ν	I	22.03
23.00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	"Y" for yes or "N dicaid days on li f census days, or is cost reporting	N" for no. nes 24 and 3 if date g period di	/or 25 of dis fferent	below? charge. from t	In column Is the he method		2	N	I	23.00
			In-State Medicaid paid days	In-Sta Medica eligil unpa days	aid S ble Me id pai			Medica HMO da <u>:</u>	ys Meo	ther di cai d days	
24 00	If this provider is an LDDS beesited	optor the	1.00	2.0	0	3.00	4.00	5.00	0	5.00	24.00
	If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state	0 0	n 	0	0	0		0	0	24.00
	Medicaid paid days in column 1, the Medicaid eligible unpaid days in col out-of-state Medicaid days in column Medicaid eligible unpaid days in col HMO paid and eligible but unpaid day	umn 2, 3, out-of-state umn 4, Medicaid									

DSPI T	Financial Systems HARRISC AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC		eriod: rom 01/01/2017	eu of Form Workshee Part I		02 1
				T,				
					Urban/Rural S 1.00		Geogr	
5.00	Enter your standard geographic classification (not wa		itus at the beg	jinning of the	1.00	2		26. C
7.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	age) sta - "2" fo	or rural. If ap	l of the cost oplicable,	2	2	2	27.0
5. 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.			CH status in	(D	3	35. (
					Begi nni ng: 1. 00	Endi n 2.00	<u> </u>	
. 00	Enter applicable beginning and ending dates of SCH st		Subscript line	36 for number	1.00	2.00		36.
. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of period	s MDH status	(D	3	37.
. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)				N		3	37.
. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.						3	38.
					Y/N 1.00	Y/N 2.00		
9. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	or (ii eage re)? Enter in co equirements in	olumn 1 "Y" accordance	N	N		39.
. 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.	per 1. E	inter "Y" for y		Ν	N	4	40.
	no m cordini z, for arscharges on or arter october i.	(300 1			V 1.0		XI X 3. 00	
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	nt for c	li sproporti onat	e share in acc	cordance N	N	N 4	45.
. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst					N	N 4	46.
	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS on the facility electing full federal capital payment				orno. N			47. 48.
. 00	Teaching Hospitals Is this a hospital involved in training residents in	approve	ed GME programs	s? Enter "Y" f	for yes N		5	56.
. 00	or "N" for no. 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 th of th (", comp	"N" for no ir nis cost report nlete Worksheet	n column 1. If ing period? E	column 1 Enter "Y"		5	57.
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complet	e Wkst. D-5.					58.
. 00	Are costs claimed on line 100 of Worksheet A? If yes	s, compi	ete wkst. D-2,	NAHE 413.85	Worksheet A	Pass-Th		59.
				Y/N	Line #	Qualific Criterior		
00	Are you claiming nursing and allied health education		costs for	1.00 N	2.00	3.00		60.
	any programs that meet the criteria under §413.85? ((see ins	structions)					.0.
		Y/N	IME	Direct GME	IME	Direct		
00	Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	5.00 0	0.00 6	61
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care							61.
	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)							
. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						6	61.
02	ACA). (see instructions) Enter the base line FTE count for primary care						6	61.

		TY HOSPITAL			u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA	Provider C	CN: 15-1331	Period: From 01/01/2017 To 12/31/2017		pared:
	Y/N	I ME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the beautime primary. 						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (li 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimar care or general surgery. (see instructions)	<u> </u>					61.06
	Pro	ogram Name		e Unweighted IME FTE Count	Direct GME FTE Count	-
61.10 Of the FTEs in line 61.05, specify each new progra	ım	1.00	2.00	3.00	4.00	61.10
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GW FTE unweighted count.	3					
 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in col umn 2, the program code. Enter in col um 3, the IME FTE unweighted count. Enter in column 4 the direct GME FTE unweighted count. 	ımn			0.00	0.00	61. 20
					1.00	-
ACA Provisions Affecting the Health Resources and					0.00	(0.00
62.00 Enter the number of FTE residents that your hospit your hospital received HRSA PCRE funding (see inst		a in this cost	reporting pe	riod for which	0.00	62.00
62.01 Enter the number of FTE residents that rotated fro during in this cost reporting period of HRSA THC p Teaching Hospitals that Claim Residents in Nonprov	om a Teachi program. (s	<u>see instructio</u>		o your hospital	0.00	62.01
63.00 Has your facility trained residents in nonprovider "Y" for yes or "N" for no in column 1. If yes, com	settings	during this c			N	63.00
			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
Contion EEOA of the ACA Deer View ETE De 1 4 4 4	Nonr	don Cottine	1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in period that begins on or after July 1, 2009 and be		5	inis base yea	i is your cost r	eporting	
64.00 Enter in column 1, if line 63 is yes, or your faci in the base year period, the number of unweighted resident FTEs attributable to rotations occurring settings. Enter in column 2 the number of unweigh resident FTEs that trained in your hospital. Enter	lity trair non-primar in all nor nted non-pr	ned residents ry care nprovider rimary care	0.0	0. OC	0. 000000	64.00
of (column 1 divided by (column 1 + column 2)). (s	ee instruc	ctions)				
Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider	FTEsin	Ratio (col. 3/ (col. 3 + col. 4))	
		0.00	Site	4.00	E 00	-
1.00		2.00	3.00	4.00	5.00	

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	AIA Provider (CCN: 15-1331 Pe	eriod:	WOI	<pre>rksheet S-2</pre>	
			Fr To	om 01/01/20 12/31/20		⁻t I :e/Time Pre	pared
	Drogram Nama	Program Code		Unweighted	5/2	2/2018 1:5 o (col. 3/	7 pm
	Program Name	Program code	Unwei ghted FTEs	FTEs in		. 3 + col.	
			Nonprovi der	Hospi tal		4))	
	1.00	0.00	Si te	1.00		- 00	-
.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	00	5.00 0.000000	65
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care							
resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3							
divided by (column 3 + column 4)). (see instructions)							
		-	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital		o (col. 1/ . 1 + col. 2))	/
Section 5504 of the ACA Current	Voar ETE Posidonts i	n Nonnrovidor Sottin	1.00	2.00	ting r	3.00	
beginning on or after July 1, 20		n Nonprovider Settin	gsEffective fo	i cost repor	ting p	Derrous	
		rv care resident	0,00	0.	00	0.00000	66.0
.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar occurring in all nonpr unweighted non-primar cal. Enter in column 3 column 2)). (see ins	rovider settings. ry care resident 3 the ratio of structions)	0.00		00 I Rati	0. 000000	
.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit	unweighted non-primar occurring in all nonpr unweighted non-primar tal. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00 Unweighted FTEs Nonprovider Site	0. Unweighted FTEs in Hospital	I Rati	0.000000 o (col. 3/ . 3 + col. 4))	
 .00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + .00 Enter in column 1, the program 	unweighted non-primar occurring in all nonpr unweighted non-primar cal. Enter in column 3 column 2)). (see ins	rovider settings. ry care resident 3 the ratio of structions)	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital 4.00	I Rati	o (col. 3/ . 3 + col.	-
.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar occurring in all nonpr unweighted non-primar cal. Enter in column 3 column 2)). (see ins Program Name	rovider settings. ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	I Rati (col	o (col. 3/ . 3 + col. 4)) 5.00	-
 O0 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 2 divided by (column 2 divided by (column 3 divided by (column 4 divided by (column 4	unweighted non-primar occurring in all nonpr unweighted non-primar cal. Enter in column 3 column 2)). (see ins Program Name	rovider settings. ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00 0.	I Rati (col	o (col. 3/ . 3 + col. 4)) 5.00 0.000000	-
 O0 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + O0 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 3 divided by (column 3 divided by (column 3 + column 4)). (see instructions) 	unweighted non-primar occurring in all nonpr unweighted non-primar cal. Enter in column 3 column 2)). (see ins Program Name 1.00	rovider settings. ry care resident 3 the ratio of structions) Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.	I Rati (col	o (col. 3/ . 3 + col. 4)) 5.00	67.1
 O0 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 2, 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 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility F O0 Is this facility an Inpatient Psychiatric facility for the patient for the program 1 + (column 2) 	unweighted non-primar occurring in all nonpri unweighted non-primar cal. Enter in column 3 column 2)). (see ins Program Name 1.00 1.00	rovider settings. ry care resident 3 the ratio of structions) Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.	I Rati (col	o (col. 3/ . 3 + col. 4)) 5.00 0.000000	67.1
 .00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 2 divided by (column 3 divided by column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 3 divided by (column 3 divided	unweighted non-primar occurring in all nonpr unweighted non-primar cal. Enter in column 3 column 2)). (see ins Program Name 1.00 1.00 1.00	Program Code 2.00 Program Code Program Code Program Code 2.00 (PF), or does it common approved GME teaching D04? Enter "Y" for y lity train residents (D)? Enter "Y" for y	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach	Unwei ghted FTEs in Hospi tal 0. 0.	I Rati (col 00 .00 2	o (col. 3/ . 3 + col. 4)) 5.00 0.000000	7 67.1
 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 + (column 2 divided by (column 1 + (column 2 divided by (column 3 divided by 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 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility F for yes or "N" for no ta 2 CFR 412.424(d)(1)(iii)(c)) co program in accordance with 42 CFR	unweighted non-primar occurring in all nonpri unweighted non-primar cal. Enter in column 3 column 2)). (see ins Program Name 1.00 1.00 2PS sychiatric Facility (I o. d the facility have ar pefore November 15, 20 Jumn 2: Did this faci FR 412.424 (d)(1)(iii) cate which program yet	rovider settings. ry care resident 3 the ratio of structions) Program Code 2.00 IPF), or does it common n approved GME teaching 004? Enter "Y" for y ility train residents 0(D)? Enter "Y" for y ear began during this	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subp ng program in t yes or "N" for n s in a new teach yes or "N" for n s cost reporting	Unwei ghted FTEs in Hospi tal 4.00 0. 1. 1. rovi der? he most o. (see i ng o. peri od.	I Rati (col 00 .00 2	o (col . 3/ . 3 + col . 4)) 5.00 0.000000	7 70.1
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96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. N 96.00 97.00 1F line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.000 Y Y 98.00 97.00 1F line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 98.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Y Y 98.01 80.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Y Y 98.01 80.02 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wst. Y Y 98.01 80.01 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation Y Y 98.02 80.03 Does title V or XIX follow Medicare (title XVIII) for a cAH relimbursed 101% of N N 98.03 98.04 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Y Y 98.04 0.00 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Y Y 98.05 0.00	95 00		0.00	0.00	95 00
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98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Ws.t. B, Pt. I, col. 255 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title VXIX. Y 98.00 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Ws.t. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Y Y 98.01 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation Y Y Y 98.02 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N N 98.03 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N N 98.03 98.03 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 10% of an out and or long title XIX. N 98.03 98.04 outpatient services cost2 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N N 98.04 98.05 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Ws.t. D. Y Y 98.05 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Ws.t. D. Y Y 98.06 98.05 Does title V or XIX follow Medicare (t	97.00		0.00	0.00	97.00
column 1 for title V, and in column 2 for title XX. 48.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XX. 49.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 49.03 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of notitle V, and in column 2 for title XIX. 49.03 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 49.04 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 49.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 40.00 Exitle V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 40.00 Exitle V or XIX follow Medicare (title XVIII) when cost reimbursement for I&R N 105.00 106.00 If this facility qualifies as a CAH; is I eligible for cost reimbursement for I&R N 107.00 107.00 If this facility qualifies as a CAH; is I eligible for cost reimbursement for I&R N 107.00 108.00 Exit West on the down Akst. B, P-1, I. col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Exit a rural hospital qualifying for an exception to the CRNA fee schedule? See 4 107.00 109.00 If this hospital qualifies as a CAH and XSH P-2, Pt. II. 100.00 Dold this hospital participate in the Rural Commu	98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post	Y	Y	98.00
98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Y Y 98.01 C, P.H. 17 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for Y Y 98.01 80.20 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation Y Y 98.01 98.01 Ded title V, and in column 2 for For title XVIII) for the calculation of observation Y Y 98.03 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N N 98.03 reimbursed 101% of inpatient services cost2 Enter "Y" for yes or "N" for no in column 1 for N N 98.03 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of N N 98.04 outpatient services cost2 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N 98.05 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wst. D, Y Y 98.05 wst. C, Pt. I. col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in colum 2 for title XIX. Y 98.06 98.05 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wst. D, Y Y 98.06 05.00 Does this hospit					
C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98. 02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation for title V, and in column 2 for title XIX. 98. 03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98. 04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98. 05 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of N N 98. 04 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98. 05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on West. C, Pt. 1, 01. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98. 06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D. Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98. 06 Does title vor XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D. Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98. 06 Does tils hospital qualify as a CAH? 105. 00 Does tils hospital qualify as a CAH? 106. 00 Fit is facility qualifies as a CAH, has it elected the all-inclusive method of payment for utraining programs? Enter "Y" for yes or "N" for no. Training programs? Enter "Y" for yes or "N" for no. Training programs? Enter "Y" for yes or "N" for no. CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Through IPy scomplete Wkst. D-2, Pt. II. 100. 00 Lid this hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 CFR Section §412.1					
title XIX. Y	98.01		Y	Y	98.01
98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 897 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Y 98.02 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N N 98.03 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N 98.04 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.05 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Y Y 98.06 010.00 If this facility qualifies as ACH? N N 105.00 105.00 Does this hospital qualify as a CAH? N N 106.00 107.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) N 10					
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Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 105.00 Does this hospital qualify as a CAH? Y 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) Y 107.00 If this facility qualifies as a CAH, is it elected the all-inclusive method of payment for outpatient services? (see instructions) Y 105.00 107.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) N 107.00 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. N 108.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. N Y N Y 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as N 110.00		5			
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Rural Providers Y 105.00 105.00 Does this hospital qualify as a CAH? Y 105.00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) N 106.00 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R N 106.00 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R N 107.00 107.00 training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If N 107.00 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" N Y 109.00 109.00 If this hospital participate in the Rural Community Hospital Demonstration project (§410A N Y 109.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A N 110.00 N 110.00 Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as N 110.00 <td></td> <td></td> <td></td> <td></td> <td></td>					
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for outpatient services? (see instructions)107.00107.00If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&RN107.00training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) IfNyes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is costNreimbursed. If yes complete Wkst. D-2, Pt. II.N108.00108.00Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42N108.00CFR Section §412.113(c). Enter "Y" for yes or "N" for no.NY109.00If 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.NY110.00Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, asN					
107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R N 107.00 training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If N 107.00 yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost N 108.00 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 0.109.00 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 Y N Y 109.00 101.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as N 107.00	106.00		. N		106.00
training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.108.00 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 Physical Occupational Speech Respiratory 1.00108.00 2.00108.00 4.00109.00 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.NYNY109.00110.00 Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, asN110.00 N110.00 N110.00 N	107.00		N		107.00
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CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" N Y N Y 109.00 1.00 1.00 1.00 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A N 110.00 Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as N 110.00		reimbursed. If yes complete Wkst. D-2, Pt. II.			
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1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" N Y N Y 109.00 1.00 2.00 3.00 4.00 109.00 Therapy services provided by outside supplier? Enter "Y" N Y N Y 109.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 Demonstration project (§410A N 110.00 Complete Worksheet E, Part A, Lines 200 through 218, and Worksheet E-2, Lines 200 through 215, as			Creash	Desident	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" N Y N Y 109.00 for yes or "N" for no for each therapy. Image: Complete transmission of the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as N Y 109.00					-
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as	109 00				109 00
for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as N 110.00	107.00				107.00
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A N 110.00 Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as N 110.00					
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A N 110.00 Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as N 110.00					
Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as			101		4.4 -
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as	110.00			N	110.00
		applicable.	3 , 40		

ealth Financial Systems HARRISON COUNT HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCI	N: 15-1331	Period: From 01, To 12,			eet S-2 me Pre	2 epared:
			1	. 00	2.0	00	-
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting po lumn 1 is Y, en ticipating in o	eriod? Ente nter the column 2.		N			111.00
				1.0	0 2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" 1 117.00 Is this facility legally-required to carry malpractice insura	If column 2 is t for long tern s) based on the for yes or "N"	s "E", ente m care (inc e definition for no.	r in colu udes n in CMS	mn N		0	115. 00 116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence poli		2		1			118.00
claim-made. Enter 2 if the policy is occurrence.		Premiums		sses	Insur	ance	
				5565	THOUT	unce	
		1.00		. 00	3.	00	
18.01 List amounts of malpractice premiums and paid losses:		518,8	392	(C	0 118. 0 [°]
			1	. 00	2.	00	
 18.02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 19.00 DO NOT USE THIS LINE 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 < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment 	ule listing cos Harmless provi column 1, "Y" alifies for the	st centers ision in AC, for yes or e Outpatien		N	N	I	118. 02 119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 21.00Did this facility incur and report costs for high cost implan	ntable devices	charged to		Y			121.0
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.				Y	5.0	01	122. 0
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	r yes and "N" ·	for no. If		N			125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, entition in column 1 and termination date, if applicable, in column 2.		ication dat	e				126. 00
27.00 If this is a Medicare certified heart transplant center, ento in column 1 and termination date, if applicable, in column 2.	er the certifi	cation date					127.0
28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.							128.0
29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter en			n				129. 0 130. 0
date in column 1 and termination date, if applicable, in colu 31.00[f this is a Medicare certified intestinal transplant center,	umn 2.						131. 0
date in column 1 and termination date, if applicable, in colu 32.00 If this is a Medicare certified islet transplant center, ent	er the certifi	cation date					132. 0
in column 1 and termination date, if applicable, in column 2. 33.00 If this is a Medicare certified other transplant center, entering in column 1 and termination date, if applicable, in column 2.	er the certifi	cation date					133. 0
 34. 00 If this is an organ procurement organization (0P0), enter the and termination date, if applicable, in column 2. 		n column 1					134. 0
All Providers 40.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y				N			140. 0

IOSPITAL AND HOSPITAL HEALTH CARE CO		COUNTY HOSPITAL Provider CC	CN: 15-1331				2 repared:
1.00		2.00			3.00	<u> </u>	<u>57 piii</u>
If this facility is part of a	chain organization, enter		ugh 143 the	name ar		of the	
home office and enter the home							
41.00Name: 42.00Street:	Contractor's Name PO Box:):	Contrac	ctor's N	umber:		141.00
43. 00 Ci ty:	State:		Zip Coo	łe∙			142.00
	jotato.		210 000				110.00
						1.00	
44.00 Are provider based physicians'	costs included in Workshe	et A?				Y	144.00
					1.00	2.00	_
45.00 If costs for renal services ar	ce claimed on West A line	71 are the costs	for		1.00	2.00	145.0
 46.00 Has the cost of the number of the cost of the cost	"Y" for yes or "N" for no /include Medicare utilizat "N" for no in column 2. dology changed from the pre no in column 1. (See CMS Pu	o in column 1. If c ion for this cost eviously filed cost	column 1 is reporting t report?		Ν		146. 0
						1.00	
47.00 Was there a change in the stat						N	147.00
48.00 Was there a change in the orde						N	148.00
49.00 Was there a change to the simp	piried cost finding method	I? Enter "Y" for ye Part A	es or "N" fo Part B		Title V	N Title XIX	149.00
		1.00	2.00		3.00	4,00	-
Does this facility contain a p	provider that qualifies for			cation o			
or charges? Enter "Y" for yes						3. 13)	
55.00Hospi tal		N	N		N	N	155. 0
56.00 Subprovi der – IPF		N	N		N	N	156.0
57.00 Subprovider - IRF 58.00 SUBPROVIDER		N	N		N	N	157.0 158.0
58. 00/S0BPROVI DER 59. 00/SNF		Ν	N		N	N	158.0
60. 00 HOME HEALTH AGENCY		N	N N		N	N	160. 0
61.00 СМНС			N		Ν	N	161. 00
							_
						1.00	_
Multicampus 65.00 Is this hospital part of a Mul	ticampus bospital that has	one or more campi	uses in dift	ferent (BSAs2	N	165. 0
Enter "Y" for yes or "N" for r		some of more campe					105.0
	Name	County		Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
66.00 If line 165 is yes, for each campus enter the name in colum O, county in column 1, state i column 2, zip code in column 3 CBSA in column 4, FTE/Campus i column 5 (see instructions)	n					0.0	00 166. 0
						1.00	-
Health Information Technology	(HIT) incentive in the Ame	erican Recoverv and	d Reinvestm	ent Act		1.00	
67.00 Is this provider a meaningful 68.00 If this provider is a CAH (lir	user under §1886(n)? Ente	er "Y" for yes or "	'N" for no.		r the	Y	167. 0 1168. 0
							4/2 -
reasonable cost incurred for t	is not a meaningful user,				ashi p		168. 0
reasonable cost incurred for t 68.01 f this provider is a CAH and	ii)? Enter "V" for yos or				enter the	9.0	99169.0
reasonable cost incurred for t 68.01 If this provider is a CAH and exception under §413.70(a)(6)(and is not a CAH (,,			
reasonable cost incurred for t 68.01 If this provider is a CAH and exception under §413.70(a)(6)(uluser (line 167 is "Y")	and is not a CAH (
reasonable cost incurred for t 68.01 If this provider is a CAH and exception under §413.70(a)(6)(69.00 If this provider is a meaningf	uluser (line 167 is "Y")	and is not a CAH (В	egi nni ng	Endi ng	
reasonable cost incurred for t 68.01 If this provider is a CAH and exception under §413.70(a)(6)(69.00 If this provider is a meaningf transition factor. (see instru	ul user (line 167 is "Y") uctions)				1.00	2.00	-
reasonable cost incurred for t 68.01 If this provider is a CAH and exception under §413.70(a)(6)(69.00 If this provider is a meaningf transition factor. (see instru	ul user (line 167 is "Y") uctions) HR beginning date and endi		eporting		<u> </u>		170. 0
reasonable cost incurred for t 68.01 If this provider is a CAH and exception under §413.70(a)(6)(69.00 If this provider is a meaningf transition factor. (see instru 70.00 Enter in columns 1 and 2 the E	ul user (line 167 is "Y") uctions) HR beginning date and endi		eporting		1.00	2.00	170. 0

SPI T	Financial Systems HARRISON COUN AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1331	Peri od:	u of Form CMS- Worksheet S-:	
				From 01/01/2017 To 12/31/2017	Part II Date/Time Pro 5/22/2018 1:	
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	sponses. Ente	er all dates in t	he	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					_
00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in c	olumn 2. (see				
			Y/N	Date	<u>V/I</u>	
00	Has the provider terminated participation in the Medicare P	rogram? If	1.00 N	2.00	3.00	2.
00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home c or medical supply companies) that are related to the provid	n 3, "V" for g management ffices, drug	N			3.
	of ficers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	of the board				
			Y/N	Type	Date 2 00	
	Financial Data and Reports		1.00	2.00	3.00	
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, ilable in	Y	С		4.
00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit rec		N			5.
				Y/N 1.00	Legal Oper. 2.00	_
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	3	e provider is	5 N		6.
)0)0	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	N N		7. 8.
00	Are costs claimed for Interns and Residents in an approved		al education	N		9.
00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		he current	Ν		10.
00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.
					Y/N 1.00	-
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	see instruct	ions.		Y	12.
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	N	13.
00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				Ν	14.
00	Did total beds available change from the prior cost reporti	Par	t A	Par		15.
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
	PS&R Data					
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Ν		N		16.
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/04/2018	Y	04/04/2018	17.
00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.
00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19

	Financial Systems HARRISON COUNT AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (CCN: 15-1331	Period: From 01/01/2017	u of Form CM Worksheet S Part II	-2
				To 12/31/2017	Date/Time P 5/22/2018 1	:57 pm
		Desci	ription	Y/N	Y/N	
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			Ν	N	20.00
	Report data for other: bescribe the other adjustments.	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		Ν		21.00
	records: Tri yes, see filstructrons.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEI	PT CHILDRENS	HOSPI TALS)			
00	Capital Related Cost	instructions			N	- 22.00
	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense			ng the cost	N N	22.00
0.00	reporting period? If yes, see instructions.			ing the cost		20.00
4.00	Were new leases and/or amendments to existing leases entere	d into during	, this cost rep	porting period?	Ν	24.00
5.00	If yes, see instructions Have there been new capitalized leases entered into during	the cost rong	rting poriod?	lf vos soo	Ν	25.00
5.00	instructions.	the cost repu	in this periou?	TT yes, see	IN	25.00
6. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	e cost report	ing period? I	f yes, see	Ν	26.00
7 00	instructions.	aget reporti	ng noried2 If	voo oubmit	N	27.00
7.00	Has the provider's capitalization policy changed during the copy.	cost reporti	ng period? IT	yes, submit	Ν	27.00
	Interest Expense					
8.00	Were new loans, mortgage agreements or letters of credit en	tered into du	iring the cost	reporting	Ν	28.00
9.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or l	bond funde (F	Nobt Sorvice D	acarica Eurod)	Ν	29.00
9.00	treated as a funded depreciation account? If yes, see instru	uctions	ebt Service Re	eserve Fund)	IN	29.00
0. 00	Has existing debt been replaced prior to its scheduled matu	rity with new	debt? If yes,	see	Ν	30.00
4 00	instructions.	c.				0.1.00
1. 00	Has debt been recalled before scheduled maturity without is instructions.	suance or new	debt? IT yes,	see	Ν	31.00
	Purchased Services					-
2.00	Have changes or new agreements occurred in patient care ser		ed through co	ntractual	Ν	32.00
2 00	arrangements with suppliers of services? If yes, see instru- If line 32 is yes, were the requirements of Sec. 2135.2 app		na to compoti	tivo bidding? If	Ν	33.00
3.00	no, see instructions.	rreu pertarm	ng to competi	tive broating? IT	IN	33.00
	Provi der-Based Physi ci ans					
4.00	Are services furnished at the provider facility under an ar	rangement wit	h provider-bas	sed physi ci ans?	Y	34.00
5 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exis	sting agroome	nte with the u	arovi dar basad	Ν	35.00
5.00	physicians during the cost reporting period? If yes, see in:		ants with the p	or ovr der -based	IN IN	35.00
				Y/N	Date	
				1.00	2.00	
6.00	Home Office Costs Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been pro-	epared by the	home office?			37.00
	If yes, see instructions.					
8.00	If line 36 is yes, was the fiscal year end of the home off			N		38.00
9.00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			N		39.00
	see instructions.					
0.00	If line 36 is yes, did the provider render services to the	home office?	lf yes, see	Ν		40.00
	instructions.					
		1	. 00	2.	00	
	Cost Report Preparer Contact Information					
1.00		TODD		SCHI AVONE		41.00
	held by the cost report preparer in columns 1, 2, and 3, respectively.					
2.00		BLUE AND COMP	ANY			42.00
				1		

BLUE AND COMPANY 43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively. 502. 992. 3506 TSCHI AVONE@BLUEANDCO. COM

43.00

Heal th	Financial Systems HARRISON	I COUNT	Y HOSPI TAL	In Lie	u of Form CMS-:	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	E	Provider CCN: 15-	eriod:	Worksheet S-2	
				rom 01/01/2017 o 12/31/2017		
		L				
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	n [DI RECTOR			41.00
	held by the cost report preparer in columns 1, 2, and	3,				
	respecti vel y.					
42.00	Enter the employer/company name of the cost report					42.00
	preparer.					
43.00	Enter the telephone number and email address of the co	ost				43.00
	report preparer in columns 1 and 2, respectively.					

^{5/22/2018 1:57} pm

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	HARRISON COUNT	Provi der CC	N· 15-1331	Peri od:	u of Form CMS-2 Worksheet S-3	
				M. 13-1331	From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/22/2018 1:5	pared: 7 pm
						I/P Days / O/P	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	<u>Visits / Trips</u> Title V	
	component	Line Number	NO. OI DEUS	Avai I abl e	CAIT HOULS	II LIE V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	21	7,6		0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		21	7,6	65 104, 856. 00		
7.00	beds) (see instructions)		21	7,0	104, 650. 00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1, 4	60 10, 248. 00	0	8.00
9.00	CORONARY CARE UNIT	01100		., .	10,210100	Ū	9.0
10.00	BURN INTENSIVE CARE UNIT						10.0
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.0
13.00	NURSERY	43.00				0	13.0
14.00	Total (see instructions)		25	9, 1	25 115, 104. 00	0	14.0
15.00	CAH visits					0	15.0
16.00	SUBPROVIDER - IPF						16.0
17.00	SUBPROVIDER – IRF						17.0
18.00	SUBPROVI DER						18.0
19.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
21.00	OTHER LONG TERM CARE					_	21.0
22.00	HOME HEALTH AGENCY	101.00				0	
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
24.00		20.00					24.0
24.10 25.00	HOSPICE (non-distinct part) CMHC - CMHC	30.00					24.1 25.0
26.00	RURAL HEALTH CLINIC						26.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	•
27.00	Total (sum of lines 14-26)	09.00	25			0	27.0
28.00	Observation Bed Days		20			0	
29.00	Ambul ance Trips					Ŭ	29.0
30.00	Employee discount days (see instruction)						30.0
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		-				32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.0

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/22/2018 1:5	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	[
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2, 018	40	4, 36	9		1.0
. 00	HMO and other (see instructions)	224	730				2.0
. 00	HMO I PF Subprovi der	224	0				3.0
. 00	HMO I RF Subprovi der	0	0				4.0
. 00	Hospital Adults & Peds. Swing Bed SNF	20	0	-	0		5.0
. 00	Hospital Adults & Peds. Swing Bed NF Hospital Adults & Peds. Swing Bed NF	20	0	2	0		6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 038	40	4, 38	-		7.0
. 00	INTENSI VE CARE UNI T	241	5	42	7		8.0
. 00	CORONARY CARE UNIT	241	5	42	.7		9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGICAL INTENSIVE CARE UNIT						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)			0-			12.0
3.00	NURSERY	0.070	0	87	-	105.05	13.0
4.00	Total (see instructions)	2, 279	45	5, 69	0.00	485.05	
5.00	CAH visits	0	0		0		15.0
6.00	SUBPROVIDER - IPF						16.
7.00	SUBPROVIDER - IRF						17. (
8.00	SUBPROVI DER						18.
9.00	SKILLED NURSING FACILITY						19.0
0. 00	NURSING FACILITY						20.0
1. 00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY	3, 334	218	4,50	0.00	8. 58	
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPI CE						24.
4. 10	HOSPICE (non-distinct part)	0	0		0		24.
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC						26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	26.1
7.00	Total (sum of lines 14-26)				0.00	493.63	27.0
8.00	Observation Bed Days		311	1, 42	8		28.
9.00	Ambulance Trips	2, 072					29.0
D. 00	Employee discount days (see instruction)				0		30.
1.00	Employee discount days - IRF				0		31.
2.00	Labor & delivery days (see instructions)	0	0		0		32.
2.01	Total ancillary labor & delivery room				0		32. (
	outpatient days (see instructions)						
3.00	LTCH non-covered days	0					33.
	LTCH site neutral days and discharges	0					33.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	HARRISON COUNT	Provi der CO	N· 15_1221	Peri od:	u of Form CMS-2552-1 Worksheet S-3	
HUSPI I	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		JN. 13-1331	From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/22/2018 1:5	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	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0		06 57	1, 442	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider				54 494 0		2.00 3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				0		4.00 5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 9.00	INTENSIVE CARE UNIT						8.00 9.00
9.00 10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 14.00	NURSERY Total (see instructions)	0.00	0	61	06 57	1, 442	13.00 14.00
14.00	CAH visits	0.00	U		57	1,442	14.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00							18.00
19.00 20.00	SKILLED NURSING FACILITY NURSING FACILITY						19.00 20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00 24.10	HOSPICE HOSPICE (non-distinct part)						24.00 24.10
25.00	CMHC - CMHC						24.10
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00 29.00	Observation Bed Days Ambulance Trips						28.00 29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room						32.01
33.00	outpatient days (see instructions) LTCH non-covered days				0		33.00
	LTCH site neutral days and discharges				0		33.01

	Financial Systems	HARRI SON COUN				eu of Form CMS-	
HOME F	IEALTH AGENCY STATI STI CAL DATA		Provider C Component		Period: From 01/01/2017 To 12/31/2017	Worksheet S-4 Date/Time Pre 5/22/2018 1:5	pared:
					Home Health	PPS	<u>/ piii</u>
					Agency I		
	1					00	
0.00	County	T; +1 o)/	T: +1 - X)/		HARRI SON	Tatal	0.00
		<u>Title V</u> 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA		1	1		1	
1.00 2.00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00			0 583 0 95.00		•
2.00	Tondup reated census count (see mistractions)	0.00	122.00		oloyees (Full Ti		2.00
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
				1.00	0.00	0.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	(0	1.00	2.00	3.00	
3.00	Administrator and Assistant Administrator(s)		40.00	0.0	0 0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.0			•
5.00 6.00	Other Administrative Personnel Direct Nursing Service			0.0			
7.00	Nursing Supervisor			0.0			•
8.00	Physical Therapy Service			1.7			•
9.00 10.00	Physical Therapy Supervisor Occupational Therapy Service			0.0			
11.00	Occupational Therapy Supervisor			0.4			•
12.00	Speech Pathology Service			0.0			
13.00 14.00	Speech Pathology Supervisor Medical Social Service			0.0			•
14.00	Medical Social Service Supervisor			0.0			
16.00	Home Health Aide			0.7			
17.00	Home Health Aide Supervisor			0.0			
18.00	OTHER: CLERICAL / PCA HOME HEALTH AGENCY CBSA CODES			2.1	3 0.00	2.13	18.00
19.00	Enter in column 1 the number of CBSAs where				2		19.00
	you provided services during the cost reporting period.						
20.00	List those CBSA code(s) in column 1 serviced			31140			20.00
	during this cost reporting period (line 20						
20. 01	contains the first code).			99915			20. 01
20.01		Full E	oi sodes	77713			20.01
			With Outliers	LUPA Epi sodes	5	Total (cols.	
		Outliers 1.00	2.00	3.00	Epi sodes 4.00	<u>1-4)</u> 5.00	
	PPS ACTIVITY DATA	1	Ĩ			1	
21.00 22.00	Skilled Nursing Visits	1, 023 127, 770					•
22.00	Skilled Nursing Visit Charges Physical Therapy Visits	653			0 2,875 9 17		
24.00	Physical Therapy Visit Charges	92, 544	4, 146	1, 18		100, 302	24.00
25.00	Occupational Therapy Visits	268			1 8	288	
26.00 27.00	Occupational Therapy Visit Charges Speech Pathology Visits	35,645			4 1,068 0 0	38, 316 0	1
28.00	Speech Pathology Visit Charges	0	C		0 0		1
29.00	Medical Social Service Visits	0	C		0 0	0	
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	0	-		0 0 0 11	0 939	
32.00	Home Health Aide Visit Charges	39, 365	11, 845			52, 365	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27,	2, 655	554	6	6 59	3, 334	33.00
34.00	29, and 31) Other Charges	0	r		0 0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28,	295, 324	-	7,62	2 6, 972		•
24 00	30, 32, and 34)	140			-	474	24 00
36.00	Total Number of Episodes (standard/non outlier)	142		2	/ ⁵	174	36.00
37.00	Total Number of Outlier Episodes		12		1		37.00
38.00	Total Non-Routine Medical Supply Charges	29,858	16, 237	6, 04	1 246	52, 382	38.00

Heal th	Financial Systems HARRISON COUNT	Y HOSPITAL		In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-1331	Period: From 01/01/2017	Worksheet S-1	0
				To 12/31/2017		pared: 7 pm
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3	divided by Li	ne 202 columr	8)	0. 253829	1 1.00
1.00	Medicaid (see instructions for each line)	divided by in	10 202 001 0		0.200027	1.00
2.00	Net revenue from Medicaid				6, 328, 039	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 and/or supplem	ental payment	s from Medica	ii d?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments	from Medicai	d		202, 552	•
6.00	Medicaid charges				35, 861, 243	
7.00	Medicaid cost (line 1 times line 6)	(I.) . .	6.1.1	0 1 5 1 6	9, 102, 623	•
8.00	Difference between net revenue and costs for Medicaid progra < zero then enter zero)	•		ies 2 and 5; IT	2, 572, 032	8.00
0.00	Children's Health Insurance Program (CHIP) (see instructions	for each line	e)		0	
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHI	P (line 11 mi	nus line 9: i	f < zero then	0	•
	enter zero)				_	
	Other state or local government indigent care program (see i	nstructions fo	or each line)			
	Net revenue from state or local indigent care program (Not i				0	
14.00	Charges for patients covered under state or local indigent c	are program (Not included	in lines 6 or	0	14.00
15.00	10) State or local indigent care program cost (line 1 times line	14)			0	15.00
16.00	Difference between net revenue and costs for state or local		program (lir	e 15 minus line		
10.00	13; if < zero then enter zero)	Thangent care			0	10.00
	Grants, donations and total unreimbursed cost for Medicaid,	CHIP and state	e∕local indig	ent care progra	ns (see	
	instructions for each line)				1	
	Private grants, donations, or endowment income restricted to				0	
18. 00 19. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Lo				0	
19.00	8, 12 and 16)	cal murgent	care programs	s (suil of fiftes	2, 572, 032	19.00
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
			1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire (see instructions)	facility	394, 03	504, 817	898, 849	20.00
21.00	Cost of patients approved for charity care and uninsured dis instructions)	counts (see	100, 01	7 504, 817	604, 834	21.00
22.00	Payments received from patients for amounts previously writt charity care	en off as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		100, 01	7 504, 817	604, 834	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for pat	ient days bey	ond a length	of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indigent ca If line 24 is yes, enter the charges for patient days beyond	's length of	0	25.00		
	stay limit					
26.00	Total bad debt expense for the entire hospital complex (see				6, 164, 683	
27.00	Medicare reimbursable bad debts for the entire hospital comp	•			739, 956	•
	Medicare allowable bad debts for the entire hospital complex Non-Medicare bad debt expense (see instructions)	(see instruc	cions)		1, 138, 393 5, 026, 290	•
28.00 29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt	evnense (see	instructions		5, 026, 290	•
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	CAPCIISC (366			2, 279, 089	
	Total unreimbursed and uncompensated care cost (line 19 plus	s line 30)			4, 851, 121	•
					•	

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	HARRISON COUNTY	Provider C	CN: 15-1331	Peri od:	Worksheet A	2552-10
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/22/2018 1:5	
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	1 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						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		2,031,178				
. 01 . 02	00101 MOB 00102 AMB DEPR		861, 837 0			861,837	
. 02	00200 NEW CAP REL COSTS-MVBLE EQUIP		1, 026, 161			66, 628 1, 026, 161	
. 01	00201 AMB EQUIP		1, 020, 101		0 109, 339		
00	00400 EMPLOYEE BENEFITS DEPARTMENT	178, 599	5, 788, 854			5, 967, 453	
01	00590 ADMI NI STRATI VE & GENERAL	1, 513, 249	3, 898, 863			5, 412, 112	
. 02	00570 ADMI TTI NG	450, 169	47, 121	497, 29	0 0	497, 290	5.0
03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	428, 370	617, 615	1, 045, 98	5 0	1, 045, 985	5.0
. 00	00700 OPERATION OF PLANT	248, 824	1, 371, 184	1, 620, 00	0 8	1, 620, 008	
01	00701 AMB PLANT OPS	0	0		0 0	0	
00	00800 LAUNDRY & LINEN SERVICE	25, 533	268, 532			294, 065	
. 00	00900 HOUSEKEEPING	453, 991	181, 242			635, 233	
0.00	01000 DI ETARY 01100 CAFETERI A	394, 716	352, 490 0			361, 797	
1.00 3.00	01300 NURSI NG ADMI NI STRATI ON	658, 401	0 81, 016		0 385,409 7 0	385, 409 739, 417	
4.00	01400 CENTRAL SERVICES & SUPPLY	247, 422	1, 725, 491			338, 769	•
5.00	01500 PHARMACY	633, 399	98, 401	731, 80			
6.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	
7.00	01700 SOCI AL SERVI CE	271, 508	14, 816		-	286, 324	•
	INPATIENT ROUTINE SERVICE COST CENTERS		· · · ·				
0. 00	03000 ADULTS & PEDIATRICS	3, 029, 113	177, 041	3, 206, 15	4 -205, 594	3, 000, 560	30. 0
1. 00	03100 I NTENSI VE CARE UNI T	449, 484	32, 589	482, 07		478, 604	31.0
3.00	04300 NURSERY	0	274	27	4 174, 315	174, 589	43.00
~ ~~	ANCI LLARY SERVICE COST CENTERS	000 077	404.057	4 447 00	4 004 070	4 404 744	1 50 0
0.00	05000 OPERATING ROOM	992, 877	424, 957				
2.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0 225, 842	0 928, 862		0 0 4 -11,667	0 1, 143, 037	
i 4. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 228, 103	928, 802				
0.00	06000 LABORATORY	787, 645	1, 271, 784			1, 874, 455	
5.00	06500 RESPI RATORY THERAPY	0	543, 618			488, 596	
6.00	06600 PHYSI CAL THERAPY	259, 273	7, 408			264, 437	
7.00	06700 OCCUPATIONAL THERAPY	0	44, 873	44, 87		44, 873	
8. 00	06800 SPEECH PATHOLOGY	0	0		0 1, 810	1, 810	68.00
9.00	06900 ELECTROCARDI OLOGY	333, 362	31, 059	364, 42		398, 717	
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 445, 265		
2.00	07200 I MPL. DEV. CHARGED TO PATI ENT	0	0		0 976, 084	976, 084	
3.00	07300 DRUGS CHARGED TO PATIENTS	355, 638	2, 119, 400	2, 475, 03	-841, 526	1, 633, 512	73.0
0 00	OUTPATIENT SERVICE COST CENTERS	21 (7)	01 774	102.45	0 21 227	70 110	
90.00	09000 CLINIC 09001 SENIOR CARE	21,676	81, 774			72, 113 280, 786	
	09100 EMERGENCY	130, 571 1, 506, 046	150, 215 542, 859				
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 300, 040	542,059	2,040,70	-0, 170	2,040,727	92.0
2.00	OTHER REIMBURSABLE COST CENTERS	I				L	1 12.00
5.00	09500 AMBULANCE SERVICES	1, 974, 381	667, 478	2, 641, 85	9 -237, 177	2, 404, 682	95.00
	10100 HOME HEALTH AGENCY	485, 659	138, 201			623, 860	101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE		215, 105	215, 10	-215, 105		113. 0
18.00		17, 283, 851	26, 685, 317	43, 969, 16	8 0	43, 969, 168	118.00
oo -	NONREI MBURSABLE COST CENTERS						1000
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	7,829,747	2,845,770			10, 675, 517	
	07950 MARKETI NG 07951 PHYSI CI AN BI LLI NG	66, 404 543, 890	336, 985 101, 930			403, 389 645, 820	
0/ 01			-				
	07952 MOB	0	/				
94.02	07952 MOB 07953 FOUNDATI ON	0	0		0 0 0 0		194. 02 194. 03

ECLASSI F	ICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CCN	: 15-1331	Period: From 01/01/2017	Worksheet A	
					To 12/31/2017	Date/Time Pre 5/22/2018 1:5	
	Cost Center Description	Adjustments	Net Expenses				
		<u>(See A-8)</u> 6.00	For Allocation 7.00				
GEN	NERAL SERVICE COST CENTERS	0100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
. 00 001	100 NEW CAP REL COSTS-BLDG & FIXT	-33, 447	2, 212, 836				1.
	101 MOB	0					1.
	102 AMB DEPR	0	66, 628				1.
	200 NEW CAP REL COSTS-MVBLE EQUIP	-18, 192					2.
	201 AMB EQUIP	0					2.
	400 EMPLOYEE BENEFITS DEPARTMENT	0	-,,				4.
	590 ADMI NI STRATI VE & GENERAL 570 ADMI TTI NG	-1, 463, 407	3, 948, 705 497, 290				5.
	570 ADMITTING 580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0					5
	700 OPERATION OF PLANT	0	1, 620, 008				7
	701 AMB PLANT OPS	0	0				7.
	800 LAUNDRY & LINEN SERVICE	0	294, 065				8.
	900 HOUSEKEEPI NG	0					9
	000 DI ETARY	0					10
	100 CAFETERI A	-138, 732					11
	300 NURSI NG ADMI NI STRATI ON	-9, 978					13
1.00 014	400 CENTRAL SERVICES & SUPPLY	0	338, 769				14
. 00 015	500 PHARMACY	0	1, 489, 665				15
. 00 016	600 MEDICAL RECORDS & LIBRARY	-22, 685	-22, 685				16
	700 SOCIAL SERVICE	0	286, 324				17
	PATIENT ROUTINE SERVICE COST CENTERS		Г Г				4
	000 ADULTS & PEDIATRICS	0					30
	100 I NTENSI VE CARE UNI T	0					31
	300 NURSERY	0	174, 589				43
	CILLARY SERVICE COST CENTERS	0	1, 196, 761				50
	200 DELIVERY ROOM & LABOR ROOM	0					52
	300 ANESTHESI OLOGY	-1, 149, 666	-				53
	400 RADI OLOGY-DI AGNOSTI C	1, 117, 000	2,041,923				54
	000 LABORATORY	-2, 539					60
	500 RESPI RATORY THERAPY	0					65
. 00 066	600 PHYSI CAL THERAPY	0					66
. 00 067	700 OCCUPATI ONAL THERAPY	-1, 464	43, 409				67
. 00 068	800 SPEECH PATHOLOGY	0	1, 810				68
. 00 069	900 ELECTROCARDI OLOGY	0	398, 717				69
. 00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 445, 265				71
	200 IMPL. DEV. CHARGED TO PATIENT	0					72
	300 DRUGS CHARGED TO PATIENTS	0	1, 633, 512				73
	TPATIENT SERVICE COST CENTERS						4
	000 CLINIC	0					90
	001 SENI OR CARE	0					90
	100 EMERGENCY	0	2, 040, 729				91
	200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92
	500 AMBULANCE SERVICES	-34, 737	2, 369, 945				95
	100 HOME HEALTH AGENCY	-34, 737					101
	ECIAL PURPOSE COST CENTERS	0	020,000				1.01
	300 I NTEREST EXPENSE	0	0				113
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	-2, 874, 847					118
	NREI MBURSABLE COST CENTERS						1
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190
	200 PHYSICIANS' PRIVATE OFFICES	0	10, 675, 517				192
	950 MARKETI NG	0	403, 389				194
	951 PHYSICIAN BILLING	0	645, 820				194
4.02079		0	0				194
	953 FOUNDATI ON	0	-				194
0.00	TOTAL (SUM OF LINES 118 through 199)	-2, 874, 847	52, 819, 047				200

	Financial Systems		HARRI SON COUNT	Y HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider C	CN: 15-1331	Peri od:	Worksheet A-	6
						From 01/01/2017 To 12/31/2017	Date/Time Pr	enared
						10 12/31/2017	5/22/2018 1:	57 pm
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A – EKG							
1.00	ELECTROCARDI OLOGY	69.00	15, 872	21, 652				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00	TOTALS	0.00	10					5.00
	B - INTEREST		15, 872	21, 652				-
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	215, 105				1.00
1.00	FIXT	1.00	0	215, 105				1.00
	TOTALS	+		215, 105				
	C - CAFETERIA	I		210,100				
1.00	CAFETERIA	11.00	203, 595	181, 814				1.00
	TOTALS		203, 595	181, 814				
	D - NURSERY	I						
1.00	NURSERY	43.00	174, 362	0				1.00
	TOTALS		174, 362	0				
	E - AMBULANCE CAPITAL							1
1.00	AMB DEPR	1. 02	0	66, 628				1.00
2.00	AMB_EQUIP	2.01	<u>0</u> <u>0</u>	109, 339				2.00
	TOTALS		0	175, 967				
	F - IMPLANTABLE DEVICES							_
1.00	IMPL. DEV. CHARGED TO	72.00	0	976, 084				1.00
	PATI ENT		+					
	TOTALS		0	976, 084				-
1 00	G - PHARMACY	45.00	055 (00	400.007				1 00
1.00	PHARMACY		355, 638	402, 227				1.00
	TOTALS H - SPEECH PATHOLOGY		355, 638	402, 227				-
1.00	SPEECH PATHOLOGY	68.00	1, 763	47				1.00
1.00	TOTALS	00.00	<u> </u>	4747				1.00
	I - SUPPLIES		1,703	47				-
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	2, 421, 349				1.00
1.00	PATI ENTS	71.00	Ŭ	2, 421, 347				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00		0.00	о	0				5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00		0.00	О	0				8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15.00	$\square \square \square \square \square \square$	0.00	0	0				15.00
	TOTALS		0	2, 421, 349				
500.00	Grand Total: Increases		751, 230	4, 394, 245				500.00

CLASS	SI FI CATI ONS			Provi der	CCN: 15-1331	Peri od:	Worksheet A-6
						From 01/01/2017 To 12/31/2017	Date/Time Prepare 5/22/2018 1:57 pr
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	-	
	6.00	7.00	8.00	9.00	10.00		
	A – EKG						
00	INTENSIVE CARE UNIT	31.00	387	C		0	1
00	LABORATORY	60.00	14, 837	C		0	2
00	EMERGENCY	91.00	577	C		0	3
00	AMBULANCE SERVICES	95.00	71	C		0	4
00	RESPIRATORY_THERAPY	65.00	0	21,652		0	5
	TOTALS		15, 872	21, 652			
	B – INTEREST						
00	INTEREST EXPENSE	1 <u>13.</u> 00	0	21 <u>5, 1</u> 05		11	1
	TOTALS		0	215, 105			
	C – CAFETERIA				1	- 1	
00	DI ETARY		203, 595	<u>181, 8</u> 14	·	0	1
	TOTALS		203, 595	181, 814			
	D - NURSERY				T	- 1	
00	ADULTS & PEDIATRICS		174, 362	C		Q	1
	TOTALS		174, 362	C)		
	E - AMBULANCE CAPITAL		I		1		
	AMBULANCE SERVICES	95.00	0	175, 967		9	1
00		0.00	0	0	<u> </u>	9	2
	TOTALS		0	175, 967			
	F - IMPLANTABLE DEVICES				1		
00	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	976, 084		0	1
	PATIENTS	+			<u> </u>	_	
	TOTALS		0	976, 084			
	G - PHARMACY	70.00	055 (00	400.007	1		
00	DRUGS_CHARGED_TO_PATIENTS	73.00	355, 638	402, 227		Ō	1
	TOTALS		355, 638	402, 227			
	H - SPEECH PATHOLOGY		1 7 (0		1		
00	PHYSICAL THERAPY		<u> </u>	47		Ō	1
	TOTALS		1, 763	47			
~~		14.00		1 () 4 1 4 4		0	1
00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 634, 144		0	1
00	ADULTS & PEDIATRICS	30.00	-	31, 232			2
00 00	I NTENSI VE CARE UNI T NURSERY	31.00 43.00	0	3, 082 47		0	3
	OPERATING ROOM	43.00 50.00	0	47 221, 073		0	5
			0			0	
00	ANESTHESI OLOGY	53.00	0	11, 667			6
00	RADI OLOGY-DI AGNOSTI C LABORATORY	54.00	0	129, 199		0	7
)0)0	RESPI RATORY THERAPY	60.00 65.00	0	170, 137 33, 370		0	8
		65.00	0			-	
	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66.00	0	434		0	10
		69.00 73.00	0	3, 228	2	0	
	DRUGS CHARGED TO PATIENTS	73.00	0	83, 661		-	12
		90.00	0	31, 337		0	13
		91.00	0	7, 599		0	14
00	AMBULANCE_SERVICES	<u>95.00</u>	<u>v</u>	61, 139		<u>o</u>	15
	TOTALS		0	2, 421, 349			

Heal th	Financial Systems	HARRI SON COUN	TY HOSPITAL			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1331		iod: m 01/01/2017 12/31/2017		pared: 7 pm
			·	Acqui si ti on	s			
		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	3, 001, 138			0	0	0	1.00
2.00	Land Improvements	3, 379, 433	0		0	0	0	2.00
3.00	Buildings and Fixtures	36, 161, 293	4, 245, 385		0	4, 245, 385	0	3.00
4.00	Building Improvements	799, 691	3, 509, 712		0	3, 509, 712	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	26, 949, 530	1, 175, 456		0	1, 175, 456	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	70, 291, 085	8, 930, 553		0	8, 930, 553	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	70, 291, 085	8, 930, 553		0	8, 930, 553	0	10.00
	· · · ·	Ending Balance	Fully					
		Ũ	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	3, 001, 138	0					1.00
2.00	Land Improvements	3, 379, 433	0					2.00
3.00	Buildings and Fixtures	40, 406, 678	0					3.00
4.00	Building Improvements	4, 309, 403	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	28, 124, 986	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	79, 221, 638	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	79, 221, 638	0					10.00

^{5/22/2018 1:57} pm

Heal th	Financial Systems	HARRI SON COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2017 To 12/31/2017		pared:
			SL	JMMARY 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 WOR	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 988, 556	0	(42, 622	0	1.00
1.01	MOB	364, 439	73, 492	242, 67	14, 040	0	1.01
1.02	AMB DEPR	0	0	(0 0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1, 026, 161	0	(0 0	0	2.00
2.01	AMB EQUIP	0	0	(0 0	0	2.01
3.00	Total (sum of lines 1-2)	3, 379, 156	73, 492	242, 67	56, 662	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)					
	1	14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2, 031, 178				1.00
1.01	MOB	167, 195	861, 837				1.01
1.02	AMB DEPR	0	0				1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1, 026, 161				2.00
2.01	AMB EQUIP	0	0				2.01
3.00	Total (sum of lines 1-2)	167, 195	3, 919, 176	1			3.00

Heal th	Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/22/2018 1:5	pared:
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			1	·		
1.00 1.01 1.02	NEW CAP REL COSTS-BLDG & FIXT MOB AMB DEPR	51, 096, 652 0 0			2 0. 644984 0 0. 000000 0 0. 000000	0	1. 00 1. 01 1. 02
2.00	NEW CAP REL COSTS-MVBLE EQUIP AMB EQUIP	28, 124, 986 0		28, 124, 98		0	2. 00 2. 01
3.00	Total (sum of lines 1-2)	79, 221, 638		79, 221, 63			3.00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY (OF CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	1	I	1			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	-		0 1, 976, 497		1.00
1.01	MOB	0	0)	0 364, 439		1.01
1.02 2.00	AMB DEPR NEW CAP REL COSTS-MVBLE EQUIP	0			0 66,628 0 1,007,969		1.02 2.00
2.00	AMB EQUIP	0			0 1,007,989		2.00
2.01	Total (sum of lines 1-2)	0			0 3, 524, 872		3.00
3.00			SI	JMMARY OF CAPI		10,472	3.00
	Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		1		1		_
1.00	NEW CAP REL COSTS-BLDG & FIXT	193, 717			0 C	2, 212, 836	1.00
1.01	MOB	242, 671			0 167, 195		1.01
1.02	AMB DEPR	0	0			66, 628	1.02
2.00 2.01	NEW CAP REL COSTS-MVBLE EQUIP	0				1, 007, 969	2. 00 2. 01
2.01	Total (sum of lines 1-2)	436, 388	56, 662		0 167, 195	109, 339 4, 258, 609	2.01
5.00		430,300	1 50,002	1	oj 107, 195	4,200,009	5.00

	Financial Systems ENTS TO EXPENSES		HARRISON COUN	Provi der CCN: 15-1331	Peri od:	u of Form CMS-2 Worksheet A-8	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	
				Expense Classification (5/22/2018 1:5	
				To/From Which the Amount i			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
F	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	В		NEW CAP REL COSTS-BLDG & FLXT	1.00	11	1.
D1	2) Investment income - MOB		0	мов	1.01	0	1.
02	(chapter 2) Investment income - AMB DEPR		0	AMB DEPR	1.02	0	1
00 I F	(chapter 2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2
)1 1	2) Investment income - AMB EQUIP		0	AMB EQUI P	2. 01	0	2
00 1	(chapter 2) Investment income - other		0		0.00	0	3
ר סו	(chapter 2) Trade, quantity, and time		0		0.00	0	4
00 F	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5
00 F	expenses (chapter 8) Rental of provider space by		0		0.00	0	6
ר 0	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7
2	stations excluded) (chapter 21) Television and radio service		0		0.00	0	8
	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9
00 F	Provi der-based physician adjustment	A-8-2	-284, 322			0	
00 5	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11
00 F	Related organization transactions (chapter 10)	A-8-1	0			0	12
00 L	Laundry and linen service Cafeteria-employees and guests	В	0 120 722	CAFETERI A	0. 00 11. 00	0	
00 F	Rental of quarters to employee and others		-136,732		0.00	0	
00 5	Sale of medical and surgical		0		0.00	0	16
F	supplies to other than patients		0		0.00	0	17
F	Sale of drugs to other than patients	5	00 (05		0.00		17
a	Sale of medical records and abstracts	В		MEDICAL RECORDS & LIBRARY	16.00		18
e	Nursing and allied health education (tuition, fees,		0		0.00	0	19
00 \	oooks, etc.) Vending machines		0		0.00	0	
i	Income from imposition of interest, finance or penalty		0	1	0.00	0	21
00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22
r 00 A	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23
00 A	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24
00 l	therapy costs in excess of limitation (chapter 14) Jtilization review – ohysicians' compensation		0	*** Cost Center Deleted **	* 114.00		25
00 [(chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26
	COSTS-BLDG & FIXT Depreciation - MOB		0	FI XT MOB	1.01	0	26
	Depreciation - AMB DEPR Depreciation - NEW CAP REL			AMB DEPR NEW CAP REL COSTS-MVBLE	1.02 2.00	0	
0	COSTS-MVBLE EQUIP Depreciation - AMB EQUIP			EQUIP AMB EQUIP	2.01	0	
00	Non-physician Anesthetist Physicians' assistant			*** Cost Center Deleted **			28 28 29

Heal th	Financial Systems		HARRISON COUN	ITY HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period: From 01/01/2017 To 12/31/2017	Worksheet A-8 Date/Time Pre 5/22/2018 1:5	pared:
				Expense Classification o	n Worksheet A	572272010 1.5	
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3.00	4,00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	А	-15, 431	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME - OTHER A&G	В	-64, 814	ADMI NI STRATI VE & GENERAL	5.01	0	33.00
33. 01	MISCELLANEOUS INCOME -	В	-78	LABORATORY	60.00	0	33. 01
33. 02	MISCELLANEOUS INCOME - AMBULANCE SER	В	-21, 020	AMBULANCE SERVICES	95.00	0	33. 02
34.00	UNNECESSARY BORROWI NG	А		NEW CAP REL COSTS-BLDG & FLXT	1.00	9	34.00
35.00	PATI ENT TELEPHONE - DEPRECIATI ON	А	-2, 761	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	35.00
35.01	PATIENT TELEPHONE - EXPENSES	A	-7, 851	ADMI NI STRATI VE & GENERAL	5.01	0	35.01
36.00	CRNA EXPENSES	A		ANESTHESI OLOGY	53.00		
37.00	LOBBYING DUES	A	-5, 230	ADMI NI STRATI VE & GENERAL	5.01	0	
38.00	NONALLOWABLE EXPENSES - HAF FEES	А	-1, 385, 512	ADMI NI STRATI VE & GENERAL	5.01	0	38.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2, 874, 847				50.00

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

Heal th	Financial Syste	ems	HARRI SON COU	NTY HOSPITAL		In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC			Provider (Period: From 01/01/2017 To 12/31/2017		
						10 12/31/2017	5/22/2018 1:5	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remunerati on	Component	Component		ider Component	
	1.00	0.00	0.00	1.00	F 00	(00	Hours	
1.00	1.00		3.00	4.00	5.00	6.00	7.00	1.00
1.00 2.00		NURSI NG ADMI NI STRATI ON ANESTHESI OLOGY	9, 978					
2.00		LABORATORY	258, 166 24, 605					2.00
3.00 4.00		EMERGENCY	322, 543				3	
4.00 5.00		AMBULANCE SERVICES	13, 717				0	4.00 5.00
6.00	0.00		0				0	
7.00	0.00		0				0	7.00
8.00	0.00		0	0			0	8.00
9.00	0.00		0	, s			0	9,00
10.00	0.00		0	0			0	
200.00			629,009	284, 322	344, 68	7	0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		Identi fi er	Limit	Unadjusted RCE	Memberships &		of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		NURSI NG ADMI NI STRATI ON	0			0 0	-	
2.00		ANESTHESI OLOGY	0			0 0	-	2.00
3.00		LABORATORY	0	-			-	
4.00 5.00		EMERGENCY AMBULANCE SERVICES	0	-			°,	4.00 5.00
5.00 6.00	95.00	AMBULANCE SERVICES	0				°	5.00 6.00
7.00	0.00		0				0	7.00
8.00	0.00		0	u u			0	
9.00	0.00		0				0	9,00
10.00	0.00		0	-			0	
200.00	0.00		0				-	
2001.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200100
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		NURSING ADMINISTRATION	0	-		9, 978		1.00
2.00		ANESTHESI OLOGY	0			258, 166		2.00
3.00		LABORATORY	0	-		2, 461		3.00
4.00		EMERGENCY	0	-		0 0		4.00
5.00		AMBULANCE SERVICES	0	-		0 13, 717		5.00
6.00	0.00		0	C		0 0		6.00
7.00	0.00 0.00		0	-				7.00
8.00 9.00	0.00		0					8.00 9.00
9.00 10.00	0.00		0					9.00
200.00	0.00		0	-		284, 322		200.00
200.00	I	1	1 0		1	207, 322	1	200.00

PART I - GENERAL INFORMATION 1.00 PART I - GENERAL INFORMATION 1.00 Ional number of weeks worked (excluding aides) (see instructions) 52 2.00 Line 1 multiplied by 15 hours per week 780 3.00 Number of unduplicated days in which supervisor or therapist was on provider site (see instructions) 0 0.00 Number of unduplicated diffs ite visits - supervisors or therapists (see instructions) 0 0.00 Number of unduplicated offs ite visits - supervisors or therapists (see instructions) 0 0.00 Number of unduplicated offs ite visits - supervisors or therapists (see instructions) 0 0.00 Number of unduplicated offs ite visits - supervisors or therapists (see instructions) 0 1.00 Standard travel expense rate 5.50 0.00 Optional travel expense rate per mile 0.00 2.00 3.00 4.00 5.00 9.00 Total hours worked 0.00 2.50.80 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 </th								
PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides) (see instructions) 52 1.00 Total number of weeks worked (excluding aides) (see instructions) 52 2.00 Line 1 multiplied by 15 hours per week 780 3.00 Number of unduplicated days in which supervisor or therapist was on provider site (see instructions) 0 4.00 Number of unduplicated days in which therapy assistant was on provider site but neither supervisor or nor therapist was on or therapists (see instructions) 0 6.00 Number of unduplicated offsite visits - supervisors or therapists (see instructions) 0 7.00 Standard travel expense rate 0 8.00 Optional travel expense rate erate per mile 5.50 9.00 Total hours worked 0.00 2.00 3.00 4.00 5.00 9.00 Total hours worked 0.00 2.00 3.00 0.00 0.00 0.00 9.00 Total hours worked 0.00 2.00 3.00 4.00 0.00 10.00 Standard travel allowance (columns 1 and 2, 0.00 0.00 0.00 0.00 0.00 0.00 0.00 10.00 Number of miles driven (provider site)								
2.00 Line 1 multiplied by 15 hours per week 780 3.00 Number of unduplicated days in which supervisor or therapists was on provider site (see instructions) 0 4.00 Number of unduplicated days in which therapy assistant was on provider site but neither supervisor on therapists was on provider site (see instructions) 0 5.00 Number of unduplicated offsite visits - supervisors or therapists (see instructions) 0 6.00 Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapists was not present during the visit(s)) (see instructions) 0 7.00 Standard travel expense rate 5.50 8.00 Optional travel expense rate per mile 5.00 8.00 Optional travel allowance (columns 1 and 2, on 0 0.00 12,500.80 0.00 0.00 9.00 Total hours worked 0.00 12,500.80 0.00 0.00 0.00 10.00 2.00 3.00 4.00 0.00 0.00 0.00 0.00 10.00 Number of travel hours (provider site) 0 0 0 0.00 0.00 0.00 0.00 10.00 Number of miles driven (provider site) 0 <								
3.00 Number of unduplicated days in which supervisor or therapist was on provider site (see instructions) 0 4.00 Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site is to unduplicated offsite visits - supervisors or therapists (see instructions) 0 5.00 Number of unduplicated offsite visits - supervisors or therapists (see instructions) 0 6.00 Number of unduplicated offsite visits - therapy assistants (include only visit smade by therapy assistant and on which supervisor and/or therapists was not present during the visit(s)) (see instructions) 0 7.00 Standard travel expense rate 5.50 8.00 Optional travel expense rate per mile 5.00 9.00 Total hours worked 0.00 2.00 3.00 4.00 5.00 9.00 Total hours worked 0.00 2.00 3.00 0.00 0.00 10.00 2.00 3.00 0.00 0.00 0.00 0.00 10.00 Standard travel allowance (column 3, ine 0) 0.00 63.70 0.00 0.00 0.00 12.01 Number of miles driven (provider site) 0 0 0 0 0 0 0 0								
nor therapist was on provider site (see instructions) 0 5.00 Number of unduplicated offsite visits - supervisors or therapists (see instructions) 0 6.00 Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions) 0 7.00 Standard travel expense rate 5.50 8.00 Optional travel expense rate per mile 5.00 9.00 Total hours worked 0.00 12.00 3.00 4.00 5.00 9.00 Total hours worked 0.00 12.50.80 0.00 0.00 0.00 10.00 2.00 3.00 4.00 5.00 0.00								
5.00 Number of unduplicated offsite visits - supervisors or therapists (see instructions) 0 6.00 Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions) 0 7.00 Standard travel expense rate 5.50 0.00 Optional travel expense rate per mile 5.50 9.00 Total hours worked 0.00 2.00 3.00 4.00 5.00 9.00 Total hours worked 0.00 63.70 0.00 0.00 0.00 10.00 AtsEA (see instructions) 0.00 63.70 0.00 0.00 0.00 10.00 Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10) 0								
6.00 Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions) 0 7.00 Standard travel expense rate expense rate expense rate per mile 5.50 8.00 Optional travel expense rate per mile 5.50 9.00 Total hours worked 0.00 2.00 3.00 4.00 5.00 9.00 Total hours worked 0.00 12,500.80 0.00 0.00 0.00 0.00 AHSEA (see instructions) 0.00 63.70 0.00 0.00 0.00 0.01 Standard travel allowance (column 3, an one-half of colum 2, line 10) 0								
instructions) instructions instructions instructions 7.00 Standard travel expense rate 5.50 8.00 Optional travel expense rate per mile 5.50 0.00 Total hours worked 0.00 2.00 3.00 4.00 5.00 9.00 Total hours worked 0.00 12,500.80 0.00 0.00 0.00 10.00 AHSEA (see instructions) 0.00 63.70 0.00 0.00 0.00 11.00 Standard travel allowance (columns 1 and 2, one-hal f of column 3, line 10) 0.00 63.70 0.00 0.00 0.00 12.00 Number of travel hours (provider site) 0 0 0 0 0 13.00 Number of miles driven (provider site) 0 0 0 0 0 13.01 Number of miles driven (provider site) 0 0 0 0 0 14.00 Supervisors (column 1, line 9 times column 1, line 10) 0 0 0 0 13.01 Number of miles driven (provider site) 0 0 0 0 0 14.00								
8.00 Optional travel expense rate per mile 0.00 Supervisors Therapists Assistants Ai des Trai nees 9.00 Total hours worked 0.00 2.00 3.00 4.00 5.00 9.00 Total hours worked 0.00 12,500.80 0.00 0.00 0.00 10.00 AHSEA (see instructions) 0.00 63.70 0.00 0.00 0.00 11.00 Standard travel allowance (columns 1 and 2, one-half of column 3, line 10) 31.85 31.85 0.00 0.00 0.00 0.00 12.01 Number of travel hours (provider site) 0								
SupervisorsTherapistsAssistantsAidesTrainees1.002.003.004.005.009.00Total hours worked0.002.003.004.005.0010.00AHSEA (see instructions)0.0063.700.000.000.0011.00Standard travel allowance (columns 1 and 2, one-half of colum 2, line 10; column 3, one-half of colum 3, line 10)31.8531.850.000.000.0012.00Number of travel hours (provider site)000000013.00Number of miles driven (provider site)000000013.01Number of miles driven (offsite)0000000014.00Supervisors (column 1, line 9 times column 1, line 10)1.00796, 301000015.00Assistants (column 2, line 9 times column 2, line 10)796, 3010000016.00Assistants (column 3, line 9 times column 3, line10)796, 3010000017.00Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)796, 301000018.00Aides (column 4, line 9 times column 5, line 10)00000019.00Frainees (column 5, line 9 times column 5, line 10)0000019.00Frainees (column 5, line 9 times column 5,								
I.00 2.00 3.00 4.00 5.00 9.00 Total hours worked 0.00 12,500.80 0.00<								
10.00 AHSEA (see instructions) 0.00 63.70 0.00 0.00 0.00 11.00 Standard travel allowance (columns 1 and 2, one-half of column 3, line 10) 31.85 31.85 0.00 0.00 0.00 12.00 Number of travel hours (provider site) 0 0 0 0 0 12.01 Number of travel hours (offsite) 0 0 0 0 0 13.01 Number of miles driven (provider site) 0 0 0 0 0 13.01 Number of miles driven (offsite) 0 0 0 0 0 14.00 Supervisors (column 1, line 9 times column 1, line 10) 1.00 0 0 0 15.00 Therapists (column 3, line 9 times column 1, line 10) 796, 301 0 0 16.00 Assistants (column 3, line 9 times column 3, line10) 0 0 0 17.00 Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others) 796, 301 0 18.00 Aides (column 4, line 9 times column 5, line 10) 0 0 0 0								
11.00 Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10) 31.85 31.85 0.00 12.00 Number of travel hours (provider site) 0 0 0 12.01 Number of travel hours (offsite) 0 0 0 13.00 Number of miles driven (provider site) 0 0 0 13.01 Number of miles driven (offsite) 0 0 0 14.00 Supervisors (column 1, line 9 times column 1, line 10) 1.00 14.00 Supervisors (column 2, line 9 times column 1, line 10) 0 15.00 Therapists (column 2, line 9 times column 1, line 10) 796, 301 16.00 Assistants (column 3, line 9 times column 3, line10) 0 17.00 Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others) 796, 301 18.00 Aides (column 4, line 9 times column 5, line 10) 0 19.00 Trainees (column 5, line 9 times column 5, line 10) 0								
one-half of column 3, line 10) 0 0 0 12.00 Number of travel hours (provider site) 0 0 0 12.01 Number of travel hours (offsite) 0 0 0 13.00 Number of miles driven (provider site) 0 0 0 13.01 Number of miles driven (offsite) 0 0 0 13.01 Number of miles driven (offsite) 0 0 0 I.00 Part 11 - SALARY EQUIVALENCY COMPUTATION 14.00 Supervisors (column 1, line 9 times column 1, line 10) 0 15.00 Therapists (column 2, line 9 times column 2, line 10) 796, 301 16.00 Assistants (column 3, line 9 times column 3, line10) 0 17.00 Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others) 796, 301 18.00 Aides (column 4, line 9 times column 4, line 10) 0 0 19.00 Trainees (column 5, line 9 times column 5, line 10) 0 0								
12.00 Number of travel hours (provider site) 0 0 0 12.01 Number of travel hours (offsite) 0 0 0 13.00 Number of miles driven (provider site) 0 0 0 13.01 Number of miles driven (offsite) 0 0 0 13.01 Number of miles driven (offsite) 0 0 0 13.01 Number of miles driven (offsite) 0 0 0 Interval bours (column of miles driven (offsite) Interval bours (column of miles column of miles driven (column								
13.00 Number of miles driven (provider site) 0 0 0 0 13.01 Number of miles driven (offsite) 0 0 0 0 13.01 Number of miles driven (offsite) 0 0 0 0 13.01 Number of miles driven (offsite) 0 0 0 13.01 Number of miles driven (offsite) 0 0 14.00 Supervisors (column 1, line 9 times column 1, line 10) 0 15.00 Therapists (column 2, line 9 times column 2, line 10) 0 16.00 Assistants (column 3, line 9 times column 3, line10) 796, 301 17.00 Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all 796, 301 0 18.00 Aides (column 4, line 9 times column 4, line 10) 0 0 19.00 Trainees (column 5, line 9 times column 5, line 10) 0								
13.01 Number of miles driven (offsite) 1.00 Part II - SALARY EQUIVALENCY COMPUTATION 14.00 Supervisors (column 1, line 9 times column 1, line 10) 0 15.00 Therapists (column 2, line 9 times column 2, line 10) 0 16.00 Assistants (column 3, line 9 times column 3, line10) 796, 301 17.00 Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others) 796, 301 18.00 Aides (column 4, line 9 times column 5, line 10) 0 19.00 Trainees (column 5, line 9 times column 5, line 10) 0								
Part II - SALARY EQUIVALENCY COMPUTATION14.00Supervisors (column 1, line 9 times column 1, line 10)015.00Therapists (column 2, line 9 times column 2, line 10)796, 30116.00Assistants (column 3, line 9 times column 3, line10)017.00Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)796, 30118.00Aides (column 4, line 9 times column 4, line 10)019.00Trainees (column 5, line 9 times column 5, line 10)0								
Part II - SALARY EQUIVALENCY COMPUTATION14.00Supervisors (column 1, line 9 times column 1, line 10)015.00Therapists (column 2, line 9 times column 2, line 10)796, 30116.00Assistants (column 3, line 9 times column 3, line10)017.00Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)796, 30118.00Aides (column 4, line 9 times column 4, line 10)019.00Trainees (column 5, line 9 times column 5, line 10)0								
15.00Therapists (column 2, line 9 times column 2, line 10)796,30116.00Assistants (column 3, line 9 times column 3, line10)017.00Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)796,30118.00Aides (column 4, line 9 times column 4, line 10)019.00Trainees (column 5, line 9 times column 5, line 10)0								
16.00Assistants (column 3, line 9 times column 3, line10)017.00Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)796, 30118.00Aides (column 4, line 9 times column 4, line 10)019.00Trainees (column 5, line 9 times column 5, line 10)0								
others) 18.00 Aides (column 4, line 9 times column 4, line 10) 19.00 Trainees (column 5, line 9 times column 5, line 10) 0								
18.00 Aides (column 4, line 9 times column 4, line 10) 0 19.00 Trainees (column 5, line 9 times column 5, line 10) 0								
Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 796, 30 If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or								
occupational therapy, line 2, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00 Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 0.00								
for respiratory therapy or columns 1 thru 3, line 9 for all others) 22.00 Weighted allowance excluding aides and trainees (line 2 times line 21) 0								
23.00 Total salary equivalency (see instructions) 796, 301								
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE Standard Travel Allowance								
24.00 Therapists (line 3 times column 2, line 11) 0								
25.00Assistants (line 4 times column 3, line 11)026.00Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)0								
27.00 Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all 0								
others) 28.00 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 0								
27)								
Optional Travel Allowance and Optional Travel Expense 29.00 Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) 0								
30.00 Assistants (column 3, line 10 times column 3, line 12) 0								
31.00Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)032.00Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of0								
columns 1-3, line 13 for all others)								
33.00Standard travel allowance and standard travel expense (line 28)034.00Optional travel allowance and standard travel expense (sum of lines 27 and 31)0								
34.00Optional travel allowance and standard travel expense (sum of lines 27 and 31)035.00Optional travel allowance and optional travel expense (sum of lines 31 and 32)0								
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense 36.00 Therapists (line 5 times column 2, line 11) 0								
37.00Assistants (line 6 times column 3, line 11)0								
00 Subtotal (sum of lines 36 and 37) 0								
39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) 0 Optional Travel Allowance and Optional Travel Expense 0								
39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) 0 Optional Travel Allowance and Optional Travel Expense 0 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 0								
39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) 0 Optional Travel Allowance and Optional Travel Expense 0								
39.00Standard travel expense (line 7 times the sum of lines 5 and 6)0Optional Travel Allowance and Optional Travel Expense040.00Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)041.00Assistants (column 3, line 12.01 times column 3, line 10)042.00Subtotal (sum of lines 40 and 41)043.00Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)0								
39.00Standard travel expense (line 7 times the sum of lines 5 and 6)0Optional Travel Allowance and Optional Travel Expense40.00Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)041.00Assistants (column 3, line 12.01 times column 3, line 10)042.00Subtotal (sum of lines 40 and 41)0								

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provider C	CN: 15-1331	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/22/2018 1:5	pared:
					Respi ratory Therapy	Cost	
						1.00	
45.00	Optional travel allowance and standard travel	expense (sum	of lines 39 ar	nd 42 - see ir	nstructions)	0	45.00
6.00	Optional travel allowance and optional travel		of lines 42 ar			0	46.00
		Therapists 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0. (0.00	0.00	47. OC
8.00	Overtime rate (see instructions)	0. 00	0.00				48.00
9.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00	0. (0.00		49.00
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0.00	0.00	50.00
1.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE	0. 00	0.00	0. (0.00	0.00	51.00
2.00	Adjusted hourly salary equivalency amount	63.70	0.00	0. (0.00		52.00
3. 00	(see instructions) Overtime cost limitation (line 51 times line	0	C		0 0		53.00
4. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	C		0 0		54.00
5.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	C		0 0		55.00
5.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	C		0 0	0	56.00
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND FYCESS COST				1.00	
7.00	Salary equivalency amount (from line 23)	IND EACESS COST	ADJUSTMENT			796, 301	57.00
3.00 9.00 0.00 1.00 2.00 3.00 4.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63	es (from lines your records)	44, 45, or 46)))		0 0 0 796, 301 481, 085	58.00 59.00 60.00 61.00 62.00 63.00 64.00
	LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory				others		100. 00 100. 01
	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	-					100. 02
01.01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 00 101. 01 101. 02
	Line $31 =$ line 29 for respiratory therapy or Line $32 =$ line 8 times columns 1 and 2, line				umns 1-3, line		102. 00 102. 01
02. 02	13 for all others Line 35 = sum of lines 31 and 32					0	102. 02

27. 00 Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others) 0 27. 00 28. 00 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 0) 0 28. 00 27. 00 Optional Travel Allowance and Optional Travel Expense 0 28. 00 28. 00 27. 00 Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) 0 29. 00 30. 00 Assistants (column 3, line 10 times column 3, line 12) 0 30. 00 31. 00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 0 31. 00 32. 00 Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of lines 20 and 30 for all others) 0 32. 00 33. 00 Standard travel allowance and standard travel expense (line 28) 0 33. 00	REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	HARRI SON COUN FURNI SHED BY	TY HOSPITAL Provider CC		In Lie Period: From 01/01/2017 To 12/31/2017 Occupational Therapy	u of Form CMS- Worksheet A-8 Parts I-VI Date/Time Pre 5/22/2018 1:5 Cost	-3 pared:		
Barr I GRAPAL INFORMATION				·			1.00			
2.00 Line 1 multiplied by 15 hours per week 190 3.00 Number of undapi Cated days in which therapy says tant we on provider site (see instructions) 4.00 4.00 Number of undapi Cated days in which therapy says tant we on provider site (see instructions) 4.00 6.00 Number of undapi Cated days in which therapy says tant wes on provider site (see instructions) 4.00 6.00 Number of undapi Cated drift is visits - therapy says starts (inclue and y visits mask by therapy assistant and or which supervises and/or therapists was not present during the visit(s)) 4.00 7.00 Saturet and or which supervises and/or therapists was not present during the visit(s)) 4.00 0.00 7.01 Saturet and or which supervises and/or therapists Assistants Additional transmission 0.00 7.01 Saturet and and therapy saturet and/or therapists Assistants Additional transmission 0.00 7.02 Saturet and and/or therapists Assistants Additional transmission 0.00 0.										
3:00 Number of undeplicated days in which supervisor or therapist as an provider site (see Instruction) 0			s) (see instruc	tions)				•		
4.00 Number of undpillicated days in which therapy assistant wis on provider site but neither supervisor in an expension of an additional expension of additional expension expension expension expension expension expension expension expe			sor or theranis	t was on provid	der site (see	instructions)		•		
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assistant and in which supervisor and/or therapist was not present during the visit(s) (see							-	•		
Instructions) Instructions Stode Stode </td <td>6.00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>6.00</td>	6.00						0	6.00		
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33.00Standard travel allowance and standard travel expense (line 28)033.0034.00Optional travel allowance and standard travel expense (sum of lines 27 and 31)034.0035.00Optional travel allowance and optional travel expense (sum of lines 31 and 32)035.00Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense036.0036.00Therapists (line 5 times column 2, line 11)036.0037.00Assistants (line 6 times column 3, line 11)037.0038.00Subtotal (sum of lines 36 and 37)038.0039.00Optional Travel Allowance and Optional Travel Expense039.0040.00Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)040.0041.00Assistants (column 3, line 12.01 times column 3, line 10)041.0043.00Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)043.0044.00Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)043.00	32.00		s 1 and 2, line	13 for respira	atory therapy	or sum of	0	32.00		
34.00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) 0 34.00 35.00 Optional travel allowance and optional travel expense (sum of lines 31 and 32) 0 35.00 Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 0 36.00 36.00 Therapists (line 5 times column 2, line 11) 0 36.00 37.00 Assistants (line 6 times column 3, line 11) 0 37.00 38.00 Subtotal (sum of lines 36 and 37) 0 38.00 39.00 Dptional Travel Allowance and Optional Travel Expense 0 39.00 00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 0 40.00 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 0 41.00 42.00 Subtotal (sum of lines 40 and 41) 0 42.00 43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 43.00 704, as appropriate. 0 43.00 0 43.00	33 00		evnense (line	28)			0	33 00		
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Standard Travel Expense36.00Therapists (line 5 times column 2, line 11)036.0037.00Assistants (line 6 times column 3, line 11)037.0038.00Subtotal (sum of lines 36 and 37)038.0039.00Standard travel expense (line 7 times the sum of lines 5 and 6)039.00Optional Travel Allowance and Optional Travel Expense040.0040.00Therapists (sum of lines 40 and 41)041.0043.00Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)043.00Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.43.00	35.00							35.00		
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37.00Assistants (line 6 times column 3, line 11)037.0038.00Subtotal (sum of lines 36 and 37)038.0039.00Standard travel expense (line 7 times the sum of lines 5 and 6)039.00Optional Travel Allowance and Optional Travel Expense040.0040.00Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)040.0041.00Assistants (column 3, line 12.01 times column 3, line 10)041.0042.00Subtotal (sum of lines 40 and 41)042.000Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)042.0043.00Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.43.00	36.00						0	36.00		
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42.00Subtotal (sum of lines 40 and 41)042.0043.00Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)043.00Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.43.00	40.00			2, line 10)			0	40.00		
43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 43.00 Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 0		Assistants (column 3, line 12.01 times column		-				•		
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			n of columns 1	3 line 13 01)				•		
or 46, as appropriate.	45.00				e of the foll	owing three line		+3.00		
44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00	44.00	or 46, as appropriate.		•				44.65		
	44.00	Standard travel allowance and standard travel	expense (sum	or lines 38 and	u 39 - see in	STRUCTIONS)	0	44.00		

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provider C	CN: 15-1331	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8 Parts I-VI Date/Time Pre 5/22/2018 1:5	pared:
					Occupational Therapy	Cost	
						1.00	
5.00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	d 42 - see in	nstructions)	0	45.00
6.00	Optional travel allowance and optional travel		of lines 42 an			0	46.00
	-	Therapists 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4.00	<u>Total</u> 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	5.00	4.00	5.00	
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0. 0	0.00	0.00	47. OC
	Overtime rate (see instructions)	0.00	0.00				48. OC
9.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.0	0. 00		49.00
	CALCULATION OF LIMIT	I					
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0.00	0.00	50. 00
	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	00 0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE	74 00	0.00	0.0			E2 00
2.00	Adjusted hourly salary equivalency amount (see instructions)	76. 82	0.00	0.0	0.00		52.00
	Overtime cost limitation (line 51 times line 52)	0	0		0 0 0 0		53.00
4.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
5.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55. OC
5. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56.00
	respiratory therapy and columns 1 through 3 for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			1.00	
8.00 9.00 0.00 1.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions)	•)		43, 409 0 0 0	58.00 59.00 60.00 61.00
	Supplies (see instructions) Total allowance (sum of lines 57-62)					0 43, 409	
	Total cost of outside supplier services (from	your records)				43, 409 44, 873	
	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION		, enter zero)			1, 464	
00. 01 00. 02	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27	sum of lines 2 therapy or su	4 and 25 for a m of lines 3 a	II others nd 4 for all	others	0	100. 00 100. 01 100. 02
01. 00 01. 01	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31				others	0	101. 00 101. 01 101. 02
02.00	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or	sum of lines 2	9 and 30 for a	II others			102.00
12 01	Line 32 = line 8 times columns 1 and 2, line	13 for respira	tory therapy o	r sum of colu	ımns 1-3, line		102. 01
2.01	13 for all others						

Heal th	Financial Systems	HARRI SON COUN	TY HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1331	Period: From 01/01/2017	Worksheet B Part I	
					To 12/31/2017	Date/Time Pre	pared:
					RELATED COSTS	5/22/2018 1:5	7 pm
				CAFITAL	LEATED COSTS		
	Cost Center Description	Net Expenses	NEW BLDG &	MOB	AMB DEPR	NEW MVBLE	
		for Cost Allocation	FLXT			EQUI P	
		(from Wkst A					
		col. 7)					
		0	1.00	1.01	1.02	2.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	2, 212, 836	2, 212, 836				1.00
1.00	00101 MOB	861,837	2, 212, 000	861, 83	37		1.00
1.02	00102 AMB DEPR	66, 628	0		0 66, 628		1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	1,007,969				1, 007, 969	
2.01 4.00	00201 AMB EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	109, 339 5, 967, 453	3, 244		0 0	0 1, 478	
4.00 5.01	00590 ADMI NI STRATI VE & GENERAL	3, 948, 705	3, 244	4, 92	-	146, 999	
5.02	00570 ADMI TTI NG	497, 290	0	.,	0 0	0	
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 045, 985	0		0 0	0	
7.00	00700 OPERATION OF PLANT 00701 AMB PLANT OPS	1, 620, 008	254, 447		0 0	115, 903	
7.01 8.00	00800 LAUNDRY & LINEN SERVICE	294,065	14, 857		0 0	0 6, 767	
9.00	00900 HOUSEKEEPING	635, 233	31, 822		0 0	14, 495	
10.00	01000 DI ETARY	361, 797	92, 595		0 0	42, 178	
11.00	01100 CAFETERIA	246, 677	46, 257		0 0	21, 071	
13.00	01300 NURSI NG ADMI NI STRATI ON	729, 439	7, 785 0		0 0	3, 546	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	338, 769 1, 489, 665	0		0 0	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	-22, 685	51, 658		0 0	23, 531	
17.00	01700 SOCIAL SERVICE	286, 324	3, 114		0 0		
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				-		
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	3, 000, 560 478, 604	376, 333 46, 987		0 0 0 0	171, 425 21, 403	
	04300 NURSERY	174, 589	9, 732		0 0	4, 433	
	ANCILLARY SERVICE COST CENTERS	· · · · ·					
50.00	05000 OPERATING ROOM	1, 196, 761	287, 437		0 0		
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0 -6, 629	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2,041,923	150, 595		0 0	68, 598	
60.00	06000 LABORATORY	1, 871, 916	79, 150		0 0	36, 054	
65.00	06500 RESPI RATORY THERAPY	488, 596	17, 225		0 0	7, 846	
66.00	06600 PHYSI CAL THERAPY	264, 437	58, 276		0 0	26, 545	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	43, 409 1, 810	0		0 0	0	1
69.00	06900 ELECTROCARDI OLOGY	398, 717	29, 584		0 0	13, 476	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 445, 265	70, 651		0 0	32, 182	
	07200 I MPL. DEV. CHARGED TO PATIENT	976,084	0		0 0		72.00
/3.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	1, 633, 512	19, 885		0 0	9, 058	73.00
90.00	09000 CLINIC	72, 113	0	40, 56	53 0	0	90.00
90. 01	09001 SENI OR CARE	280, 786	0	29, 42		0	
91.00	09100 EMERGENCY	2, 040, 729	106, 382	40, 56	53 0	48, 458	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	2, 369, 945	0		0 66, 628	0	95.00
101.00	10100 HOME HEALTH AGENCY	623, 860	0	28, 74			101.00
440.00	SPECIAL PURPOSE COST CENTERS						1110.00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	41, 094, 321	2, 080, 730	144, 22	66, 628	947, 794	113.00
0. 00	NONREI MBURSABLE COST CENTERS	11,074,321	2,000,730	144, 22	00, 020	747,774	1.10.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 219		0 0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	10, 675, 517	107, 306		0 0		192.00
			0 471		0 0	1, 581	194.00
194. OC	07950 MARKETI NG	403, 389	3, 471			- · · · ·	
194. 00 194. 01	07951 PHYSICIAN BILLING	403, 389 645, 820	8, 110	717 /	0 0		194.01
194.00 194.01 194.02	07951 PHYSICIAN BILLING 07952 MOB			717, 61	0 0 15 0 0 0	0	194. 01 194. 02
194.00 194.01 194.02 194.03	07951 PHYSICIAN BILLING 07952 MOB 07953 FOUNDATION		8, 110	717, 61	0 0 5 0 0 0	0	194. 01 194. 02 194. 03
194.00 194.01 194.02	07951 PHYSICIAN BILLING 07952 MOB 07953 FOUNDATION Cross Foot Adjustments Negative Cost Centers		8, 110		0 0 0 0	0 0	194. 01 194. 02 194. 03 200. 00 201. 00

1.00 00100 1.01 00101 1.02 00102 2.00 00200 2.01 00201 4.00 00400 5.01 00590 5.02 00570 5.03 00580 7.00 00700 7.01 00700 1.00 01000 13.00 01300 14.00 01400 15.00 01500 16.00 01600 17.00 01700 18.00 03000 30.00 03000 30.00 03000 50.00 05200 52.00 05200 53.00 05300 53.00 05400 60.00 06000 67.00 06700 68.00 06800 69.00 07100 71.00 07100 72.00 07200 73.00 07300 73.00 <	2 AMB DEPR D NEW CAP REL COSTS-MVBLE EQUIP 1 AMB EQUIP EMPLOYEE BENEFITS DEPARTMENT D ADMINISTRATIVE & GENERAL D ADMITTING CASHIERING/ACCOUNTS RECEIVABLE D OPERATION OF PLANT 1 AMB PLANT OPS D LAUNDRY & LINEN SERVICE D HOUSEKEEPING D DI ETARY CAFETERIA D NURSING ADMINISTRATION	CAPI TAL <u>RELATED COSTS</u> AMB EQUI P 2. 01 109, 339 0 0 0 0 0 0 0 0 0 0 0 0 0	EMPLOYEE BENEFI TS DEPARTMENT 4. 00 5, 972, 175 353, 779 105, 244 100, 148 58, 172 0	4A 4, 777, 126 602, 534 1, 146, 133	59, 914	ADMI TTI NG 5. 02 662, 448	1.00 1.01 1.02 2.00 2.01 4.00 5.01
1.00 00100 1.01 00101 1.02 00102 2.00 00200 2.01 00201 4.00 00400 5.01 00590 5.02 00570 5.03 00580 7.00 00700 7.01 00701 8.00 08000 9.00 09000 11.00 01100 13.00 01300 14.00 01400 15.00 05200 16.00 04000 17.00 01700 11.00 03000 20.00 05200 52.00 05200 53.00 05300 54.00 05400 65.00 06600 67.00 06700 68.00 06800 69.00 07100 71.00 07100 72.00 07200 73.00 07300 90.00 09000 </th <th>NEW CAP REL COSTS-BLDG & FIXT 1 MOB 2 AMB DEPR NEW CAP REL COSTS-MVBLE EQUIP 1 AMB EQUIP D MEW CAP REL COSTS-MVBLE EQUIP 1 AMB EQUIP D EMPLOYEE BENEFITS DEPARTMENT 2 ADMI NI STRATIVE & GENERAL 2 ADMI NI STRATIVE & GENERAL 2 ADMI TTING CASHI ERI NG/ACCOUNTS RECEIVABLE 2 OPERATION OF PLANT 1 AMB PLANT OPS 2 HOUSEKEEPING 2 DI ETARY CAFETERIA NURSI NG ADMI NI STRATI ON</th> <th>109, 339 0 0 0 0 0 0 0 0 0 0 0</th> <th>5, 972, 175 353, 779 105, 244 100, 148 58, 172</th> <th>4, 777, 126 602, 534 1, 146, 133</th> <th>4, 777, 126 59, 914</th> <th>662, 448</th> <th>1.01 1.02 2.00 2.01 4.00 5.01</th>	NEW CAP REL COSTS-BLDG & FIXT 1 MOB 2 AMB DEPR NEW CAP REL COSTS-MVBLE EQUIP 1 AMB EQUIP D MEW CAP REL COSTS-MVBLE EQUIP 1 AMB EQUIP D EMPLOYEE BENEFITS DEPARTMENT 2 ADMI NI STRATIVE & GENERAL 2 ADMI NI STRATIVE & GENERAL 2 ADMI TTING CASHI ERI NG/ACCOUNTS RECEIVABLE 2 OPERATION OF PLANT 1 AMB PLANT OPS 2 HOUSEKEEPING 2 DI ETARY CAFETERIA NURSI NG ADMI NI STRATI ON	109, 339 0 0 0 0 0 0 0 0 0 0 0	5, 972, 175 353, 779 105, 244 100, 148 58, 172	4, 777, 126 602, 534 1, 146, 133	4, 777, 126 59, 914	662, 448	1.01 1.02 2.00 2.01 4.00 5.01
1.00 00100 1.01 00101 1.02 00102 2.00 00200 2.01 00201 4.00 00400 5.01 00590 5.02 00570 5.03 00580 7.00 00700 7.01 00701 8.00 08800 9.00 0900 11.00 01100 13.00 01300 14.00 01400 15.00 01500 16.00 01600 17.00 01700 10.00 03100 30.00 03000 20.00 05200 52.00 05200 53.00 05300 54.00 05400 65.00 06500 65.00 06500 65.00 06500 67.00 07100 71.00 07100 72.00 07200 13.00 07300	NEW CAP REL COSTS-BLDG & FIXT 1 MOB 2 AMB DEPR NEW CAP REL COSTS-MVBLE EQUIP 1 AMB EQUIP D MEW CAP REL COSTS-MVBLE EQUIP 1 AMB EQUIP D EMPLOYEE BENEFITS DEPARTMENT 2 ADMI NI STRATIVE & GENERAL 2 ADMI NI STRATIVE & GENERAL 2 ADMI TTING CASHI ERI NG/ACCOUNTS RECEIVABLE 2 OPERATION OF PLANT 1 AMB PLANT OPS 2 HOUSEKEEPING 2 DI ETARY CAFETERIA NURSI NG ADMI NI STRATI ON		353, 779 105, 244 100, 148 58, 172	602, 534 1, 146, 133	59, 914		1.01 1.02 2.00 2.01 4.00 5.01
1.01 00101 1.02 00102 2.00 00200 2.01 00201 4.00 00400 5.01 00590 5.02 00570 5.03 00580 7.00 00700 8.00 00800 9.00 00900 10.00 01000 11.00 01100 13.00 01500 16.00 01600 17.00 01700 10.00 03000 30.00 03000 31.00 03000 31.00 05000 52.00 05200 53.00 05300 54.00 05400 65.00 06500 65.00 06500 65.00 06500 65.00 06500 67.00 07000 71.00 07100 72.00 07200 73.00 07300 0.00 <	1 MOB 2 AMB DEPR) NEW CAP REL COSTS-MVBLE EQUI P 1 AMB EQUI P 2 EMPLOYEE BENEFITS DEPARTMENT) ADMI NI STRATI VE & GENERAL) ADMI NI STRATI VE & GENERAL) ADMI TTI NG 0 CASHI ERI NG/ACCOUNTS RECEI VABLE) OPERATI ON OF PLANT 1 AMB PLANT OPS 1 LAUNDRY & LI NEN SERVI CE) HOUSEKEEPI NG) DI ETARY 0 CAFETERI A) NURSI NG ADMI NI STRATI ON		353, 779 105, 244 100, 148 58, 172	602, 534 1, 146, 133	59, 914		1.01 1.02 2.00 2.01 4.00 5.01
30. 00 03000 31. 00 03100 43. 00 04300 ANCI L 0500 50. 00 05000 52. 00 05200 53. 00 05300 54. 00 05400 60. 00 06000 65. 00 06500 66. 00 06600 67. 00 06700 68. 00 06800 69. 00 07100 72. 00 07200 00. 00 09000 90. 00 09000 90. 00 09000 91. 00 09100 92. 00 09200 01. 00 01000 95. 00 09500 101. 00 10100 113. 00 11300	D CENTRAL SERVI CES & SUPPLY D PHARMACY D MEDI CAL RECORDS & LI BRARY D SOCI AL SERVI CE		5, 969 106, 138 44, 682 47, 598 153, 926 57, 844 231, 225 0 63, 475	2, 048, 530 0 321, 658 787, 688 541, 252 361, 603 894, 696 396, 613 1, 720, 890 52, 504 354, 331	203, 700 0 31, 985 78, 325 53, 820 35, 957 88, 966 39, 438 171, 120 5, 221	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 03 7. 00 7. 01 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
31.00 03100 43.00 04300 ANCI L 50.00 50.00 05200 52.00 05200 53.00 05300 54.00 05400 60.00 06000 65.00 06500 67.00 06700 68.00 06800 69.00 07100 71.00 07100 72.00 07200 90.00 09000 90.01 09010 91.00 09100 92.00 07200 071.00 07100 91.00 09100 92.00 09200 01.00 07100 10100 01100 113.00 11300	FIENT ROUTINE SERVICE COST CENTERS					-	1
50.00 05000 52.00 05200 53.00 05300 54.00 05400 60.00 06000 65.00 06500 66.00 06000 67.00 06700 68.00 06800 69.00 06900 71.00 07100 72.00 07200 73.00 07300 90.00 09000 90.01 09010 92.00 09200 0THER 95.00 95.00 10100 113.00 11300	D ADULTS & PEDI ATRI CS D I NTENSI VE CARE UNI T D NURSERY	0 0 0	667, 407 104, 993 40, 764	4, 215, 725 651, 987 229, 518	64, 832	54, 205 4, 844 6, 707	31.00
52.00 05200 53.00 05300 54.00 05400 60.00 06000 65.00 06500 66.00 06600 67.00 06700 68.00 06900 71.00 07100 72.00 07200 73.00 07300 90.00 09000 90.01 09010 92.00 02200 0THER 95.00 95.00 09500 10100 SPECI. 113.00 11300	LARY SERVICE COST CENTERS	0	232, 123	1, 847, 251	183, 685	49, 489	50.00
53.00 05300 54.00 05400 60.00 06000 65.00 06500 66.00 06400 67.00 06700 68.00 06800 69.00 07100 72.00 07200 73.00 07300 90.00 09000 90.01 09001 91.00 09000 92.00 07200 01TPA 95.00 95.00 09500 01100 09100 95.01 010100 SPECI 113.00	D DELIVERY ROOM & LABOR ROOM	0	232, 123	1, 647, 231		49, 489	1
60.00 06000 65.00 06500 66.00 06600 67.00 06700 68.00 06800 69.00 07100 71.00 07100 73.00 07300 90.00 09000 90.01 09001 91.00 09000 92.00 09200 01142 09100 95.00 09500 10100 10100 113.00 11300	ANESTHESI OLOGY	0	52, 799	46, 170	-	7, 712	1
65.00 06500 66.00 06600 67.00 06700 68.00 06800 69.00 06900 71.00 07100 72.00 07200 73.00 07000 90.00 09000 90.01 09000 92.00 09200 95.00 09500 101.00 10100 SPECI. 113.00	RADI OLOGY-DI AGNOSTI C	0	287, 116	2, 548, 232		177, 108	1
66.00 06600 67.00 06700 68.00 06800 69.00 06900 71.00 07100 72.00 07200 73.00 07000 90.00 09000 90.00 09000 91.00 09100 92.00 07100 01.00 07100 95.00 09500 101.00 10100 SPECI. 113.00	D LABORATORY	0	180, 673	2, 167, 793		104, 730	
67.00 06700 68.00 06800 69.00 06900 71.00 07100 72.00 07200 73.00 07300 00.00 09000 90.00 09000 90.00 09000 92.00 09200 0THER 95.00 95.00 09500 101.00 10100 SPECI. 113.00	D RESPI RATORY THERAPY D PHYSI CAL THERAPY	0	0 60, 203	513, 667 409, 461		6, 479 9, 991	
69.00 06900 71.00 07100 72.00 07200 73.00 07300 90.00 09000 90.00 09000 92.00 09000 92.00 09200 01HER 095.00 95.00 09500 101.00 10100 SPECI 113.00	OCCUPATIONAL THERAPY	0	00, 203	43, 409		1, 247	
71.00 07100 72.00 07200 73.00 07300 00.01 09000 90.00 09000 91.00 09000 92.00 09200 0THER 095.00 101.00 10100 SPECI 113.00	SPEECH PATHOLOGY	0	412	2, 222		352	
72.00 07200 73.00 017300 0UTPA 09000 90.00 09000 91.00 09000 92.00 09100 92.00 09200 00THER 95.00 95.00 09500 101.00 10100 SPECI. 113.00	DELECTROCARDI OLOGY	0	81, 647	523, 424		31, 186	
73.00 07300 OUTPA 0000 90.00 09000 91.00 09100 92.00 09200 95.00 09500 101.00 10100 SPECI. 113.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 548, 098 976, 084		31, 094 10, 642	
OUTPA 90.00 09000 90.01 09001 91.00 09200 92.00 09200 0THER 95.00 95.00 09500 101.00 SPECI. 113.00 11300	D DRUGS CHARGED TO PATIENTS	0	0	1, 662, 455		34, 244	
90. 01 09001 91. 00 09100 92. 00 09200 0THER 95. 00 09500 101. 00 10100 SPECI. 113. 00 11300	ATIENT SERVICE COST CENTERS						
91. 00 09100 92. 00 09200 0THER 95. 00 09500 101. 00 10100 SPECI. 113. 00 11300		0	5, 068				
92.00 09200 0THER 95.00 09500 101.00 10100 SPECI 113.00 11300	I SENI OR CARE DEMERGENCY	0	30, 526 351, 961	340, 735 2, 588, 093		3, 025 89, 135	
95.00 101.00 500 09500 101.00 500 500 113.00 11300	OBSERVATION BEDS (NON-DISTINCT PART)	0	331, 901	2, 566, 043		07, 135	92.00
101. 00 <u>10100</u> <u>SPECI</u> 113. 00 11300	R REIMBURSABLE COST CENTERS						
SPECI . 113. 00 11300	DAMBULANCE SERVICES	109, 339	461, 570				
113.0011300	DHOME HEALTH AGENCY	0	113, 541	766, 145	76, 183	2, 625	101.00
	AL PURPOSE COST CENTERS	1					113.00
118.00 NONRE	SUBTOTALS (SUM OF LINES 1 through 117) EIMBURSABLE COST CENTERS	109, 339	3, 999, 003	38, 211, 253	3, 324, 592	662, 448	
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	19, 240			190.00
	PHYSICIANS' PRIVATE OFFICES	0	1, 830, 493	12, 662, 195			192.00
194.0007950 194.0107951	JMARKETING 1 PHYSICIAN BILLING	0	15, 524 127, 155	423, 965 784, 779			194.00 194.01
194. 02 07952		0	127, 135	717, 615			194.01
194.0307953		0	0	0		0	194.03
200.00	2 MOB 3 FOUNDATI ON			0			200.00
201.00 202.00	2 MOB	0 109, 339	0 5, 972, 175	0 52, 819, 047	0 4, 777, 126		201.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	HARRI SON COUN	Provi der C		eriod: rom 01/01/2017	u of Form CMS- Worksheet B Part I	2002-10
			_		o 12/31/2017	Date/Time Pre 5/22/2018 1:5	pared: 7 pm
	Cost Center Description	CASHI ERI NG/ACC OUNTS RECEI VABLE	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5.03	7.00	7.01	8.00	9.00	
	GENERAL SERVICE COST CENTERS	1	1	1			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 1.02	00101 MOB 00102 AMB DEPR						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.00	00201 AMB EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590 ADMI NI STRATI VE & GENERAL						5.01
5.02	00570 ADMI TTI NG						5.02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 260, 101					5.03
7.00	00700 OPERATION OF PLANT	0	2, 252, 230				7.00
7.01	00701 AMB PLANT OPS	0	0	0			7.01
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	20, 498 43, 904	0	374, 141 33, 626	943, 543	8.00 9.00
10.00	01000 DI ETARY		127, 752		24, 803	55,095	
	01100 CAFETERIA	0	63, 820		0	27, 524	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	10, 741	0	0	4, 632	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500 PHARMACY	0	0	0	0	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	71, 272	0	-	30, 737	
17.00	01700 SOCI AL SERVI CE	0	4, 296	0	0	1, 853	17.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	103, 122	519, 221	0	148, 314	223, 924	30.00
30.00	03100 I NTENSI VE CARE UNI T	9, 215				223, 924 27, 958	
	04300 NURSERY	12,760				5, 790	
101 00	ANCI LLARY SERVI CE COST CENTERS	12,700	10/120			6,776	
50.00	05000 OPERATI NG ROOM	94, 151	396, 570	0	20, 626	171, 029	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
53.00	05300 ANESTHESI OLOGY	14, 672		0	0	0	
	05400 RADI OLOGY-DI AGNOSTI C	336, 769		0	39, 892	89,606	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	199, 242 12, 325			476	47, 095 10, 249	
66.00	06600 PHYSI CAL THERAPY	12, 325			3, 906	34, 675	
67.00	06700 OCCUPATI ONAL THERAPY	2, 372		0	0,700	0,079	1
68.00	06800 SPEECH PATHOLOGY	670		0	0	0	
69.00	06900 ELECTROCARDI OLOGY	59, 330	40, 816	0	9, 109	17, 603	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	59, 155	97, 475	0	0	42, 038	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	20, 246		0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	65, 148	27, 435	0	0	11, 832	73.00
90.00	OUTPATIENT SERVICE COST CENTERS	1, 639	0	0	1, 891	0	90.00
	09001 SENI OR CARE	5, 756				0	
	09100 EMERGENCY	169, 575			71, 934	63, 299	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				,		92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	69, 955					95.00
101.00	10100 HOME HEALTH AGENCY	4, 993	0	0	0	0	101.00
112 00	SPECIAL PURPOSE COST CENTERS	1					1112 00
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	1, 260, 101	2, 069, 967	0	367, 673	864, 939	113.00
116.00	NONREIMBURSABLE COST CENTERS	1,200,101	2,009,907	0	307,073	004, 939	1110.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18, 237	0	0	7, 865	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	148, 048		-		192.00
	07950 MARKETI NG	0	4, 789		0		194.00
	07951 PHYSICIAN BILLING	0	11, 189		0		194.01
	07952 MOB	0	0	0	0		194.02
	07953 FOUNDATI ON	0	0	0	0	0	194.03
200.00							200.00
201.00		0	0 2, 252, 230	0	0		201.00
201.00	TOTAL (sum lines 118 through 201)	1, 260, 101		0	374, 141	943, 543	

	Financial Systems	HARTSON COUNT	Y HOSPITAL	ou		u of Form CMS-2	2552-10
	LLOCATI ON - GENERAL SERVI CE COSTS		Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre 5/22/2018 1:5	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL N SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00100 New CAP REL COSTS-BLDG & FIXT						1.00
	00102 AMB DEPR						1.02
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	00201 AMB EQUIP						2.01
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00590 ADMI NI STRATI VE & GENERAL						5.01
	00570 ADMI TTI NG						5.02
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.03
	00700 OPERATION OF PLANT 00701 AMB PLANT OPS						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
1	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY	802, 722					10.00
	01100 CAFETERI A	0	488, 904	Ļ			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	14, 283	1, 013, 31	8		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	11, 913		0 447, 964		14.00
	01500 PHARMACY	0	5, 972		0 0	1, 897, 982	15.00
	01600 MEDI CAL RECORDS & LI BRARY	0	25, 495		0 2, 043	0	16.00
	01700 SOCIAL SERVICE	0	6, 081		0 435	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	618, 099	104 105	445 74	10 750	0	20.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	60, 409	104, 195 14, 704			0	30.00 31.00
	04300 NURSERY	124, 214	5, 925			0	
	ANCI LLARY SERVI CE COST CENTERS	121,211	0,720	20,10	. 20	0	10.00
	05000 OPERATI NG ROOM	0	38, 733	173, 13	8 12, 422	0	50. OC
	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	1, 247		0 1, 023	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	43, 130		0 16, 272	0	54.00
	06000 LABORATORY	0	25, 058		0 77,659	0	60.00
	06500 RESPI RATORY THERAPY	0	C		0 1, 392	0	65.00
	06600 PHYSI CAL THERAPY	0	6, 362		0 618	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	C 47			0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	47 9, 278			0	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7, 27C		0 176, 888	0	71.00
1	07200 I MPL. DEV. CHARGED TO PATIENT	0	C		0 119, 465	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	C		0 935	1, 897, 982	
	OUTPATIENT SERVICE COST CENTERS				-		
	09000 CLI NI C	0	577	2, 57		0	
	09001 SENI OR CARE	0	3, 508			0	
	09100 EMERGENCY	0	49, 773	222, 48	7 10, 770	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	0	C		0 12, 516	0	95.00
	10100 HOME HEALTH AGENCY	0	C		0 12, 516 0 0		101.00
	SPECIAL PURPOSE COST CENTERS	9		/	0 0	0	101.00
	11300 I NTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	802, 722	366, 281	1, 013, 31	8 447, 964	1, 897, 982	
ĺ	NONREIMBURSABLE COST CENTERS	·	· · ·	· · · · · ·			1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	99, 218		0 0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 559		0 0		192.00
	07950 MARKETI NG	0	21, 846		0 0		194.00
	07951 PHYSICIAN BILLING	0	C		0 0		194.01
	07952 MOB	0	C		0 0		194.02
	07953 FOUNDATION	0	C		0 0	0	194.03
200.00 201.00	Cross Foot Adjustments		~			_	200.00
	Negative Cost Centers	0	C	1	0		201.00
201.00	TOTAL (sum lines 118 through 201)	802, 722	488, 904	1, 013, 31	8 447, 964	1, 897, 982	1202 00

Heal th	Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CCI	N: 15-1331	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre 5/22/2018 1:5	epared: 57 pm
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS		<u>г</u>				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB 00102 AMB DEPR						1.01
1.02 2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.00	00201 AMB EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590 ADMI NI STRATI VE & GENERAL						5.01
5.02	00570 ADMI TTI NG						5. 02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.03
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 AMB PLANT OPS						7.01
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	187, 272					16.00
17.00	01700 SOCIAL SERVICE	0	402, 230				17.00
30, 00	03000 ADULTS & PEDI ATRI CS	15, 325	309, 719	7, 207, 54	2 0	7, 207, 542	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 369		999, 41		999, 415	1
43.00	04300 NURSERY	1, 896	62, 241	511, 81	5 0	511, 815	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	40.004		0.001.00		0.001.005	1 50 00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	13, 991 0	1 1	3, 001, 08	0 0	3, 001, 085 0	
53.00	05300 ANESTHESI OLOGY	2, 180		77, 59	-	77, 595	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	50, 058		3, 762, 22		3, 762, 229	1
60.00	06000 LABORATORY	29, 609	1 1	2, 975, 94		2, 975, 946	
65.00	06500 RESPI RATORY THERAPY	1, 832		621, 26		621, 263	1
66.00	06600 PHYSI CAL THERAPY	2, 824		607, 96		607, 961	1
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	353 100		51, 69		51, 697	1
69.00	06900 ELECTROCARDI OLOGY	8, 817		3, 61 794, 16		3, 612 794, 163	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 791		2, 117, 47		2, 117, 477	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3, 009		1, 226, 50		1, 226, 505	
73.00	07300 DRUGS CHARGED TO PATIENTS	9, 681	0	3, 875, 02	2 0	3, 875, 022	73.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS					107.101	
		244		137, 42		1077 121	
	09001 SENI OR CARE 09100 EMERGENCY	855 25, 200		403, 66 3, 694, 39		403, 663 3, 694, 391	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	23, 200		5, 074, 55	0		92.00
	OTHER REIMBURSABLE COST CENTERS		· · ·				
	09500 AMBULANCE SERVICES	10, 396	1 1	3, 449, 27			
101.00	10100 HOME HEALTH AGENCY	742	0	850, 68	8 0	850, 688	101.00
112 00	SPECIAL PURPOSE COST CENTERS		1				112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	187, 272	402, 230	36, 368, 76	0	36, 368, 761	113.00
110.00	NONREIMBURSABLE COST CENTERS	107,272	402,230	30, 300, 70	0	30, 300, 701	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	146, 47	/3 0	146, 473	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	14, 141, 18	0	14, 141, 189	
	07950 MARKETI NG	0	0	494, 82		494, 823	
	07951 PHYSICIAN BILLING	0	0	878, 82		878, 829	
		0	0	788, 97		788, 972	
194.03 200.00	07953 FOUNDATION Cross Foot Adjustments	0					194.03 200.00
200.00		n	0		0 0		200.00
202.00		187, 272	402, 230	52, 819, 04			

	Financial Systems	HARRI SON COUN		N. 1E 1001		u of Form CMS-	2552-10
ALLUCA	TION OF CAPITAL RELATED COSTS		Provider CC	N: 15-1331	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre 5/22/2018 1:5	epared:
			CAPI TAL RELATED COSTS				
	Cost Center Description	Di rectl y Assi gned New Capi tal	NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUI P	
		Related Costs 0	1.00	1.01	1. 02	2.00	
	GENERAL SERVICE COST CENTERS	1					
1.00 1.01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB						1.00
1.01	00102 AMB DEPR						1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 AMB EQUIP						2.01
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL	0	3, 244 322, 714	4, 92	0 0 29 0		
5.01	00570 ADMINISTRATIVE & GENERAL	0	322, 714	4, 72	0 0		1
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0		0 0		1
7.00	00700 OPERATION OF PLANT	0	254, 447		0 0	115, 903	7.00
7.01	00701 AMB PLANT OPS	0	0		0 0		
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	14, 857 31, 822		0 0	6, 767 14, 495	
9.00 10.00	01000 DI ETARY	0	92, 595		0 0	42, 178	
11.00	01100 CAFETERI A	0	46, 257		0 0		
13.00	01300 NURSI NG ADMI NI STRATI ON	0	7, 785		0 0	3, 546	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	-	
15.00	01500 PHARMACY	0	0		0 0		
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	51, 658 3, 114		0 0		
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	5, 114		0 0	1, 418	17.00
30.00	03000 ADULTS & PEDIATRICS	0	376, 333		0 0	171, 425	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	46, 987		0 0	21, 403	31.00
43.00	04300 NURSERY	0	9, 732		0 0	4, 433	43.00
50.00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATING ROOM	ol	287, 437		0 0	130, 930	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	207, 437		0 0		
53.00	05300 ANESTHESI OLOGY	0	0		0 0		1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	150, 595		0 0	68, 598	54.00
60.00	06000 LABORATORY	0	79, 150		0 0	36, 054	
65.00		0	17, 225		0 0		
66.00	06600 PHYSI CAL THERAPY	0	58, 276		0 0		
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0			0	1
69.00	06900 ELECTROCARDI OLOGY	0	29, 584		0 0	13, 476	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	70, 651		0 0		
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	19, 885		0 0	9, 058	73.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	0	40, 56	53 0	0	90.00
90.00	09001 SENI OR CARE	0	0	29, 42			
91.00	09100 EMERGENCY	0	106, 382	40, 56			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	0	28, 74	0 66,628 14 0		95.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	20,74		0	
113.00	11300 I NTEREST EXPENSE						113.00
118.00		0	2, 080, 730	144, 22	66, 628	947, 794	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 219		0 0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 MARKETING	0	107, 306 3, 471		0 0		192.00 194.00
	07950 MARKETING 07951 PHYSICIAN BILLING	0	3, 471 8, 110		0 0		194.00
	07952 MOB	0	0, 110	717, 61	-		194.02
	07953 FOUNDATI ON	0	0		0 0		194.03
	Croce Foot Adjustments	1				1	200.00
200.00	5	. I					200.00
	Negative Cost Centers	0	0 2, 212, 836	861, 83	0 0 37 66, 628		201.00

Heal th	Financial Systems	HARRI SON COUNT	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	F	Period: From 01/01/2017 Fo 12/31/2017	Worksheet B Part II Date/Time Pre 5/22/2018 1:5	pared: 7 pm
	Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	ADMI TTI NG	
		2.01	2A	4.00	5. 01	5.02	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
$\begin{array}{c} 1. \ 00\\ 1. \ 01\\ 1. \ 02\\ 2. \ 00\\ 2. \ 01\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 7. \ 00\\ 7. \ 01\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB 00102 AMB DEPR 00200 NEW CAP REL COSTS-MVBLE EQUI P 00201 AMB EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL 00570 ADMINISTRATIVE & GENERAL 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00700 OPERATION OF PLANT 00701 AMB PLANT OPS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	0 0 0 0 0 0 0 0 0 0 0 0	4, 722 474, 642 0 370, 350 21, 624 46, 317 134, 773 67, 328	28(83 79 44 0 84 84 35 35	474, 922 5, 957 11, 331 20, 252 0 0 3, 180 4 7, 787 5, 351 3, 575	6, 040 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 1. \ 01\\ 1. \ 02\\ 2. \ 00\\ 2. \ 01\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 7. \ 00\\ 7. \ 01\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ \end{array}$
13.00	01300 NURSING ADMINISTRATION	0	11, 331	122		0	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0	46		0	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	75, 189			0	16.00
17.00	01700 SOCIAL SERVICE	0	4, 532	50	3, 503	0	17.00
30. 00 31. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04300 NURSERY	0 0 0	547, 758 68, 390 14, 165	83	6, 446	492 44 61	30. 00 31. 00 43. 00
50.00	ANCI LLARY SERVICE COST CENTERS	0	418, 367	184	18, 262	450	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	410, 307	(430	52.00
53.00	05300 ANESTHESI OLOGY	0	0	42		70	53.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	219, 193 115, 204	227		1, 632 951	54.00 60.00
65.00	06500 RESPI RATORY THERAPY	0	25, 071	(59	65.00
66.00	06600 PHYSI CAL THERAPY	0	84, 821	48		91	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0			11 3	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	0	43, 060	65	5 5, 175	283	69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	102, 833 0			282 97	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	28, 943			311	
	OUTPATIENT SERVICE COST CENTERS	-					
90.00 90.01	09000 CLINIC 09001 SENIOR CARE	0	40, 563 29, 423		1, 164 1 3, 369	8 27	
91.00	09100 EMERGENCY	0	195, 403				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	109, 339	175, 967	365	29, 732		95.00
	10100 HOME HEALTH AGENCY	0	28, 744				101.00
112 00	SPECIAL PURPOSE COST CENTERS				1		112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	109, 339	3, 348, 713	3, 165	5 330, 533	6, 040	113.00 118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19, 240) 190		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	156, 185				192.00
	07950 MARKETING 07951 PHYSICIAN BILLING	0	5, 052 11, 804				194. 00 194. 01
194.02	207952 MOB	0	717, 615		7, 094	0	194. 02
194.03 200.00	C7953 FOUNDATION Cross Foot Adjustments	0	0	(0 0	0	194. 03 200. 00
200.00		0	0		0 0		201.00
202.00) TOTAL (sum lines 118 through 201)	109, 339	4, 258, 609	4, 722	474, 922	6, 040	202.00

	ncial Systems	HARRI SON COUN				eu of Form CMS-	2552-10
ALLOCATION	OF CAPITAL RELATED COSTS		Provider C	CN: 15-1331	Period: From 01/01/2017 To 12/31/2017		
	Cost Center Description	CASHI ERI NG/ACC OUNTS RECEI VABLE	OPERATION OF PLANT	AMB PLANT OP	S LAUNDRY & LI NEN SERVICE	HOUSEKEEPI NG	
locur		5.03	7.00	7.01	8.00	9.00	
	RAL SERVICE COST CENTERS ONEW CAP REL COSTS-BLDG & FIXT					1	1.00
	1 MOB						1.00
	2 AMB DEPR						1.02
	O NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 0020	1 AMB EQUIP						2.01
	0 EMPLOYEE BENEFITS DEPARTMENT						4.00
	O ADMINISTRATIVE & GENERAL						5.01
	O ADMITTING	11 410					5.02
	0 CASHI ERI NG/ACCOUNTS RECEI VABLE 0 OPERATI ON OF PLANT	11, 410	390, 648				5.03
	1 AMB PLANT OPS	0	390, 040		0		7.00
	O LAUNDRY & LINEN SERVICE	0	3, 555		0 28, 364		8.00
	O HOUSEKEEPI NG	0	7, 615		0 2,549		
10.00 0100	0 DI ETARY	0	22, 159	,	0 1,880	3, 758	10.00
	0 CAFETERI A	0	11, 070	1	0 0		1
	O NURSI NG ADMI NI STRATI ON	0	1, 863	1	0 0	316	
	O CENTRAL SERVICES & SUPPLY	0	0		0 0	0	
	O PHARMACY O MEDI CAL RECORDS & LI BRARY	0	12, 362			0 2, 096	
	0 SOCIAL SERVICE		745			2,090	
	TIENT ROUTINE SERVICE COST CENTERS		, 10	1		120	17.00
	0 ADULTS & PEDIATRICS	938	90, 056		0 11, 245	15, 272	30.00
	O INTENSIVE CARE UNIT	84	11, 244		0 0		31.00
	0 NURSERY	116	2, 329		0 0	395	43.00
	LLARY SERVICE COST CENTERS	05/	(0.705		0 1 5 (4	11.77	50.00
	O OPERATING ROOM O DELIVERY ROOM & LABOR ROOM	856	68, 785		0 1,564	-	
	0 ANESTHESI OLOGY	133					
	0 RADI OLOGY-DI AGNOSTI C	3, 013	36, 038		0 3,024		
60.00 0600	0 LABORATORY	1, 812			0 0		
65.00 0650	0 RESPI RATORY THERAPY	112	4, 122		0 36	699	65.00
	0 PHYSI CAL THERAPY	173			0 296		
	0 OCCUPATIONAL THERAPY	22	0		0 0	-	
	0 SPEECH PATHOLOGY 0 ELECTROCARDI OLOGY	6 540	7, 080		0 C 0 691	0 1, 201	
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS	538		1	0 091		
	O IMPL. DEV. CHARGED TO PATIENT	184			0 0		1
	O DRUGS CHARGED TO PATIENTS	593	4, 759		0 0	807	
	ATIENT SERVICE COST CENTERS	1		1	1	1	
		15			0 143		
	1 SENI OR CARE	52			0 0	-	
	0 EMERGENCY 0 OBSERVATION BEDS (NON-DISTINCT PART)	1, 542	25, 458		0 5,453	4, 317	91.00 92.00
	R REIMBURSABLE COST CENTERS						92.00
	O AMBULANCE SERVICES	636	C		0 993	0	95.00
	O HOME HEALTH AGENCY	45)	0 0		101.00
	I AL PURPOSE COST CENTERS						
	0 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	11, 410	359, 034		0 27,874	58, 991	118.00
	EIMBURSABLE COST CENTERS O GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 163		0 0	E 24	190.00
	O PHYSICIANS' PRIVATE OFFICES		25, 679		0 490		190.00
	0 MARKETI NG	0	831		0 0		194.00
	1 PHYSI CI AN BILLING	0	1, 941		0 0		194.01
194.020795		0	0		0 0	0	194. 02
	3 FOUNDATI ON	0	0		0 0	0	194. 03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0					201.00
202.00	TOTAL (sum lines 118 through 201)	11, 410	390, 648	1	0 28, 364	04, 352	202.00

				Fr	01/01/0017	Doret 11	
				Tc	rom 01/01/2017 0 12/31/2017	Part II Date/Time Pre 5/22/2018 1:5	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS			1 1			1 1 00
	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB						1.00
	00102 AMB DEPR						1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	00201 AMB EQUIP						2.01
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00590 ADMI NI STRATI VE & GENERAL 00570 ADMI TTI NG						5. 01 5. 02
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02
	00700 OPERATION OF PLANT						7.00
	00701 AMB PLANT OPS						7.01
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG	1/7 05/					9.00
	01000 DI ETARY 01100 CAFETERI A	167, 956 0	83, 888				10.00
	01300 NURSI NG ADMI NI STRATI ON	0	2, 451				13.00
	01400 CENTRAL SERVICES & SUPPLY	0	2, 044		6, 011		14.00
15.00	01500 PHARMACY	0	1, 025	0	0	18, 221	15.00
	01600 MEDICAL RECORDS & LIBRARY	0	4, 374		27	0	
	01700 SOCIAL SERVICE	0	1, 043	0	6	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	129, 326	17, 878	11, 458	144	0	30.00
	03100 I NTENSI VE CARE UNI T	12, 640	2, 523		44	0	1
	04300 NURSERY	25, 990	1, 017		0	0	
	ANCILLARY SERVICE COST CENTERS	i					
	05000 OPERATING ROOM	0	6, 646	4, 259	167	0	
	05200 DELIVERY ROOM & LABOR ROOM	0	0	-	0	0	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	214 7, 400		14 218	0	
	06000 LABORATORY	0	4, 300		218 1, 042	0	
	06500 RESPI RATORY THERAPY	0	4, 300 0		19	0	1
	06600 PHYSI CAL THERAPY	0	1, 092	0	8	0	1
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
	06800 SPEECH PATHOLOGY	0	8	, i i i i i i i i i i i i i i i i i i i	0	0	
	06900 ELECTROCARDI OLOGY	0	1, 592		14	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	-	2, 375 1, 603	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	1,003	18, 221	
	OUTPATIENT SERVICE COST CENTERS				10	10/ 221	
	09000 CLI NI C	0	99		2	0	
	09001 SENI OR CARE	0	602		3	0	
	09100 EMERGENCY	0	8, 540	5, 473	144	0	
	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS						92.00
	09500 AMBULANCE SERVICES	0	0	0	168	0	95.00
	10100 HOME HEALTH AGENCY	0	C		0		101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113.00
118.00		167, 956	62, 848	24, 928	6, 011	18, 221	118.00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17, 024	0	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	268		0		192.00
	07950 MARKETI NG	o	3, 748		0 0		194.00
	07951 PHYSICIAN BILLING	0	C	0	0		194.01
	07952 MOB	О	C	0	0		194.02
	07953 FOUNDATI ON	0	C	0	0	0	194. 03
200.00			-		-	-	200.00
200.00	Negative Cost Centers	0 167, 956	0	0 24, 928	0 6, 011		201.00

Heal th	Financial Systems	HARRI SON COUN	ITY HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre 5/22/2018 1:5	pared: 7 pm
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
1 00	GENERAL SERVICE COST CENTERS	[1 1				1 1 00
1.00 1.01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB						1.00
1.01	00102 AMB DEPR						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 AMB EQUIP						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590 ADMI NI STRATI VE & GENERAL						5.01
5.02 5.03	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02 5.03
5.03 7.00	00700 OPERATION OF PLANT						7.00
7.00	00701 AMB PLANT OPS						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA						11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13.00 14.00
14.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	84, 349					16.00
17.00	01700 SOCIAL SERVICE	0	10, 005				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	6, 906 617		881, 38 106, 39		881, 382 106, 392	1
43.00	04300 NURSERY	855		49, 42		49, 429	1
10.00	ANCI LLARY SERVI CE COST CENTERS	000	1,010	17, 12	<u> </u>	17, 127	10.00
50.00	05000 OPERATI NG ROOM	6, 305	0	537, 51		537, 510	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	1
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	983	1	1, 91		1, 912	1
60. 00	06000 LABORATORY	22, 514 13, 343	1	324, 56 180, 37		324, 562 180, 379	1
65.00	06500 RESPI RATORY THERAPY	825		36, 02		36, 021	1
66.00	06600 PHYSI CAL THERAPY	1, 273	0	108, 16		108, 161	1
67.00	06700 OCCUPATI ONAL THERAPY	159	1	62		621	67.00
68.00	06800 SPEECH PATHOLOGY	45	1	8		84	1
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	3, 973 3, 962		64, 69 145, 06		64, 694 145, 068	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 356		143,00		143, 008	1
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 363	-	74, 44	-	74, 445	1
	OUTPATIENT SERVICE COST CENTERS	1					
	09000 CLINIC	110		12, 17		12, 171	90.00
	09001 SENI OR CARE 09100 EMERGENCY	385 11, 356		34, 27 284, 36			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 300		204, 30	0		91.00
72.00	OTHER REIMBURSABLE COST CENTERS		1				/2.00
	09500 AMBULANCE SERVICES	4, 685		212, 88			
101.00	10100 HOME HEALTH AGENCY	334	. 0	36, 81	1 0	36, 811	101.00
440.00	SPECIAL PURPOSE COST CENTERS		1 1		-		1110 00
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	84, 349	10, 005	3, 134, 04	4 0	3, 134, 044	113.00
110.00	NONREIMBURSABLE COST CENTERS	04, 347	10,005	3, 134, 04	4 0	3, 134, 044	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	40, 15	3 0	40, 153	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	313, 57	7 0	313, 577	1
	07950 MARKETI NG	0	0	13, 97			194.00
	07951 PHYSICIAN BILLING	0	0	21, 93			194.01
	07952 MOB 07953 FOUNDATI ON		0	724, 70	0 0	724, 709	194.02 194.03
200.00					0 0		200.00
201.00		10, 218	0	10, 21	8 0		201.00
202.00	TOTAL (sum lines 118 through 201)	94, 567	10, 005	4, 258, 60	9 0	4, 258, 609	202.00

OST ALLOCATION - STATISTICAL BASIS	HARRI SON COUNT	Provi der CC	F	eriod: rom 01/01/2017	u of Form CMS- Worksheet B-1	
				0 12/31/2017	Date/Time Pre 5/22/2018 1:5	
		CAPI	TAL RELATED C	OSTS		
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	AMB EQUI P (SQUARE FEET)	
	1.00	1.01	1.02	2.00	2.01	
GENERAL SERVICE COST CENTERS .00 00100 NEW CAP REL COSTS-BLDG & FIXT	136, 433					1 1.
.01 00101 MOB .02 00102 AMB DEPR .00 00200 NEW CAP REL COSTS EQUI P .01 00201 AMB EQUI P .01 00201 AMB EQUI P .00 00200 NEW CAP REL COSTS MVBLE EQUI P .01 00201 AMB EQUI P .00 00400 EMPLOYEE BENEFI TS DEPARTMENT	200	34, 271 0 0	11, 032	136, 433 0 200	11, 032 0	1. 1. 2. 2.
01 00590 ADMI NI STRATI VE & GENERAL 02 00570 ADMI TTI NG	19, 897 0	196 0	C	19, 897 0	0	5. 5.
03 00580 CASHI ERING/ACCOUNTS RECEIVABLE 00 00700 OPERATI ON OF PLANT 01 00701 AMB PLANT OPS	0 15, 688 0	0 0 0	C C C	0 15, 688 0	0 0 0	7.
. 00 00800 LAUNDRY & LINEN SERVICE . 00 00900 HOUSEKEEPING 0. 00 01000 DIETARY	916 1, 962 5, 700	0 0 0	C	916 1, 962 5, 700	0 0 0	9.
1. 00 01100 CAFETERIA	5, 709 2, 852	0	C	5, 709 2, 852	0	10. 11.
3. 00 01300 NURSI NG ADMI NI STRATI ON	480	0	C	480	0	
4. 00 01400 CENTRAL SERVI CES & SUPPLY 5. 00 01500 PHARMACY	0	0	C	0	0 0	
5. 00 01600 MEDICAL RECORDS & LIBRARY	3, 185	0	C		0	
7. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	192	0	C	192	0	17.
0. 00 03000 ADULTS & PEDIATRICS	23, 203	0	C		0	
. 00 03100 I NTENSI VE CARE UNI T 3. 00 04300 NURSERY	2, 897 600	0	C		0 0	
ANCI LLARY SERVICE COST CENTERS	17.700			17 700		
0. 00 05000 OPERATING ROOM 2. 00 05200 DELIVERY ROOM & LABOR ROOM	17, 722	0	C		0 0	
. 00 05300 ANESTHESI OLOGY	0	0	C	0	0	
1. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 00 06000 LABORATORY	9, 285 4, 880	0	C	9, 285 4, 880	0	54 60
5. 00 06500 RESPI RATORY THERAPY	1, 062	0	C	1, 062	0	65
0. 00 06600 PHYSI CAL THERAPY 0. 00 06700 OCCUPATI ONAL THERAPY	3, 593 0	0	C	3, 593 0	0	66 67
3. 00 06800 SPEECH PATHOLOGY	0	0	C	0	0	68
 00 06900 ELECTROCARDIOLOGY 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 	1, 824 4, 356	0	C	1, 824 4, 356	0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	o	C	0	0	72
8. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	1, 226	0	C	1, 226	0	73
0. 00 09000 CLINIC	0	1, 613	C	0	0	
0. 01 09001 SENI OR CARE 1. 00 09100 EMERGENCY	0 6, 559	1, 170 1, 613	C		0	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,007	1,013		0,007	0	92
OTHER REIMBURSABLE COST CENTERS	0	0	11, 032	0	11, 032	1 05
1.0010100 HOME HEALTH AGENCY	0	1, 143	C			101
SPECIAL PURPOSE COST CENTERS 3. 00 11300 I NTEREST EXPENSE						113
8.00 SUBTOTALS (SUM OF LINES 1 through 11 NONREI MBURSABLE COST CENTERS		5, 735	11, 032			118
0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2.00 19200 PHYSICIANS' PRIVATE OFFICES	815 6, 616	0	C			190 192
4. 00 07950 MARKETI NG	214	Ö	C	214	0	194
4. 01 07951 PHYSI CLAN BILLING 4. 02 07952 MOB	500	0 28, 536	0	500 0		194 194
4. 03 07953 FOUNDATI ON	0	0	C	0		194
0.00 Cross Foot Adjustments 1.00 Negative Cost Centers						200 201
2.00 Cost to be allocated (per Wkst. B, Part I)	2, 212, 836	861, 837	66, 628			202
3.00Unit cost multiplier (Wkst. B, Part4.00Cost to be allocated (per Wkst. B, Part II)	1) 16. 219214	25. 147705	6. 039521	7. 388015	9. 911077	203 204
5.00 Unit cost multiplier (Wkst. B, Part						205
06.00 NAHE adjustment amount to be allocat (per Wkst. B-2)	ed					206.
07.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207

	Financial Systems LOCATION – STATISTICAL BASIS	HARRI SON COUNT	TY HOSPITAL Provider CC		ri od:	u of Form CMS-2 Worksheet B-1	2552-10
				To	om 01/01/2017 12/31/2017	Date/Time Pre	
	Cost Center Description	BENEFITS DEPARTMENT	Reconciliation#	ADMI NI STRATI VE & GENERAL (ACCUM COST)	ADMI TTI NG (GROSS CHARGES)	5/22/2018 1:5 CASHI ERI NG/ACC OUNTS RECEI VABLE	
		(GROSS SALARI ES)				(GROSS CHARGES)	
		4.00	5A. 01	5.01	5. 02	5.03	
	GENERAL SERVICE COST CENTERS						1.00
1.01 1.02	20101 MOB 20102 AMB DEPR 20200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 1.01 1.02 2.00
2.01	DO201 AMB EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL	25, 545, 293	4 777 104	49 041 021			4.00 5.01
	00590 ADMINISTRATIVE & GENERAL	1, 513, 249 450, 169	-4, 777, 126 0	48, 041, 921 602, 534	143, 280, 694		5.01
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	428, 370	0	1, 146, 133	0	143, 280, 694	5.03
	00700 OPERATION OF PLANT 00701 AMB PLANT OPS	248, 824 0	0	2, 048, 530	0	0	7.00 7.01
	00800 LAUNDRY & LINEN SERVICE	25, 533	0	321, 658	0	0	8.00
	DO900 HOUSEKEEPI NG	453, 991	0	787, 688	0	0	9.00
	01000 DI ETARY 01100 CAFETERI A	191, 121 203, 595	0	541, 252	0	0	10.00
	01300 NURSING ADMINISTRATION	203, 595 658, 401	0	361, 603 894, 696	0	0	11.00 13.00
	01400 CENTRAL SERVICES & SUPPLY	247, 422	0	396, 613	0	0	14.00
		989, 037	0	1, 720, 890	0	0	15.00
	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0 271, 508	0	52, 504 354, 331	0	0	16.00 17.00
	NPATIENT ROUTINE SERVICE COST CENTERS				- 1		11100
	03000 ADULTS & PEDIATRICS	2,854,751	0	4, 215, 725	11, 725, 081	11, 725, 081	30.00
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	449, 097 174, 362	0	651, 987 229, 518	1, 047, 774 1, 450, 814	1, 047, 774 1, 450, 814	31.00 43.00
	ANCILLARY SERVICE COST CENTERS			L.			
	05000 OPERATING ROOM	992, 877	0	1, 847, 251	10, 705, 043	10, 705, 043	50.00
	D5200 DELIVERY ROOM & LABOR ROOM D5300 ANESTHESI OLOGY	0 225, 842	0	0 46, 170	1, 668, 250	0 1, 668, 250	52.00 53.00
	D5400 RADI OLOGY-DI AGNOSTI C	1, 228, 103	0	2, 548, 232	38, 296, 666	38, 296, 666	
	D6000 LABORATORY	772, 808	0	2, 167, 793	22, 654, 053	22, 654, 053	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 257, 510	0	513, 667 409, 461	1, 401, 373 2, 161, 044	1, 401, 373 2, 161, 044	65.00 66.00
	06700 OCCUPATI ONAL THERAPY	207,010	0	43, 409	269, 707	269, 707	67.00
	06800 SPEECH PATHOLOGY	1, 763	0	2, 222	76, 236	76, 236	
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	349, 234 0	0	523, 424 1, 548, 098	6, 745, 920 6, 725, 940	6, 745, 920 6, 725, 940	
	07200 IMPL. DEV. CHARGED TO PATIENT	0	Ő	976, 084	2, 302, 010	2, 302, 010	
	D7300 DRUGS CHARGED TO PATIENTS	0	0	1, 662, 455	7, 407, 374	7, 407, 374	73.00
	DUTPATIENT SERVICE COST CENTERS	21, 676	0	117, 744	186, 377	186, 377	90.00
	D9001 SENI OR CARE	130, 571	0	340, 735	654, 445	654, 445	
	09100 EMERGENCY	1, 505, 469	0	2, 588, 093	19, 280, 859	19, 280, 859	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	D9500 AMBULANCE SERVICES	1, 974, 310	0	3, 007, 482	7, 953, 988	7, 953, 988	95.00
	10100 HOME HEALTH AGENCY	485, 659	0	766, 145	567, 740	567, 740	101.00
	SPECIAL PURPOSE COST CENTERS						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	17, 105, 252	-4, 777, 126	33, 434, 127	143, 280, 694	143, 280, 694	
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	ol	19, 240	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	7, 829, 747	0	19, 240	0		190.00
	D7950 MARKETI NG	66, 404	0	423, 965	О	0	194. 00
	07951 PHYSICIAN BILLING 07952 MOB	543, 890 0	0	784, 779	0		194. 01 194. 02
	07952 MOB 07953 FOUNDATI ON	0	0	717, 615 0	o		194.02
200.00	Cross Foot Adjustments						200. 00
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	5, 972, 175		1 777 10/	442 440		201.00
202.00	Part I)	5,972,175		4, 777, 126	662, 448	1, 260, 101	202.00
203.00 204.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 233788 4, 722		0. 099437 474, 922	0. 004623 6, 040	0. 008795 11, 410	
205.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 000185		0.009886	0.000042	0.000080	205.00
	11)						
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00
I	Traits III anu IV)	I I	I	I	I	l	I

COST A		cial Systems TON – STATISTICAL BASIS	HARRISON COUN	Provider C		Period:	u of Form CMS-2 Worksheet B-1	
						rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/22/2018 1:5	pared: 7 pm
		Cost Center Description	PLANT (SQUARE FEET)	AMB PLANT OPS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	FEET)	DI ETARY (TOTAL PATI ENT DAYS)	
	CENED	AL SERVICE COST CENTERS	7.00	7.01	8.00	9.00	10.00	
1.00 1.01 1.02 2.00 2.01 4.00 5.01 5.02 5.03 7.00 7.01	00100 00101 00200 00201 00400 00590 00570 00580 00700	NEW CAP REL COSTS-BLDG & FIXT	100, 648 0	11, 032				1. 00 1. 02 2. 00 2. 07 4. 00 5. 02 5. 02 7. 00 7. 00
8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00	00900 01000 01100 01300 01400 01500 01600 01700	LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE ENT ROUTINE SERVICE COST CENTERS	916 1,962 5,709 2,852 480 0 0 3,185 192	0 0 0 0 0 0 0 0 0	216, 097 19, 422 14, 326 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	97,770 5,709 2,852 480 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 3, 185	5, 674 0 0 0 0	8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00
30. 00		ADULTS & PEDIATRICS	23, 203	0	85, 663	3 23, 203	4, 369	30. 00
31.00		INTENSIVE CARE UNIT	2, 897	0	0			31.00
43.00		NURSERY LARY SERVICE COST CENTERS	600	0		600	878	43.00
50.00		OPERATING ROOM	17, 722	0	11, 913	17, 722	0	50.00
52.00		DELIVERY ROOM & LABOR ROOM	0	0	Ċ		0	52.00
53.00		ANESTHESI OLOGY	0	0	C	0 0	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	9, 285	0	23, 041		0	54.00
60.00			4,880	0	075	.,		60.00
65.00		RESPI RATORY THERAPY	1,062	0	275		0	65.00
66.00 67.00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	3, 593 0	0	2, 256		0	66.00 67.00
57.00		SPEECH PATHOLOGY	0	0			0	68.00
59.00		ELECTROCARDI OLOGY	1,824	0	5, 261	-		69.00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 356	0	3, 201		0	71.0
72.00		IMPL. DEV. CHARGED TO PATIENT	0	0			0	72.0
		DRUGS CHARGED TO PATIENTS	1, 226	0				73.0
		TIENT SERVICE COST CENTERS	· · ·					
		CLI NI C	0	0	1, 092	2 0	0	90.00
		SENI OR CARE	0	0	C	,	0	
		EMERGENCY	6, 559	0	41, 548	6, 559	0	
92.00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS						92.0
25 00		AMBULANCE SERVICES	0	11, 032	7, 564	0	0	95.0
		HOME HEALTH AGENCY	0	0	(0		101.0
	SPECI	AL PURPOSE COST CENTERS						
		INTEREST EXPENSE						113.0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92, 503	11, 032	212, 361	89, 625	5, 674	118.00
100.00		MBURSABLE COST CENTERS	015	0		015	0	1100 0
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	815 6, 616	0	3, 736	815 6, 616		190. 0 192. 0
192.00	07950	MARKETI NG	214	0	3,730	214		194. 0
		PHYSICIAN BILLING	500	0		500		194.0
94.02	07952	МОВ	0	0	0	0 0	0	194.0
		FOUNDATION	0	0	C	0 0	0	194.03
200.00		Cross Foot Adjustments						200.00
01.00 02.00	1	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	2, 252, 230	0	374, 141	943, 543	802, 722	201. 0 202. 0
203.00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	22. 377295 390, 648	0. 000000 0	1. 731357 28, 364			
04. UC		Part II)	3. 881329	0. 000000	0. 131256	0. 658198	29. 600987	205. 00
	D	Unit cost multiplier (Wkst. B, Part	0.001027					
205.00		II) NAHE adjustment amount to be allocated	0.001027					206. 0
204. 00 205. 00 206. 00 207. 00	þ	11)	0.001027					206. 00 207. 00

Cost Center Description CAFTERIA (CHURD) NUESTING CONTENT CONTENT Content Structure Content Content Content Content Content Content Content Content Content Content Conte		Financial Systems LLOCATION - STATISTICAL BASIS	HARRI SON COUN	ITY HOSPITAL Provider CC	N: 15-1331 P	In Lie	u of Form CMS- Worksheet B-1	
Cost Center Bescription CALL TERM A (ROWS) NURSING Services (D) CHIESING Services (D) CHIESING SERVICES (CROSS (CROSS (D) CHIESING SERVICES (CROSS (CROSS (D) CHIESING SERVICES (CROSS (CROSS (D) CHIESING SERVICES (CROSS (CROSS (D) CHIESING SERVICES (CROSS (CROSS (D) CHIESING (CROSS (D) CHIESING (CROSS (CROSS (D) CHIESING (CROSS (CROSS (CROSS (D) CHIESING (CROSSS					F	rom 01/01/2017	Date/Time Pre	pared:
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1 of 00101 M08 1 of 00101 M08 1 of 00100 M08 EVA 1 of 00 1 of 000 M08 EVA 1 of 00 1 of 000 M08 EVA 1 of 00 1 of 000 M08 EVA 1 of 0 1 of 000 M08 EVA 1 of 0 1 of 000 M08 EVA 1 of 0 1 of 000 M08 1 of 00 1 of 000 M08 1 of 000 M08 1 of 00 1 of 000 M08 1 of 00 1 of 000 M08 1 of 0 1 of 000 M08 1 of 0 1 of 00 1 of 000 M08 1 of 0 1 of 0 1 of 0 1 of 000 M08 1 of 0 1 of		GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	10.00	
16 00 0 10600 MEDICAL, RECORDS & LIBRARY 1, 635 0 16, 693 0 143, 280, 69 1 NPATIENT ROUTINE SERVICE 0 201 0 1700	$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 2.\ 00\\ 2.\ 01\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 7.\ 00\\ 7.\ 01\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB 00102 AMB DEPR 00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL 00570 ADMINISTRATIVE & GENERAL 00570 OPERATION OF PLANT 00700 OPERATION OF PLANT 00700 OPERATION OF PLANT 00700 AMB PLANT OPS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	916	14, 538	3, 660, 082			1.00 1.01 1.02 2.00 2.01 4.00 5.01 5.02 5.03 7.00 7.01 8.00 9.00 10.00 11.00 13.00 14.00
17. 00 017.00 507.14. SERVICE 390 0 3.552 0 10 00 03000 AULTS & PEDIATRICS 6.662 6.662 87.832 0 11,725.06 30 00 03000 INTENSIVE CABLE UNIT 943 26.731 0 1,450.81 ANCLLIARY SERVICE COST CENTERS	15.00	01500 PHARMACY	383	0				15.00
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43. 00 04300 NURSERY 380 380 227 0 1,450,81 ANCILLARY SERVICE COST CENTERS							11, 725, 081	
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92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) Image: constraint of the service								
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Part I) Part I) 15.593034 69.701334 0.122392 18,979.820000 0.00130 204.00 Cost to be allocated (per Wkst. B, Part I) 15.593034 69.701334 0.122392 18,979.820000 0.00130 205.00 Unit cost multiplier (Wkst. B, Part I) 12.675512 1.714679 0.001642 182.210000 0.00058		Negative Cost Centers			= -			201.00
203.00 204.00Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)15.593034 83,88869.701334 24,9280.122392 6,01118,979.820000 18,2210.00130 94,56205.00Unit cost multiplier (Wkst. B, Part II)2.6755121.7146790.001642182.2100000.00058	202.00		488, 904	1, 013, 318	447, 964	1, 897, 982	187, 272	202.00
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200, 00 minit adjustiliciti allouiti to be all'ocateu		11)						206.00
(per Wkst. B-2)		(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00							207.00

	Financial Systems LLOCATION - STATISTICAL BASIS	HARRI SON COUNT	Y HOSPITAL Provider CCN: 15-1331	Peri od:	u of Form CMS-2552-10 Worksheet B-1
				From 01/01/2017 To 12/31/2017	Date/Time Prepared:
	Cost Center Description	SOCI AL SERVI CE		<u> </u>	5/22/2018 1:57 pm
	· · · · · · · · · · · · · · · · · · ·				
		(TOTAL PATIENT DAYS)			
	· · · · · · · · · · · · · · · · · · ·	17.00			
1.00	GENERAL SERVICE COST CENTERS				1.00
1.00	00101 MOB				1.00
1.02	00102 AMB DEPR				1. 02
2.00 2.01	00200 NEW CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590 ADMINISTRATIVE & GENERAL				5. 01
5.02	00570 ADMI TTI NG				5. 02
5.03 7.00	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00700 OPERATI ON OF PLANT				5. 03 7. 00
7.01	00701 AMB PLANT OPS				7. 01
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY				9.00 10.00
11.00	01100 CAFETERI A				11.00
13.00	01300 NURSING ADMINISTRATION				13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY				14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY				16.00
	01700 SOCIAL SERVICE	5, 674			17.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	4.2(0			
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	4, 369 427			30.00 31.00
43.00	04300 NURSERY	878			43.00
50.00	ANCI LLARY SERVI CE COST CENTERS				
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0			50.00 52.00
53.00	05300 ANESTHESI OLOGY	0			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			54.00
60.00 65.00		0			60.00
66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0			65. 00 66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0			67.00
68.00	06800 SPEECH PATHOLOGY	0			68.00
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0			69.00 71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0			73.00
90.00	OUTPATIENT SERVICE COST CENTERS	0			90.00
	09001 SENI OR CARE	0			90.00
91.00	09100 EMERGENCY	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				92.00
95.00	09500 AMBULANCE SERVICES	0			95.00
	10100 HOME HEALTH AGENCY	0			101.00
110 00	SPECIAL PURPOSE COST CENTERS	1			110.00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	5, 674			113. 00 118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 MARKETI NG	0			192. 00 194. 00
	07951 PHYSICIAN BILLING	0			194.00
194.02	07952 MOB	0			194.02
194.03 200.00	07953 FOUNDATION Cross Foot Adjustments	0			194. 03 200. 00
200.00					200.00
202.00	Cost to be allocated (per Wkst. B, Part I)	402, 230			202.00
203.00 204.00		70. 890025 10, 005			203. 00 204. 00
204.00	Part II)	10,003			204.00
205.00		1. 763306			205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00					207.00

Health Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1331	Peri od:	Worksheet C Part I	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/22/2018 1:5	pared: 7 pm
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1	1	1			
30. 00 03000 ADULTS & PEDI ATRI CS	7, 207, 542		7, 207, 54		0	
31.00 03100 INTENSIVE CARE UNIT	999, 415		999, 41		0	
43. 00 04300 NURSERY	511, 815		511, 81	15 0	0	43.00
ANCI LLARY SERVICE COST CENTERS		1				
50. 00 05000 OPERATI NG ROOM	3, 001, 085		3, 001, 08		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	
53. 00 05300 ANESTHESI OLOGY	77, 595		77, 59		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 762, 229		3, 762, 22		0	54.00
60. 00 06000 LABORATORY	2, 975, 946		2, 975, 94		0	60.00
65. 00 06500 RESPI RATORY THERAPY	621, 263		02.72		0	65.00
66. 00 06600 PHYSI CAL THERAPY	607, 961		607, 96		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	51, 697		51, 69		0	67.00
68.00 06800 SPEECH PATHOLOGY	3, 612		3, 61		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	794, 163		794, 16		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 117, 477		2, 117, 47		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 226, 505		1, 226, 50		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 875, 022		3, 875, 02	22 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	1	1				
90. 00 09000 CLINIC	137, 421		137, 42		0	
90. 01 09001 SENI OR CARE	403, 663		403, 66		0	
91. 00 09100 EMERGENCY	3, 694, 391		3, 694, 39		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 769, 363		1, 769, 36	53	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	3, 449, 271		3, 449, 27		0	
101.0010100 HOME HEALTH AGENCY	850, 688		850, 68	38	0	101.00
SPECIAL PURPOSE COST CENTERS				-1		
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	38, 138, 124					200. 00
201.00 Less Observation Beds	1, 769, 363		1, 769, 36			201.00
202.00 Total (see instructions)	36, 368, 761	0	36, 368, 76	51 0	0	202.00

Health Financial Systems	HARRI SON COUNT	TY HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/22/2018 1:5	
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9,00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS	8, 596, 993		8, 596, 99	3		30.00
31. 00 03100 I NTENSI VE CARE UNI T	1,047,774		1, 047, 77			31.00
43. 00 04300 NURSERY	1, 450, 814		1, 450, 81			43.00
ANCI LLARY SERVICE COST CENTERS	.,,		.,,			
50. 00 05000 OPERATI NG ROOM	2, 717, 401	7, 987, 642	10, 705, 04	3 0. 280343	0.00000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0.000000	0.000000	52.00
53.00 05300 ANESTHESI OLOGY	436,000	1, 232, 250	1, 668, 25	0 0. 046513	0.000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 283, 806	36, 012, 860	38, 296, 66	6 0.098239	0.000000	54.00
60. 00 06000 LABORATORY	3, 551, 692	19, 102, 361	22, 654, 05	3 0. 131365	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	946, 148	455, 225	1, 401, 37	3 0. 443325	0.000000	65.00
66.00 06600 PHYSI CAL THERAPY	603, 310	1, 557, 734	2, 161, 04	4 0. 281327	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	73, 067	196, 640	269, 70	7 0. 191678	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	53, 945	22, 291	76, 23	6 0. 047379	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	516, 576	6, 229, 344	6, 745, 92	0 0. 117725	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 937, 634	3, 788, 306	6, 725, 94	0 0. 314822	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 386, 029	915, 981	2, 302, 01	0 0. 532797	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 252, 786	5, 154, 588	7, 407, 37	4 0. 523130	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	186, 377	186, 37	7 0. 737328	0. 000000	90.00
90. 01 09001 SENI OR CARE	0	654, 445	654, 44	5 0. 616802	0.000000	90.01
91.00 09100 EMERGENCY	566, 904	18, 713, 955	19, 280, 85	9 0. 191609	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 726	3, 119, 362	3, 128, 08	8 0. 565637	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	7, 953, 988	7, 953, 98	8 0. 433653	0.000000	95.00
101.00 10100 HOME HEALTH AGENCY	0	567, 740	567, 74	0		101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	29, 429, 605	113, 851, 089	143, 280, 69	4		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	29, 429, 605	113, 851, 089	143, 280, 69	4		202.00

Health Financial Systems	HARRISON COUNTY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1331	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/22/2018 1:5	epared: 57 pm
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 I NTENSI VE CARE UNI T					31.00
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS	· · · · ·				1
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
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69.00 06900 ELECTROCARDI OLOGY	0.000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					1
90. 00 09000 CLINIC	0. 000000				90.00
90. 01 09001 SENI OR CARE	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					
95. 00 09500 AMBULANCE SERVI CES	0. 000000				95.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial S	Systems	HARRI SON COUN	ITY HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RA	TIO OF COSTS TO CHARGES		Provider C	CN: 15-1331	Period: From 01/01/2017 To 12/31/2017		epared: 57 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	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	ROUTINE SERVICE COST CENTERS						
	S & PEDIATRICS	7, 207, 542		7, 207, 54		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	ISI VE CARE UNI T	999, 415		999, 41		999, 415	31.00
43.00 04300 NURSE		511, 815		511, 81	5 0	511, 815	43.00
	SERVICE COST CENTERS						
50.00 05000 0PERA		3, 001, 085		3, 001, 08	s5 0	3, 001, 085	
	ERY ROOM & LABOR ROOM	0			0 0	C	52.00
53.00 05300 ANEST	HESI OLOGY	77, 595		77, 59	05 0	77, 595	53.00
54.00 05400 RADI 0	LOGY-DI AGNOSTI C	3, 762, 229		3, 762, 22	.9 0	3, 762, 229	54.00
60.00 06000 LABOR	ATORY	2, 975, 946		2, 975, 94	6 0	2, 975, 946	60.00
65.00 06500 RESPI	RATORY THERAPY	621, 263	C	621, 26	03 0	621, 263	65.00
66.00 06600 PHYSI	CAL THERAPY	607, 961	C	607, 96	01 0	607, 961	66.00
67.00 06700 0CCUP	ATIONAL THERAPY	51, 697	C	51, 69	07 0	51, 697	67.00
68.00 06800 SPEEC	H PATHOLOGY	3, 612	C	3, 6	2 0	3, 612	68.00
69.00 06900 ELECT	ROCARDI OLOGY	794, 163		794, 16	03 0	794, 163	69.00
71.00 07100 MEDIC	AL SUPPLIES CHARGED TO PATIENTS	2, 117, 477		2, 117, 47	7 0	2, 117, 477	71.00
72.00 07200 I MPL.	DEV. CHARGED TO PATIENT	1, 226, 505		1, 226, 50	05 0	1, 226, 505	72.00
73.00 07300 DRUGS	CHARGED TO PATIENTS	3, 875, 022		3, 875, 02	2 0	3, 875, 022	73.00
OUTPATI ENT	SERVICE COST CENTERS						
90.00 09000 CLI NI	С	137, 421		137, 42	1 0	137, 421	90.00
90. 01 09001 SENI 0	R CARE	403, 663		403, 66	03 0	403, 663	90.01
91.00 09100 EMERG	ENCY	3, 694, 391		3, 694, 39	0 0	3, 694, 391	91.00
92.00 09200 OBSER	VATION BEDS (NON-DISTINCT PART)	1, 769, 363		1, 769, 36	3	1, 769, 363	92.00
OTHER REIME	BURSABLE COST CENTERS						
95.00 09500 AMBUL	ANCE SERVICES	3, 449, 271		3, 449, 27	'1 0	3, 449, 271	95.00
101.00 10100 HOME	HEALTH AGENCY	850, 688		850, 68	8	850, 688	101.00
SPECIAL PUR	RPOSE COST CENTERS						1
113.00 11300 I NTER	EST EXPENSE						113.00
200.00 Subto	tal (see instructions)	38, 138, 124	C	38, 138, 12	.4 0	38, 138, 124	200.00
	Observation Beds	1, 769, 363		1, 769, 36		1, 769, 363	
202.00 Total	(see instructions)	36, 368, 761				36, 368, 761	202.00

Health Financial Systems	HARRI SON COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/22/2018 1:5	
		Titl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	8, 596, 993		8, 596, 99	3		30.00
31.00 03100 INTENSIVE CARE UNIT	1,047,774		1,047,77	4		31.00
43. 00 04300 NURSERY	1, 450, 814		1, 450, 81	4		43.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 717, 401	7, 987, 642	10, 705, 04	3 0. 280343	0.00000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000	0.000000	52.00
53.00 05300 ANESTHESI OLOGY	436,000	1, 232, 250	1, 668, 25	0.046513	0.000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 283, 806	36, 012, 860	38, 296, 66	0. 098239	0.000000	54.00
60. 00 06000 LABORATORY	3, 551, 692	19, 102, 361	22, 654, 05	0. 131365	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	946, 148	455, 225	1, 401, 37	3 0.443325	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	603, 310	1, 557, 734	2, 161, 04	4 0. 281327	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	73,067	196, 640	269, 70	0. 191678	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	53, 945	22, 291		6 0.047379	0.000000	68.00
69.00 06900 ELECTROCARDI OLOGY	516, 576	6, 229, 344	6, 745, 92	0 0.117725	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,937,634	3, 788, 306	6, 725, 94	0 0. 314822	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 386, 029	915, 981	2, 302, 01	0 0.532797	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 252, 786	5, 154, 588	7, 407, 37	4 0. 523130	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS	· · · · ·					
90. 00 09000 CLI NI C	0	186, 377	186, 37	7 0.737328	0.00000	90.00
90. 01 09001 SENI OR CARE	0	654, 445	654, 44	5 0. 616802	0.000000	90.01
91.00 09100 EMERGENCY	566, 904	18, 713, 955	19, 280, 85	9 0. 191609	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 726	3, 119, 362	3, 128, 08	0. 565637	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	0	7, 953, 988	7, 953, 98	0. 433653	0.00000	95.00
101.00 10100 HOME HEALTH AGENCY	0	567, 740	567, 74	0		101.00
SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		•			1
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	29, 429, 605	113, 851, 089	143, 280, 69	4		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	29, 429, 605	113, 851, 089	143, 280, 69	4		202.00

Health Financial Systems	HARRISON COUNTY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1331	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/22/2018 1:5	epared: 57 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 I NTENSI VE CARE UNI T					31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS	· · · · · ·				
50. 00 05000 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
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATIONAL THERAPY	0, 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90.00
90. 01 09001 SENI OR CARE	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					
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/22/2018 1:5	
		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	537, 510	10, 705, 043	0. 05021	1 563, 810	28, 309	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	1, 912	1, 668, 250	0. 00114	111, 500	128	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	324, 562	38, 296, 666	0.00847	⁷ 5 940, 878	7, 974	54.00
60. 00 06000 LABORATORY	180, 379	22, 654, 053	0.00796	1, 434, 010	11, 418	60.00
65. 00 06500 RESPI RATORY THERAPY	36, 021	1, 401, 373	0. 02570	609, 177	15, 658	65.00
66. 00 06600 PHYSI CAL THERAPY	108, 161	2, 161, 044		415,664	20, 804	66.00
67.00 06700 OCCUPATI ONAL THERAPY	621	269, 707	0.00230	48, 563	112	67.00
68.00 06800 SPEECH PATHOLOGY	84	76, 236			2	68.00
69. 00 06900 ELECTROCARDI OLOGY	64, 694				2, 549	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	145,068				31,042	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	12, 890				3, 362	
73.00 07300 DRUGS CHARGED TO PATIENTS	74, 445	7, 407, 374	0. 01005	1, 053, 008	10, 583	73.00
OUTPATIENT SERVICE COST CENTERS	· · · ·		1			
90. 00 09000 CLINIC	42, 171	186, 377	0, 22626	07 0	0	90.00
90. 01 09001 SENI OR CARE	34, 271			0	0	90.01
91. 00 09100 EMERGENCY	284, 361				1, 288	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	216, 368					•
OTHER REIMBURSABLE COST CENTERS				, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	2, 063, 518	123, 663, 385		7, 572, 553	133, 304	200.00

Health Financial Systems	HARRISON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2017 To 12/31/2017		narod
				10 12/31/2017	5/22/2018 1:5	
			× XVIII	Hospi tal	Cost	/ p
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS	-			1		
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
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	1 (J 0	0	73.00
0UTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC				0 0	0	90.00
90. 00 109000 CETNIC 90. 01 109001 SENIOR CARE	0				0	90.00
91. 00 09100 EMERGENCY	0				0	90.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		1		0	92.00
OTHER REIMBURSABLE COST CENTERS		1	1 · · ·	5	0	/2.00
95. 00 09500 AMBULANCE SERVICES			1			95.00
200.00 Total (lines 50 through 199)	0	c c		o o	0	200.00
	-		1	-1 -1	-	

^{5/22/2018 1:57} pm

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2017 To 12/31/2017		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
	Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	(8	7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 O5000 OPERATING ROOM	0	0		0 10, 705, 043		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0.000000	
53.00 05300 ANESTHESI OLOGY	0	0		0 1, 668, 250		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 38, 296, 666		
60. 00 06000 LABORATORY	0	0		0 22, 654, 053		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 401, 373		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 161, 044		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 269, 707		
68.00 06800 SPEECH PATHOLOGY	0	0		0 76, 236		•
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 6, 745, 920		•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 6, 725, 940		•
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 2, 302, 010		•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 7, 407, 374	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS				- 1		
90. 00 09000 CLINIC	0	0		0 186, 377		
90. 01 09001 SENI OR CARE	0	0		0 654, 445		90.01
91.00 09100 EMERGENCY	0	0		0 19, 280, 859	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 3, 128, 088	0.000000	92.00
OTHER REI MBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES					1	95.00
200.00 Total (lines 50 through 199)	0	0		0 123, 663, 385	1	200. 00

^{5/22/2018 1:57} pm

Health Financial Systems	HARRI SON COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/22/2018 1:5	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 000000	563, 810		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	111, 500		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	940, 878		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	1, 434, 010		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	609, 177		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	415, 664		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	48, 563		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	2, 106		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	265, 762		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 439, 242		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	600, 401		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 053, 008		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 SENI OR CARE	0. 000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 000000	87, 354		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 078		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		7, 572, 553		0 0	0	200. 00

^{5/22/2018 1:57} pm

Health Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1331	Period:	Worksheet D	
				From 01/01/2017 To 12/31/2017		pared.
				10 12/01/2011	5/22/2018 1:5	7 pm
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Rei mbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)	5.00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.000040	0	1 710 1	10 0	0	
50. 00 05000 OPERATING ROOM	0. 280343		1, 718, 1		-	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0.000000		200 5	0	e e e e e e e e e e e e e e e e e e e	
53. 00 05300 ANESTHESI OLOGY	0.046513		280, 50		0	53.00
54.00 O5400 RADI OLOGY-DI AGNOSTI C	0.098239		12, 133, 7		0	54.00
60. 00 06000 LABORATORY	0. 131365		5, 415, 4		0	60.00
65.00 06500 RESPI RATORY THERAPY	0. 443325		271, 3		0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 281327		390, 0		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 191678		58, 9		0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 047379		8, 2		0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 117725		2, 263, 9		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 314822		917, 1		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 532797		214, 5		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 523130	0	2, 256, 7	1, 161	0	73.00
OUTPATIENT SERVICE COST CENTERS	1	1		-1	1	
90. 00 09000 CLINIC	0. 737328		33, 8		-	
90. 01 09001 SENI OR CARE	0. 616802		607, 2		0	90.01
91.00 09100 EMERGENCY	0. 191609		5, 215, 3			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 565637	0	1, 152, 8	47 0	0	92.00
OTHER REI MBURSABLE COST CENTERS		1	1		I	
95.00 09500 AMBULANCE SERVICES	0. 433653			0		95.00
200.00 Subtotal (see instructions)		0	32, 938, 0	32 2, 182	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	32, 938, 03	32 2, 182	0	202.00

Health Financial Systems	HARRISON COUN	TY HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/22/2018 1:5	
		Title	XVIII	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	481, 663					50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	13, 047	0				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 192, 006	0				54.00
60. 00 06000 LABORATORY	711, 398					60.00
65. 00 06500 RESPI RATORY THERAPY	120, 313					65.00
66. 00 06600 PHYSI CAL THERAPY	109, 728					66.00
67.00 06700 OCCUPATI ONAL THERAPY	11, 299	0				67.00
68.00 06800 SPEECH PATHOLOGY	392	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	266, 528	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	288, 735	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	114, 299	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 180, 559	607				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	24, 935	0				90.00
90. 01 09001 SENI OR CARE	374, 535	0				90.01
91.00 09100 EMERGENCY	999, 304	196				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	652, 093	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	6, 540, 834	803				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	6, 540, 834	803				202.00

Health Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	VACCINE COST	Provider C	CN: 15-1331	Peri od:	Worksheet D	
		Component	CCN: 15-Z331	From 01/01/2017 To 12/31/2017	Part V Date/Time Pre	narodi
		Component	CCN. 15-2551	10 12/31/2017	5/22/2018 1:5	
		Title	e XVIII	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge		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			
	1.00		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0. 280343	0	1	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 280343			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 048513			0 0	0	54.00
60. 00 06000 LABORATORY	0. 131365			0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 443325			0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 281325			0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 281327			0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 047379				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 117725				0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 314822				0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 514022			0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 523130			0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	0.020100	<u> </u>	I	<u> </u>		/0.00
90. 00 09000 CLINIC	0. 737328	0		0 0	0	90.00
90. 01 09001 SENI OR CARE	0. 616802			0 0	0	
91. 00 09100 EMERGENCY	0, 191609			0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 565637	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	1 -		· · · ·		
95. 00 09500 AMBULANCE SERVICES	0. 433653			0		95.00
200.00 Subtotal (see instructions)	1	0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program	1			0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO Component (CN: 15-1331 CCN: 15-Z331	Period: From 01/01/2017 To 12/31/2017		
		T: +1 o	xvi i	Swing Beds - SNF	5/22/2018 1:5 Cost	o/pm
	Cos			Swing Beas - SNF	COST	
Cost Center Description	Cost	Cost	-			
cost center bescription	Reimbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0					54.00
60. 00 06000 LABORATORY	0					60.00
65. 00 06500 RESPI RATORY THERAPY	0					65.00
66. 00 06600 PHYSI CAL THERAPY	0					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0					67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0					69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					72.00
72.00 07200 TMPL. DEV. CHARGED TO PATTENT 73.00 07300 DRUGS CHARGED TO PATTENTS	0	-				73.00
OUTPATIENT SERVICE COST CENTERS	0	0				/3.00
90. 00 09000 CLINIC	0	0				90.00
90. 00 09000 CLINIC 90. 01 09001 SENI OR CARE	0	0				90.00
90. 01 09001 SENTOR CARE 91. 00 09100 EMERGENCY	0	0				90.01
	0	0				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0				92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	0		1			95.00
	0					
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	_	_				202 00
202.00 Net Charges (line 200 - line 201)	0	0	1			202.00

Health Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1331	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/22/2018 1:5	pared:
		Titl	e XIX	Hospi tal	Cost	<u>, bii</u>
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		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	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	0. 280343	0		0 82, 076	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 046513	0		0 11, 250	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 098239	0		0 499, 600	0	54.00
60. 00 06000 LABORATORY	0. 131365	0		0 328, 509	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 443325	0		0 3, 244	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 281327	0		0 18, 471	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 191678	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.047379	0		0 351	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 117725	0		0 44, 539	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 314822	0		0 52,647	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 532797	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 523130	0		0 97,036	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0. 737328	0		0 0	0	90.00
90. 01 09001 SENI OR CARE	0. 616802	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0. 191609	0		0 475, 946	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 565637	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			•			1
95. 00 09500 AMBULANCE SERVICES	0. 433653	0	I	0		95.00
200.00 Subtotal (see instructions)		0		0 1, 613, 669	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	1	0 1, 613, 669	0	202.00

Health Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/22/2018 1:5	
			e XIX	Hospi tal	Cost	
		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	-		1			
50. 00 05000 OPERATI NG ROOM	0	23, 009				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	523	1			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	49, 080	1			54.00
60. 00 06000 LABORATORY	0	43, 155	1			60.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 438				65.00
66. 00 06600 PHYSI CAL THERAPY	0	5, 196				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	17				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	5, 243				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16, 574				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	50, 762				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
90. 01 09001 SENI OR CARE	0	0				90.01
91.00 09100 EMERGENCY	0	91, 196				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	0	286, 193				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	286, 193				202.00

MPUTA	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1331	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre 5/22/2018 1:5	
		Title XVIII	Hospi tal	Cost	/ piii
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s. excluding newborn)		5, 817	1.
00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		5, 797	2
	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3
	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		4, 369	4
00	Total swing-bed SNF type inpatient days (including private roo	5 7	er 31 of the cost	20	5
	reporting period		21 - 6 + +		
00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) arter December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7
20	reporting period		1 -6	0	
00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	m days) after December 3	or the cost	0	8
00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	2, 018	9
00	newborn days)			20	10
00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	20	
00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11
00	December 31 of the cost reporting period (if calendar year, er			0	1.0
00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	x only (including privat	e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar ye				
	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14 15
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT		<u></u>		
00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	of the cost		17
00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18
00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	155.02	19
00	reporting period		h+	0.00	
00	Medicaid rate for swing-bed NF services applicable to services reporting period	Salter December 31 01 t	ne cost	0.00	20
	Total general inpatient routine service cost (see instructions			7, 207, 542	
00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	a period (line 6	0	23
	x line 18)				
	Swing-bed cost applicable to NF type services through December 7 x line 19)	r 31 of the cost reporti	ng period (line	0	24
	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost o	(line 21 minus line 26)		24, 781 7, 182, 761	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			7,102,701	21
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ·	÷line 28)		0 0. 000000	30 31
00	Average private room per diem charge (line 29 ÷ line 3)	/		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)		+:>	0.00	
	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin		tions)	0. 00 0. 00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36
00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	7, 182, 761	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			ł
00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 239. 05	
	Program general inpatient routine service cost (line 9 x line Medically persesting private room cost applicable to the Program			2, 500, 403	
. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 2, 500, 403	40

COMPUTATI ON	ncial Systems N OF INPATIENT OPERATING COST	HARRISON COUN		CN: 15-1331	Period:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/22/2018 1:5	
			Title	e XVIII	Hospi tal	Cost	,, bu
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00 NURS	ERY (title V & XIX only)	0	(0.0	0 00	0	42.
	nsive Care Type Inpatient Hospital Units	000 415	40	1 2 240 1		F(4.072	43.
	NSIVE CARE UNIT NARY CARE UNIT	999, 415	427	2, 340. 5	241	564, 073	43.
	INTENSIVE CARE UNIT						44
	I CAL I NTENSI VE CARE UNI T						46
1	R SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
00 Drage		+ D 2 2	11			1.00	10
	ram inpatient ancillary service cost (Wks I Program inpatient costs (sum of lines 4		· · ·)		2, 212, 957 5, 277, 433	
	THROUGH COST ADJUSTMENTS			///3/		5, 277, 433	47
	through costs applicable to Program inpa	tient routine	services (from	n Wkst. D, sun	of Parts I and	0	50
111)							
	through costs applicable to Program inpa	itient ancillar	y services (fi	om Wkst. D, s	sum of Parts II	0	51
. 00 Tota	IV) I Program excludable cost (sum of lines 5	0 and 51				0	52
	I Program inpatient operating cost exclud		lated non-phy	vsician anestr	netist and	0	
	cal education costs (line 49 minus line 5		natoa, non prij		iotrot, and	0	
	ET AMOUNT AND LIMIT COMPUTATION						
	ram di scharges					0	
	et amount per discharge					0.00	
	et amount (line 54 x line 55) Terence between adjusted inpatient operati	na cost and ta	ract amount (1	ino 56 minus	lino 52)	0	
	is payment (see instructions)	ny cost and ta	inger anount (i	The so minus	TTHE 55)	0	
	er of lines 53/54 or 55 from the cost rep	ortina period	endi na 1996. u	updated and co	mpounded by the	0.00	
	et basket			-p			
	er of lines 53/54 or 55 from prior year of					0.00	
	ine 53/54 is less than the lower of lines					0	61
	h operating costs (line 53) are less than Int (line 56), otherwise enter zero (see i		s (Tines 54 x	60), or 1% or	the target		
	ef payment (see instructions)	11311 4011 0113)				0	62
	wable Inpatient cost plus incentive payme	ent (see instru	ictions)			0	63
	RAM INPATIENT ROUTINE SWING BED COST						
	<pre>care swing-bed SNF inpatient routine cost ructions)(title XVIII only)</pre>	s through Dece	mber 31 of the	ecost reporti	ng period (See	24, 781	64
	care swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the d	cost reporting	period (See	0	65
	ructions)(title XVIII only)				, p (
	I Medicare swing-bed SNF inpatient routir	ne costs (line	64 plus line 6	55)(title XVII	l only). For	24, 781	66
	(see instructions)		December 21				
	e V or XIX swing-bed NF inpatient routine e 12 x line 19)	e costs through	December 31 0	or the cost re	eporting period	0	67
	e V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	0	68
	e 13 x line 20)				0.1		
	I title V or XIX swing-bed NF inpatient r					0	69
	III - SKILLED NURSING FACILITY, OTHER NU led nursing facility/other nursing facili						70
	isted general inpatient routine service co						71
	ram routine service cost (line 9 x line 7			-/			72
5	cally necessary private room cost applica		ı(line 14 x li	ne 35)			73
. 00 Tota	I Program general inpatient routine servi	ce costs (line	72 + line 73))			74
	tal-related cost allocated to inpatient r	routine service	costs (from V	Vorksheet B, F	Part II, column		75
	line 45) diem capital-related costs (line 75 ÷ lir	2)					76
	ram capital-related costs (line 75 ÷ line) ram capital-related costs (line 9 x line)	,					77
	tient routine service cost (line 74 minus						78
	regate charges to beneficiaries for excess		rovider record	ls)			79
	I Program routine service costs for compa	nrison to the c	ost limitation	າ (line 78 mir	nus line 79)		80
	tient routine service cost per diem limit						81
	tient routine service cost limitation (li						82
	sonable inpatient routine service costs (s		is)				83
	ram inpatient ancillary services (see ins ization review - physician compensation (ns)				84
	I Program inpatient operating costs (sum						86
	IV - COMPUTATION OF OBSERVATION BED PASS						
	I observation bed days (see instructions)					1, 428	87
	sted general inpatient routine cost per o	liem (line 27 ÷	line 2)			1, 239. 05	88
	ervation bed cost (line 87 x line 88) (see					1, 769, 363	

Health Financial Systems	HARRI SON COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Pre 5/22/2018 1:5	
		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	881, 382	7, 207, 542	0. 12228	6 1, 769, 363	216, 368	90.00
91.00 Nursing School cost	0	7, 207, 542	0.00000	0 1, 769, 363	0	91.00
92.00 Allied health cost	0	7, 207, 542	0.00000	0 1, 769, 363	0	92.00
93.00 All other Medical Education	0	7, 207, 542	0. 00000	0 1, 769, 363	0	93.00

^{5/22/2018 1:57} pm

Health Financial Systems HARRISON COUNTY	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1331	Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	narad
			10 12/31/2017	5/22/2018 1:5	
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			2, 901, 503		30.00
31. 00 03100 I NTENSI VE CARE UNI T			632, 866		31.00
43. 00 04300 NURSERY			002,000		43.00
ANCI LLARY SERVI CE COST CENTERS		1		I	
50. 00 05000 OPERATI NG ROOM		0. 2803	43 563, 810	158, 060	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000	0 00	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 0465	13 111, 500	5, 186	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0982			54.00
60. 00 06000 LABORATORY		0. 1313			
65. 00 06500 RESPI RATORY THERAPY		0. 44332			
66. 00 06600 PHYSI CAL THERAPY		0. 2813			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 1916			67.00
68.00 06800 SPEECH PATHOLOGY		0.0473			68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1177			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3148			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 73. 00 07300 DRUGS CHARGED TO PATI ENTS		0. 5327 0. 5231		319, 892 550, 860	72.00 73.00
0UTPATIENT SERVICE COST CENTERS		0.5231	1, 053, 008	550, 860	/3.00
90. 00 09000 CLINIC		0. 7373	28 0	0	90.00
90. 01 09001 SENI OR CARE		0. 6168		0	90.01
91. 00 09100 EMERGENCY		0. 1916		-	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5656			92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			7, 572, 553	2, 212, 957	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			7, 572, 553		202.00

Health Financial Systems HARRISON COUNTY	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1331	Peri od:	Worksheet D-3	
	Component	CCN: 15-Z331	From 01/01/2017 To 12/31/2017	Date/Time Pre	narad
	component	CCN. 15-2551	10 12/31/2017	5/22/2018 1:5	
	Title	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE 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
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 28034	13 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 28032			50.00
53. 00 05300 ANESTHESI OLOGY		0.0465			52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0.0485		0	54.00
60. 00 06000 LABORATORY		0. 13136		0	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 44332			
66. 00 06600 PHYSI CAL THERAPY		0. 28132			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 1916			67.00
68. 00 06800 SPEECH PATHOLOGY		0. 04737		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 11772		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 31482		1, 690	1
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 53279		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 52313		2, 515	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 73732	28 0	0	90.00
90. 01 09001 SENI OR CARE		0. 61680	02 0	0	90.01
91.00 09100 EMERGENCY		0. 19160	09 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 56563	37 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		_			
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			28, 003	9, 237	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			28, 003		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 15-1331 Period: From 01/01/2017 To Worksheet D-3 Date/Time Prepared: 5/22/2018 1:57 pm Cost Center Description Title XIX Hospital Cost Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Charges Program Costs (col. 1 x col. 2) 30.00 03000 ADULTS & PEDIATRICS 30.00 30.00 30.00 31.00 03000 NURSERY 263,094 30.00 31.00 43.00 04300 NURSERY 96,593 43.00 30.00 31.00 52.00 05200 DELIVERY ROM & LABOR ROOM 0.280343 39,080 10,956 50.00 52.00 05200 DELIVERY ROM & LABOR ROOM 0.000000 0 0 52.00 54.00 05400 RADIOGY -DI AGNOSTIC 0.08239 36,317 3,568 54.00 60.00 LABORATORY 0.131365 84,573 11,10 60.00
Image: Construct Construction To 12/31/2017 Date/Time Prepared: 5/22/2018 1: 57 pm Cost Center Description Title XIX Hospital Cost Inpatient Program Costs (col. 1 x col. 2) Inpatient Program Costs (col. 1 x col. 2) 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 31.00 03100 INTENSIVE CARE UNIT 266,3094 30.00 43.00 04300 NURSERY 96,593 43.00 ANCI LLARY SERVICE COST CENTERS 0.280343 39,080 10,956 50.00 52.00 05200 DERATING ROOM 0.280343 39,080 10,956 50.00 53.00 05300 ANESTHESI OLOGY 0.046513 6,500 302 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098239 36,317 3,568 54.00
Impact of Cost Center Description Title XIX Hospital Cost Inpatient Program Costs (col. 1 x col. 2) Impatient Inpatient Program Costs Cost Inpatient Program Costs (col. 1 x col. 2) 2) 1.00 2.00 3.00 20 30.00
Title XIX Hospital Cost Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Costs (cl. 1 x col. 2) 1.00 2.00 3.00 1.00 2.00 3.00 03000 ADULTS & PEDI ATRICS 263,094 30.00 31.00 03100 INTENSI VE CARE UNI T 266,340 31.00 43.00 04300 NURSERY 96,593 43.00 ANCI LLARY SERVI CE COST CENTERS 0.280343 39,080 10,956 50.00 50.00 05000 DERATI NG ROOM 0.280343 39,080 10,956 50.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.046513 6,500 302 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098239 36,317 3,568 54.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS Program Costs (col. 1 x col. 2) Program Costs (col. 1 x col. 2) 30.00 03000 ADULTS & PEDI ATRI CS 1.00 2.00 3.00 31.00 03100 I NTENSI VE CARE UNI T 263,094 30.00 31.00 43.00 04300 NURSERY 96,593 43.00 ANCI LLARY SERVI CE COST CENTERS 0.280343 39,080 10,956 50.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 52.00 50.00 50.00 50.00 52.00 50.00 (0.046513 6,500 30.20 53.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 0.098239 36, 317 3,568 54.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS Charges (col. 1 x col. 2) 30.00 3.00 3.00 3.00 31.00 03000 ADULTS & PEDI ATRI CS 263,094 30.00 31.00 03100 I NTENSI VE CARE UNI T 263,094 31.00 43.00 04300 NURSERY 96,593 43.00 ANCI LLARY SERVI CE COST CENTERS 96,593 43.00 52.00 05000 OPERATI NG ROOM 0.280343 39,080 10,956 50.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 50.00 302 53.00 53.00 05300 ANESTHESI OLOGY 0.044513 6,500 302 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098239 36,317 3,568 54.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDI ATRI CS 263,094 30.00 31.00 03100 I NTENSI VE CARE UNI T 263,094 31.00 43.00 04300 NURSERY 96,593 43.00 ANCI LLARY SERVI CE COST CENTERS 0.280343 39,080 10,956 50.00 05000 OPERATI NG ROOM 0.280343 39,080 10,956 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 52.00 53.00 05300 ANESTHESI OLOGY 0.046513 6,500 302 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098239 36,317 3,568 54.00
I.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 30.00 ADULTS & PEDIATRICS 263,094 30.00 31.00 03100 NTENSI VE CARE UNIT 26,340 31.00 43.00 04300 NURSERY 96,593 43.00 ANCI LLARY SERVI CE COST CENTERS 0.280343 39,080 10,956 50.00 05000 OPERATI NG ROOM 0.280343 39,080 10,956 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 52.00 53.00 05300 ANESTHESI OLOGY 0.046513 6,500 302 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098239 36,317 3,568 54.00
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATRICS 263,094 30.00 31.00 03100 NTENSI VE CARE UNI T 26,340 31.00 43.00 04300 NURSERY 96,593 43.00 ANCI LLARY SERVICE COST CENTERS 0.280343 39,080 10,956 50.00 50.00 05000 OPERATI NG ROOM 0.280300 00 52.00 53.00 54.00 54.00 73.568 54.00
30.00 03000 ADULTS & PEDIATRICS 263,094 30.00 31.00 03100 INTENSIVE CARE UNIT 26,340 31.00 43.00 04300 NURSERY 96,593 43.00 ANCILLARY SERVICE COST CENTERS 0.280343 39,080 10,956 50.00 50.00 05000 OPERATING ROOM 0.280343 39,080 10,956 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 53.00 05300 ANESTHESI OLOGY 0.046513 6,500 302 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098239 36,317 3,568 54.00
31.00 03100 INTENSI VE CARE UNIT 26, 340 31.00 43.00 04300 NURSERY 96, 593 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 DPERATI NG ROOM 0.280343 39, 080 10, 956 50.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 50.00 52.00
43. 00 04300 NURSERY 96, 593 43. 00 ANCI LLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0. 280343 39, 080 10, 956 50. 00 50. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 000000 0 52. 00 53. 00 05300 ANESTHESI OLOGY 0. 046513 6, 500 302 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 098239 36, 317 3, 568 54. 00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 0.280343 39,080 10,956 50.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 52.00 53.00 05300 ANESTHESI OLOGY 0.046513 6,500 302 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098239 36,317 3,568 54.00
50.00 05000 0PERATI NG ROOM 0.280343 39,080 10,956 50.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 52.00 53.00 05300 ANESTHESI OLOGY 0.046513 6,500 302 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098239 36,317 3,568 54.00
53.00 05300 ANESTHESI OLOGY 0.046513 6,500 302 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098239 36,317 3,568 54.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.098239 36, 317 3, 568 54.00
60. 00 06000 LABORATORY 0. 131365 84, 573 11, 110 60. 00
65.00 06500 RESPI RATORY THERAPY 0.443325 30, 401 13, 478 65.00
66.00 06600 PHYSI CAL THERAPY 0.281327 2,920 821 66.00
67.00 06700 OCCUPATI ONAL THERAPY 0.191678 361 69 67.00
68.00 06800 SPEECH PATHOLOGY 0 0 68.00
69.00 06900 ELECTROCARDI OLOGY 0.117725 9, 502 1, 119 69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 314822 73, 196 23, 044 71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 0.532797 0 0 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 523130 40, 857 21, 374 73. 00 OUTPATIENT SERVICE COST CENTERS 73. 00
90. 00 09000 CLINIC 0. 737328 0 0 90. 00
90. 01 09001 SENI OR CARE 0 0 90. 01
91. 00 09100 EMERGENCY 0. 191609 9, 018 1, 728 91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 565637 0 0 92. 00
OTHER RELIMBURSABLE COST CENTERS
95.00 09500/AMBULANCE SERVICES 95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98) 332, 725 87, 569 200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00
202.00 Net charges (line 200 minus line 201) 332, 725 202.00

Health Financial Systems	IARRI SON COUNTY	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-1331	Peri od:	Worksheet D-3	
		Component	CCN: 15-Z331	From 01/01/2017 To 12/31/2017	Date/Time Pre	pared [.]
					5/22/2018 1:5	
		Ti tl		Swing Beds - SNF		
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00		2)	
			1.00	2.00	3.00	
			1		1	20.00
30. 00 03000 ADULTS & PEDI ATRI CS				0		30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY				0		31.00 43.00
ANCI LLARY SERVI CE COST CENTERS				0		43.00
50. 00 05000 OPERATI NG ROOM			0. 28034	13 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM			0. 2803			52.00
53. 00 05300 ANESTHESI OLOGY			0. 0465		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 09823		0	54.00
60. 00 06000 LABORATORY			0. 13130		0	60.00
65. 00 06500 RESPIRATORY THERAPY			0. 44332		0	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 28132		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY			0. 1916		0	67.00
68. 00 06800 SPEECH PATHOLOGY			0.0473		0	68.00
69. 00 06900 ELECTROCARDI OLOGY			0. 11772		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 31482		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT			0. 53279		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 52313	30 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			•		•	1
90. 00 09000 CLINIC			0. 73732	28 0	0	90.00
90. 01 09001 SENI OR CARE			0. 61680	02 0	0	90. 01
91.00 09100 EMERGENCY			0. 1916	09 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 56563	37 0	0	92.00
OTHER REIMBURSABLE COST CENTERS				-		
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (sum of lines 50 through 94 and 96				0	0	200. 00
201.00 Less PBP Clinic Laboratory Services-Progr	am only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			l	0		202.00

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Peri od:	Worksheet E	2552-10
			From 01/01/2017 To 12/31/2017	Part B Date/Time Pre	
		Title XVIII	Hospi tal	5/22/2018 1:5 Cost	/ pm
				1.00	
-	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			6, 541, 637	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruction OPPS payments)	ctions)		0	
4.00	Outlier payment (see instructions)			0	4.00
4.01	Outlier reconciliation amount (see instructions)			0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	uctions)		0. 000 0	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, col. 13, line 200		0	9.00
	Total cost (sum of lines 1 and 10) (see instructions)			6, 541, 637	1
	COMPUTATION OF LESSER OF COST OR CHARGES				1
12.00	Reasonable charges Ancillary service charges			0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	line 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for	navmont for convisos on	a chargo basi s	0	15.00
	Amounts that would have been realized from patients liable for			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(1 3	5		
	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	17.00
	Excess of customary charges over reasonable cost (complete or	nlvifline 18 exceeds li	ne 11) (see	0	1
	instructions)	-			
20.00	Excess of reasonable cost over customary charges (complete or instructions)	nly if line 11 exceeds li	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			6, 607, 053	21.00
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see inst Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	tructions)		0	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
	Deductibles and coinsurance (for CAH, see instructions)			63, 052	
	Deductibles and Coinsurance relating to amount on line 24 (fo Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			5, 510, 415 1, 033, 586	1
27.00	instructions)	prus the sum of fries 22		1, 033, 300	27.00
	Direct graduate medical education payments (from Wkst. E-4, I	-		0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29))		0 1, 033, 586	
	Primary payer payments			885	1
32.00	Subtotal (line 30 minus line 31)			1, 032, 701	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11)	CES)		0	33.00
	Allowable bad debts (see instructions)			1, 058, 470	1
35.00	Adjusted reimbursable bad debts (see instructions)			688, 006	35.00
	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	tructions)		727, 326 1, 720, 707	
	MSP-LCC reconciliation amount from PS&R			1, 720, 707	37.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	39.50 39.97
	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla	aced devices (see instruc	tions)	0	39.97
39.99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	39.99
	Subtotal (see instructions)			1, 720, 707	1
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			34, 414 0	
	Interim payments			2, 378, 262	1
	Tentative settlement (for contractors use only)			0	42.00
	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2	chapter 1	-691, 969 0	1
	§115. 2			0	
i i	TO BE COMPLETED BY CONTRACTOR				00.00
00 00	Original outlier amount (see instructions)			0	1
	· · · · · · · · · · · · · · · · · · ·			0	91.00
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions)				91.00 92.00 93.00

VALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1331	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part I Date/Time Prep 5/22/2018 1:57	pared
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	тв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		4, 327, 12	24	2, 378, 262	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero					3.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					1
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3.
04				0	0	3
05	Drovidan ta Drognom			0	0	3.
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3
50 51	ADJUSTMENTS TO FROGRAM			0	0	
52				0	0	3
53				0	0	3
54				0	0	3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3.
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 327, 12	24	2, 378, 262	4
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
00	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	5
02 03				0	0	5
03	Provider to Program			0	0	5
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
01	the cost report. (1) SETTLEMENT TO PROVIDER		201 24		o	,
01 02	SETTLEMENT TO PROVIDER		381, 36		0 691, 969	6
02	Total Medicare program liability (see instructions)		4, 708, 48	0	1, 686, 293	
50			+, 700, 40	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

	I Financial Systems HARRISON COUN SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-1331	Period: From 01/01/2017	eu of Form CMS-: Worksheet E-1 Part I	
		Component (CCN: 15-Z331	To 12/31/2017		
				Swing Beds - SNI		
		I npati en	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		31, 63	34	0	
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3
00	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
)1	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
03				0	0	
)4)5				0	0	-
05	Drovidor to Drogram			0	0	3
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	
53				0	0	
54				0	0	3
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		31, 63	34	0	4
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					15
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider		1	1	1	
01	TENTATI VE TO PROVI DER			0	0	
)2				0	0	
)3	Provider to Program			0	0	5
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
11	the cost report. (1)			7	_	
)1))	SETTLEMENT TO PROVIDER		2, 03		0	-
02	SETTLEMENT TO PROGRAM		33, 67	0	0	-
00	Total Medicare program liability (see instructions)		33, 6,	Contractor	NPR Date	7
				Number	(Mo/Day/Yr)	
		(C	1.00	2.00	
00	Name of Contractor					8

From 01/01/2017 Part To 12/31/2017 Date	rksheet E-1 rt II te/Time Prepared: 22/2018 1:57 pm
0,22	
Title XVIII Hospital	Cost
	1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1.00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2	3.00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	7.00
8.00 Calculation of the HIT incentive payment (see instructions)	8.00
9.00 Sequestration adjustment amount (see instructions)	9.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH	
30.00 Initial/interim HIT payment adjustment (see instructions)	30.00
31.00 Other Adjustment (specify)	31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

^{5/22/2018 1:57} pm

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1331	Peri od:	Worksheet E-2	
		Component CCN: 15-Z331	From 01/01/2017 To 12/31/2017	Date/Time Pre	
		Title XVIII	Swing Beds - SNF	5/22/2018 1:5 Cost	/ pm
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient routine services - swing bed-SNF (see instructions)		25, 029	0] 1.
00	Inpatient routine services - swing bed-NF (see instructions)				2
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par-	t A, and sum of Wkst. D,	9, 329	0	3
~~	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see in:			0.00	
00	Per diem cost for interns and residents not in approved teach instructions)	ing program (see		0.00	4
00	Program days		20	0	5
00	Interns and residents not in approved teaching program (see in	nstructions)	20	0	
00	Utilization review - physician compensation - SNF optional me		0	-	7
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	5	34, 358	0	8
00	Primary payer payments (see instructions)		0	0	9
. 00	Subtotal (line 8 minus line 9)		34, 358	0	
. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	0	0	11
~~	professional services)		24.250	0	1 10
. 00 . 00	Subtotal (line 10 minus line 11) Coinsurance billed to program patients (from provider records) (oveludo, coi psuranco	34, 358	0	
. 00	for physician professional services)		0	0	13
. 00	80% of Part B costs (line 12 x 80%)			0	14
. 00	Subtotal (enter the lesser of line 12 minus line 13, or line	14)	34, 358	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16
. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			16
. 55	Rural community hospital demonstration project (§410A Demonst	ration) payment	0		16
	adjustment (see instructions)		_	_	
. 99	Demonstration payment adjustment amount before sequestration		0	0	
. 00 . 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		0	0	1
00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	
. 00	Total (see instructions)		34, 358	0	
. 01	Sequestration adjustment (see instructions)		687	0	
. 02	Demonstration payment adjustment amount after sequestration)		0	0	19
. 00	Interim payments		31, 634	0	20
. 00	Tentative settlement (for contractor use only)		0	0	
. 00	Balance due provider/program (line 19 minus lines 19.01, 20, a	-	2, 037	0	
. 00	Protested amounts (nonallowable cost report items) in accordance	nce with CMS Pub. 15-2,	0	0	23
	<u>chapter 1, §115.2</u> Rural Community Hospital Demonstration Project (§410A Demonst				
	Is this the first year of the current 5-year demonstration pe				200
5.00	Century Cures Act? Enter "Y" for yes or "N" for no.	The under the 21st			200
	Cost Reimbursement				1
1.00	Medicare swing-bed SNF inpatient routine service costs (from)	Wkst. D-1, Pt. II, line			201
	66 (title XVIII hospital))				
2.00	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst. D-3, col. 3, lin	ie		202
2 00	200 (title XVIII swing-bed SNF)) Total (sum of lines 201 and 202)				202
	Medicare swing-bed SNF discharges (see instructions)				203 204
+. 00	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-vear demonst	ration	1204
	period)	The goal of the carre	int o year demonst	ration	
5.00	Medicare swing-bed SNF target amount				205
5. 00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t	imes line 204)			206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburg				
	Program reimbursement under the §410A Demonstration (see inst				207
3.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	2, col. 1, sum of lines	1		208
	and 3) Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209
	Reserved for future use				209
0.00	Comparision of PPS versus Cost Reimbursement				1210
	Total adjustment to Medicare swing-bed SNF PPS payment (line :				215

LCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1331	Peri od:	Worksheet E-2
		Component CCN: 15-Z331	From 01/01/2017 To 12/31/2017	
		Title XIX	Swing Beds - SNF	
			Part A	Part B
			1.00	2.00
	COMPUTATION OF NET COST OF COVERED SERVICES			
00	Inpatient routine services - swing bed-SNF (see instructions)		0	
00	Inpatient routine services - swing bed-NF (see instructions)		0	
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		0	
~ ~	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins		0.00	
00	Per diem cost for interns and residents not in approved teachi	ng program (see	0.00	
00	instructions) Program days		0	
00	Interns and residents not in approved teaching program (see in	estructions)	0	
20	Utilization review - physician compensation - SNF optional met		0	
20	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	
20	Primary payer payments (see instructions)		0	
. 00	Subtotal (line 8 minus line 9)		0	1
00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	1
	professional services)			'
. 00	Subtotal (line 10 minus line 11)		0	1
00	Coinsurance billed to program patients (from provider records)) (exclude coinsurance	0	1
	for physician professional services)			
. 00	80% of Part B costs (line 12 x 80%)		0	1
. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 1	14)	0	1
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	1
50	Pioneer ACO demonstration payment adjustment (see instructions	5)		1
55	Rural community hospital demonstration project (§410A Demonstr	ration) payment		1
	adjustment (see instructions)			
. 99	Demonstration payment adjustment amount before sequestration		0	1
	Allowable bad debts (see instructions)		0	1
01	Adjusted reimbursable bad debts (see instructions)		0	1
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	1
00	Total (see instructions)		0	1
01	Sequestration adjustment (see instructions)		0	1
	Demonstration payment adjustment amount after sequestration)		0	1
	Interim payments Tentetive cettlement (for contractor use colu)		0	2
00 00	Tentative settlement (for contractor use only) Relance due provider (program (line 10 minus lines 10 01 - 20 - c	and 21)	0	2
00	Balance due provider/program (line 19 minus lines 19.01, 20, a Protested amounts (nonallowable cost report items) in accordar	-	0	2
00	chapter 1, §115.2	ice with CMS Pub. 15-2,	0	2
	Rural Community Hospital Demonstration Project (§410A Demonstr	cation) Adjustment		
	Is this the first year of the current 5-year demonstration per			20
	Century Cures Act? Enter "Y" for yes or "N" for no.			
	Cost Reimbursement			
I. 00	Medicare swing-bed SNF inpatient routine service costs (from V	Wkst. D-1, Pt. II, line		20
	66 (title XVIII hospital))			
2.00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, lir	ne	20
	200 (title XVIII swing-bed SNF))			
	Total (sum of lines 201 and 202)			20
	Medicare swing-bed SNF discharges (see instructions)			20
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	ent 5-year demonst	tration
	period) Madicara cwing had SNE target amount			20
	Medicare swing-bed SNF target amount Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mos lino 204)		20
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs			20
	Program reimbursement under the §410A Demonstration (see instr			20
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	2	1	20
	and 3)	_, cor. 1, com of filles	•	20
. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)		20
	Reserved for future use	,		21
	Comparision of PPS versus Cost Reimbursement		I	

	Financial Systems HARRISON COUN			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Time Pre 5/22/2018 1:5	pared:
		Title XVIII	Hospi tal	Cost	
		·			
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAL	RE PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			5, 277, 433	
2.00	Nursing and Allied Health Managed Care payment (see instruc	tions)		0	
3.00	Organ acquisition			0	
4.00	Subtotal (sum of lines 1 through 3)			5, 277, 433	
5.00	Primary payer payments			13, 017	
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			5, 317, 190	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
7 00	Reasonable charges Routine service charges			0	7 00
7.00 8.00	5			0	7.00 8.00
8.00 9.00	Ancillary service charges Organ acquisition charges, net of revenue			0	
9.00	Total reasonable charges			0	
10.00	Customary charges			0	10.00
11.00	Aggregate amount actually collected from patients liable fo	r payment for services on	a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable			0	
12100	had such payment been made in accordance with 42 CFR 413.13		a onargo saoro	Ũ	
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0,000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds li	ne 6) (see	0	15.00
	instructions)	5	, ,		
16.00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds lir	ne 14) (see	0	16.00
	instructions)			_	
17.00	Cost of physicians' services in a teaching hospital (see in:	structions)		0	17.00
18.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Direct graduate medical education payments (from Worksheet	F 4 line 40)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	E-4, 1111e 49)		5, 317, 190	
20.00	Deductibles (exclude professional component)			564, 564	
20.00	Excess reasonable cost (from line 16)			0	
21.00	Subtotal (line 19 minus line 20 and 21)			4, 752, 626	
23.00	Coi nsurance			1, 702, 020	
24.00	Subtotal (line 22 minus line 23)			4, 752, 626	
25.00	Allowable bad debts (exclude bad debts for professional ser	vices) (see instructions)		79, 923	
26.00	Adjusted reimbursable bad debts (see instructions)			51, 950	
27.00	Allowable bad debts for dual eligible beneficiaries (see in:	structions)		37, 352	
28.00	Subtotal (sum of lines 24 and 25, or line 26)	/		4, 804, 576	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29.50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration	n		0	29.99
30.00	Subtotal (see instructions)			4, 804, 576	30.00
30. 01	Sequestration adjustment (see instructions)			96, 092	30.01
30. 02	Demonstration payment adjustment amount after sequestration			0	
31.00	Interim payments			4, 327, 124	
32.00	Tentative settlement (for contractor use only)			0	
33.00	Balance due provider/program (line 30 minus lines 30.01, 30			381, 360	
34.00	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-2.	chapter 1.	0	34.00

BALANC	Financial Systems HARRISON COUNT E SHEET (If you are nonproprietary and do not maintain Notation	TY HOSPITAL Provider C	CN: 15-1331 Pe	eri od:	u of Form CMS-2 Worksheet G	10
	ype accounting records, complete the General Fund column		F	rom 01/01/2017 0 12/31/2017	Date/Time Pre	nared
onl y)					5/22/2018 1:5	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS		-	-		
1.00	Cash on hand in banks	1, 593, 029		0	0	1.00
2.00 3.00	Temporary investments Notes receivable	3, 700, 431	0	0	0	2.00 3.00
4.00	Accounts receivable	26, 167, 166	-	0	0	4.00
5.00	Other receivable	940, 174	0	Ő	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-18, 590, 469	0	0	0	6.00
7.00	Inventory	1, 117, 279		0	0	7.00
8.00	Prepaid expenses	824, 766		0	0	8.00
9.00 10.00	Other current assets Due from other funds	14, 827	0	0	0	9.00 10.00
11.00	Total current assets (sum of lines 1-10)	15, 767, 203	-	0	0	11.00
	FIXED ASSETS	10//01/200				
12.00	Land	3, 001, 138	0	0	0	12.00
13.00	Land improvements	3, 379, 433		0	0	13.00
	Accumulated depreciation	-2, 262, 011	0	0	0	14.00
15.00 16.00	Buildings Accumulated depreciation	40, 406, 678 -20, 405, 347	0	0	0	15.00 16.00
17.00	Leasehold improvements	4, 309, 403		0	0	17.00
18.00	Accumulated depreciation	-1, 940, 030		0	0	18.00
	Fixed equipment	0	0	0	0	19.00
20. 00	Accumulated depreciation	0	0	0	0	20.00
	Automobiles and trucks	0	0	0	0	21.00
	Accumulated depreciation	0 124 004	0	0	0	22.00
	Major movable equipment Accumulated depreciation	28, 124, 986 -24, 758, 221		0	0	23.00 24.00
	Mi nor equi pment depreci abl e	24, 730, 221	0	0	0	25.00
	Accumul ated depreciation	0	0	0	0	26.00
	HIT designated Assets	0	0	0	0	27.00
	Accumulated depreciation	0	0	0	0	28.00
	Minor equipment-nondepreciable	0 054 020	0	0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	29, 856, 029	0	U	0	30.00
31.00	Investments	8, 730, 176	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1, 407, 057	0	0	0	34.00
35.00 36.00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	10, 137, 233 55, 760, 465		0	0	35.00 36.00
30.00	CURRENT LIABILITIES	55, 700, 405	0	U.	0	30.00
37.00	Accounts payable	2, 502, 120	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2, 415, 137	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
	Notes and Loans payable (short term)	0	0	0	0	40.00
41.00 42.00	Deferred income Accelerated payments	0	0	0	0	41.00 42.00
43.00	Due to other funds	0	0	0	0	42.00
	Other current liabilities	31, 308	0	Ő	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4, 948, 565		0	0	45.00
	LONG TERM LIABILITIES			1		
46.00	Mortgage payable	0	0	0	0	46.00
47.00 48.00	Notes payable Unsecured Loans	6, 508, 178 4, 883, 000		0	0	47.00 48.00
49.00	Other long term liabilities	4, 883, 000	0	0	0	48.00
	Total long term liabilities (sum of lines 46 thru 49)	11, 391, 178	0	0	0	50.00
	Total liabilities (sum of lines 45 and 50)	16, 339, 743	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	39, 420, 722				52.00
53.00 54.00	Specific purpose fund Donor created - endowment fund balance - restricted		0	o		53.00 54.00
54.00 55.00	Donor created - endowment fund balance - restricted			0		54.00 55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant			5	0	57.00
58.00	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion	20 400 700	_	~	~	E0 00
59.00 60.00	Total fund balances (sum of lines 52 thru 58)	39, 420, 722		0	0	59.00 60.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	55, 760, 465	0	U	0	00.00

HARRI SON COUNTY	' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	Provider CC	CN: 15-1331	Period: From 01/01/2017 To 12/31/2017	Worksheet G-1 Date/Time Pre	pared:
General	Fund	Speci al	Purpose Fund	Endowment Fund	
1.00	2.00	3.00	4.00	5.00	
	41, 011, 699 -1, 590, 977 39, 420, 722 0 39, 420, 722 0 39, 420, 722 0 39, 420, 722	5.00		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
Endowment Fund	PI ant	Fund			
6.00	7.00	8.00	_		
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
000	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
	General	General Fund 1.00 2.00 41,011,699 -1,590,977 39,420,722 0 <td>Provi der CCN: 15-1331 General Fund Special 1.00 2.00 3.00 41,011,699 -1,590,977 -1,590,977 39,420,722 0 0 0 39,420,722 0 0 0 39,420,722 0 0 0 39,420,722 0 0 0 39,420,722 0 0 0</td> <td>Provi der CCN: 15-1331 Peri od: From 01/01/2017 To 12/31/2017 General Fund Speci al Purpose Fund 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 3.00 4.00 0 0 41.011.699 0 0 -1.590.977 39,420,722 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>Provi der CCN: 15-1331 Peri od: From 01/01/2017 To 12/31/2017 Worksheet G-1 Date/Time Prej 5/22/2018 1:5 General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4.00 5.00 41,011,699 -1,590,977 0 - 0 0 -1,590,977 0</td>	Provi der CCN: 15-1331 General Fund Special 1.00 2.00 3.00 41,011,699 -1,590,977 -1,590,977 39,420,722 0 0 0 39,420,722 0 0 0 39,420,722 0 0 0 39,420,722 0 0 0 39,420,722 0 0 0	Provi der CCN: 15-1331 Peri od: From 01/01/2017 To 12/31/2017 General Fund Speci al Purpose Fund 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 3.00 4.00 0 0 41.011.699 0 0 -1.590.977 39,420,722 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Provi der CCN: 15-1331 Peri od: From 01/01/2017 To 12/31/2017 Worksheet G-1 Date/Time Prej 5/22/2018 1:5 General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4.00 5.00 41,011,699 -1,590,977 0 - 0 0 -1,590,977 0

STATEM	Financial Systems HARRISON COUNTY ENT OF PATIENT REVENUES AND OPERATING EXPENSES	HOSPITAL Provider C	CN: 15-1331	Peri	i od:	u of Form CMS-2 Worksheet G-2	
STATE	LINE OF FATTERE REVENUES AND OF ERVETING EAFENDES		SN. 13 1331		m 01/01/2017 12/31/2017	Parts I & II Date/Time Pre 5/22/2018 1:5	pared:
	Cost Center Description	1	Inpati ent		Outpatient	Total	
	·		1.00		2.00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal		8, 398, 6	80		8, 398, 680	1.00
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVI DER						4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		8, 398, 6	080		8, 398, 680	10.00
	Intensive Care Type Inpatient Hospital Services						
11.00	I NTENSI VE CARE UNI T		1, 098, 6	91		1, 098, 691	11.00
12.00	CORONARY CARE UNI T						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGICAL INTENSIVE CARE UNIT						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	1, 098, 6	91		1, 098, 691	16. OC
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9, 497, 3	371		9, 497, 371	17.00
18.00	Ancillary services		19, 463, 0)38	122, 627, 417	142, 090, 455	18.00
19.00	Outpatient services		1	0	9, 976	9, 976	19.00
20.00	RURAL HEALTH CLINIC		1	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		1	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1		567, 740	567, 740	22.00
23.00	AMBULANCE SERVI CES		1	0	7, 953, 988	7, 953, 988	23.00
24.00	СМНС		1				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE						26.00
27.00	OTHER (SPECIFY)			0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	28, 960, 4	109	131, 159, 121	160, 119, 530	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES						1
29.00	Operating expenses (per Wkst. A, column 3, line 200)				55, 693, 894		29.00
30.00	ADD (SPECIFY)		1	0			30.00
31.00			1	0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECIFY)			0	-		37.00
38.00				0			38.00
39.00				Ő			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)			-	0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer			55, 693, 894		43.00
.0.00	to Wkst. G-3, line 4)				30, 0, 0, 0, 4		10.00

Heal th	Financial Systems	HARRI SON COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider CC	CN: 15-1331	Peri od:	Worksheet G-3	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	harod
					10 12/31/2017	5/22/2018 1:5	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part					160, 119, 530	1.00
2.00	Less contractual allowances and discounts on	patients' account	S			108, 939, 040	2.00
3.00	Net patient revenues (line 1 minus line 2)					51, 180, 490	3.00
4.00	Less total operating expenses (from Wkst. G-		13)			55, 693, 894	4.00
5.00	Net income from service to patients (line 3	minus line 4)				-4, 513, 404	5.00
	OTHER INCOME						
6.00	Contributions, donations, bequests, etc					14, 754	6.00
7.00	Income from investments					412, 180	7.00
8.00	Revenues from telephone and other miscellane	ous communication	servi ces			0	8.00
9.00	Revenue from television and radio service					0	9.00
10.00	Purchase di scounts					4, 094	10.00
11.00	Rebates and refunds of expenses					0	11. 00 12. 00
12.00 13.00	Parking lot receipts					0	12.00
13.00	Revenue from laundry and linen service Revenue from meals sold to employees and que	ctc				138, 732	13.00
	Revenue from rental of living quarters	515				136, 732	14.00
	Revenue from sale of medical and surgical su	nnling to other th	an nationte			0	16.00
	Revenue from sale of drugs to other than pat		ian patrents			0	17.00
	Revenue from sale of medical records and abs					22, 685	
	Tuition (fees, sale of textbooks, uniforms,					22,003	19.00
	Revenue from gifts, flowers, coffee shops, a					0	20.00
	Rental of vending machines					0	21.00
22.00						229, 139	
23.00						59, 499	
24.00						1, 089, 322	
24.01						952, 022	
	Total other income (sum of lines 6-24)					2, 922, 427	
	Total (line 5 plus line 25)					-1, 590, 977	
	OTHER EXPENSES (SPECIFY)					0	27.00
	Total other expenses (sum of line 27 and sub	scripts)				0	28.00
29.00	Net income (or loss) for the period (line 26	minus line 28)				-1, 590, 977	29.00

ARALTSIS DF HOSPITAL-BASED HORE FRALTH ACENCY UDSIS Provider CC: 15-132 (19) 22/21/2317 Port dim Transmitter Port dim Transmitter P	Heal th	Financial Systems		HARRI SON COUN	TY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HW COX 1b-7242 To Total list rise prepared. Isource Jose Prepared. Isource <thjose prepared.<br="">Isource <thjose prepared.isource<="" td="" th<=""><td>ANALYS</td><td>IS OF HOSPITAL-BASED HOME HEALT</td><td>H AGENCY COSTS</td><td></td><td>Provider C</td><td></td><td></td><td>Worksheet H</td><td></td></thjose></thjose>	ANALYS	IS OF HOSPITAL-BASED HOME HEALT	H AGENCY COSTS		Provider C			Worksheet H	
Instrument Sal aries Jergi oyee Remoti Ts Instruction (see (see (see (see (see (see (see (se					HHA CCN:				
Salaries Engloye Franzortation/Durtract/OPD Other Cost Other Cost 1.00 2.00 3.00 4.00 5.00 6.00 1.00 Capital Sciences 0							Home Health		7 pm
Itement is (see Instructions) chasted Services cold s. 0 cold s. 0 1.00 2.00 3.00 4.00 5.00 6.00 1.01 Capital Related - High A Fixtures 0								FFJ	
Image: construct and constructions in the image			Sal ari es				r Other Costs		
Interface 1.00 2.00 3.00 4.00 5.00 6.00 1.00 Copit fall Related - Blog & Copit fall Related - Blog & Cop				Benefits					
1.00 Copi Tai Rel ated - Bidg. 8 0 <th< td=""><td></td><td></td><td>1.00</td><td>2.00</td><td></td><td></td><td>5.00</td><td></td><td></td></th<>			1.00	2.00			5.00		
Los Fixtures Image: Constraint of the second of the secon						1			1 4 44
2.00 Capit Is Related - Movable 0	1.00				U		0	0	1.00
3.00 Plant Operation & Maintenance 0 <	2.00				C		0	0	2.00
4.00 Transportation 0	0.00								
5.00 Admin istrative and General 107,99 0 0 0 100,417 207,013 5.00 HMA REPURSABLE SERVICES 5.00 0 106,172 207,013 6.00 5.00 6.00 5.01 6.00 5.01 6.00 5.01 6.00 5.01 6.00 5.01 6.00 5.01 6.00 5.00 0 0 6.00 5.00 0 0 6.00 5.00 0 0 0 0 0 22.28 8.00 0			0	-				-	1
HIM RETMURGRARE SERVICES		•	107, 398	-	0		-	-	1
7.00 Physical Therapy 140,722 0 7,410 0 147,683 7,00 9.00 Speech Pathology 0,90 0		HHA REIMBURSABLE SERVICES				1			
0.00 Occupational Therapy 26,198 0 2,050 0 0 24.64 8,00 0									
9.00 Speech Pathology 0				-			-		
11 00 Home Healt h Aide 56,945 0 8,616 0 0 65,561 11.00 12.00 Durgs 0							0 0		
12 00 Supplies (see instructions) 0			-	0	C		0 0		1
13.00 Drugs 0 0 0 0 0 0 0 0 13.00 <				0	8, 616		0		
0 Def 0 0 0 0 0 0 0 14.00 HAM. NORE IMBURSABLE SERVICES 0			-	0	0				
15:00 Iome Dial yisi Aide Services 0 <			-	-	0		-		1
16.00 respiratory 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 16.00 0						1			
17.00 Private Dufy Nursing 0 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td>-</td> <td>-</td> <td></td>				-			-	-	
B. 00 Clinic 0				-				-	
20.00 Day Care Program 0			0	0	0		0 0	-	
21.00 Home Del Ivered Meal's Program 0			0	0	C		0 0	0	1
22.00 Homemaker Service 0			0	0	0		0 0	-	1
23.00 All Others (specify) 0 0 0 0 0 0 0 0 0 23.00 23.50 Telemedicine 485.659 0 28.264 0 109,937 623.860 24.00 24.00 Total (sum of lines 1-23) Reclassificati on Reclassified Trial Balance (col. 6 + col. 7) Adjustments (col. 7) Net Expenses for Allocation (col. 8 + col. 9) 100 623.860 24.00 2.00 Capital Related - Bidg. & Fixtures 7.00 8.00 9.00 10.00 10.00 10.00 2.00 Capital Related - Movable Equipment 0 0 0 0 0 0 2.00 3.00 Plant Operation & Maintenance 0 0 0 0 0 0 4.00 0.00 Skilled Nursing Care 0 147,682 0 147,682 147,682 7.00 0.00 Speech Pathology 0 0 0 0 0 0 0 0 0 0 0 0 <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td>1</td>			0	0	0				1
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Recl assi fi cati on Recl assi fi cati ri al Balance col. 7) Adjustments of Al location (col. 8 + col. 9) Net Expenses for Al location (col. 8 + col. 9) Image: Col. (col. 7) Image: Col. 9) Image: Col. (col. 6 + col. 7) Net Expenses for Al location (col. 8 + col. 9) Image: Col. (col. 7) Image: Col. 9) Image: Col. (col. 6 + col. 7) Image: Col. 9) Image: Col. (col. 7) Image: Col. 9) Image: Col. (col. 6 + col. 7) Image: Col. 9) Image: Col. 7) Image: Col. 9) Image: Col. 7) Image: Col. 9) Image: Col. 7) Image: Col.	23.50	Tel emedi ci ne	0	0	C		0 0	0	
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GENERAL SERVICE COST CENTERS Control Co			7.00		0.00		_		-
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3.00 Plant Operation & Maintenance 0 <	2.00		0	0	C		D		2.00
4.00 Transportation 0	3.00		0	0	C		b		3.00
HHA REIMBURSABLE SERVICES 6.00 Skilled Nursing Care 0 165,034 0 165,034 6.00 7.00 Physical Therapy 0 147,682 0 147,682 7.00 8.00 Occupational Therapy 0 28,248 0 28,248 8.00 9.00 Speech Pathology 0 0 0 0 9.00 11.00 Home Heal th Aide 0 65,561 0 0 10.00 12.00 Supplies (see instructions) 0 9,520 0 9,520 12.00 13.00 Drugs 0 0 0 0 13.00 14.00 ME 0 0 0 0 13.00 14.00 ME 0 0 0 0 14.00 HHA NONREIMBURSABLE SERVICES 0 0 0 0 14.00 148.00 Respiratory Therapy 0 0 0 0 15.00 16.00 Drivate Duty Nursin							C		1
6.00 Skilled Nursing Care 0 165,034 0 165,034 6.00 7.00 Physical Therapy 0 147,682 0 147,682 7.00 8.00 Occupational Therapy 0 28,248 0 28,248 8.00 9.00 Speech Pathol ogy 0 0 0 0 9.00 10.00 Medical Social Services 0 0 0 0 9.00 11.00 Home Heal th Aide 0 65,561 0 65,561 11.00 12.00 Supplies (see instructions) 0 9,520 9,520 12.00 13.00 13.00 Drugs 0 0 0 0 14.00 HHA NONREIMBURSABLE SERVICES 0 0 0 15.00 15.00 16.00 Respiratory Therapy 0 0 0 15.00 15.00 17.00 Private Duty Nursing 0 0 0 0 18.00 19.00 Halth Promotion Activities 0 0 0 20.00 20.00 <td< td=""><td>5.00</td><td></td><td>0</td><td>207, 815</td><td>0</td><td>207, 81</td><td>5</td><td></td><td>5.00</td></td<>	5.00		0	207, 815	0	207, 81	5		5.00
7.00 Physical Therapy 0 147,682 0 147,682 7.00 8.00 Occupational Therapy 0 28,248 0 28,248 8.00 9.00 Speech Pathology 0 0 0 0 9.00 10.00 Medical Social Services 0 0 0 0 10.00 11.00 Home Heal th Aide 0 65,561 0 65,561 11.00 12.00 Supplies (see instructions) 0 9,520 9,520 12.00 13.00 Drugs 0 0 0 0 14.00 HA NONREI MBURSABLE SERVICES 0 0 0 14.00 HA NONREI MBURSABLE SERVICES 0 0 0 15.00 16.00 Respiratory Therapy 0 0 0 16.00 17.00 Private Duty Nursing 0 0 0 18.00 19.00 Heal th Promoti on Activities 0 0 0 19.00 10.00 Day Care Program 0 0 0 0 </td <td>6 00</td> <td></td> <td>0</td> <td>165_034</td> <td>0</td> <td>165.03</td> <td>4</td> <td></td> <td>6.00</td>	6 00		0	165_034	0	165.03	4		6.00
8.00 Occupational Therapy 0 28,248 0 28,248 8.00 9.520 9.00 9.520 9.00 9.520 9.00 9.520 9.00 9.520 9.00 9.520 9.00 9.50 9.00 9.50 9.00 9.50 9.00 9.50 9.00 9.00 9.00 9.00 9.00 9.00 9									
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17.00 Private Duty Nursing 0 0 0 0 17.00 18.00 Clinic 0 0 0 0 18.00 19.00 Heal th Promotion Activities 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 21.00 22.00 22.00 Homemaker Service 0 0 0 22.00 23.00 23.00 23.00 23.50 7el emedicine 0 0 0 23.50							-		
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21.00 Home Delivered Meals Program 0 0 0 21.00 22.00 Homemaker Service 0 0 0 22.00 23.00 All Others (specify) 0 0 0 23.00 23.50 Tel emedicine 0 0 0 0 23.50			0	0	0				
22.00 Homemaker Service 0 0 0 22.00 23.00 Al I Others (specify) 0 0 0 23.00 23.50 Tel emedicine 0 0 0 0 23.50			0	0					
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24. 00 [101a1 (Sulli 01 111185 1-23) [U] 623, 860] U] 623, 860] [24. 00			0	0					
	∠4.00	Total (Sum OF FILES 1-23)	1 0	0∠3, 80U	l U	′l 0∠3,860			∠4. UU

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable. 5/22/2018 1:57 pm

Heal th	Financial Systems		HARRI SON COUNT	Y HOSPITAI		Inlie	u of Form CMS-	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST		Provider C	CN: 15-1331	Period: From 01/01/2017	Worksheet H-1 Part I	
				HHA CCN:	15-7242	To 12/31/2017	Date/Time Pre	pared:
						Home Health	5/22/2018 1:5 PPS	07 pm
						Agency I		
			Capital Rela	ated Costs				
		Net Expenses	BIdgs &	Movabl e	Plant	Transportation		
		for Cost Allocation	Fixtures	Equi pment	Operation 8 Maintenance		(cols. 0-4)	
		(from Wkst. H,						
		<u>col. 10)</u> 0	1.00	2.00	3.00	4.00	4A. 00	
	GENERAL SERVICE COST CENTERS				1			
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable	0		0			0	2.00
3.00	Equipment Plant Operation & Maintenance	0	0	0		0	C	3.00
4.00	Transportation	0	Ō	0		0 0		4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	207, 815	0	0		0 0	207, 815	5.00
6.00	Skilled Nursing Care	165, 034	0	0		0 0	165, 034	6.00
7.00	Physical Therapy	147, 682	0	0		0 0		
8.00 9.00	Occupational Therapy Speech Pathology	28, 248	0	0		0 0	28, 248 0	
10.00	Medical Social Services	0	Ō	0		0 0	0	10.00
11.00 12.00	Home Health Aide Supplies (see instructions)	65, 561 9, 520	0	0		0 0	65, 561 9, 520	
13.00	Drugs	9, 320	0	0		0	9, 520	
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.00
15.00	HOME Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0		
17.00 18.00	Private Duty Nursing Clinic	0	0	0		0 0		
19.00	Health Promotion Activities	0	Ō	0		0 0	0	19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0		0 0		
22.00	Homemaker Service	0	0	0		0 0	0	
23. 00 23. 50	All Others (specify) Telemedicine	0	0	0		0 0 0 0	0	
	Total (sum of lines 1-23)	623, 860	0	0		0 0	623, 860	
		Administrative						
		& General 5.00	<u>4A + 5)</u> 6.00					-
	GENERAL SERVICE COST CENTERS	1						
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable							2.00
3.00	Equipment Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	207, 815						5.00
6.00	Skilled Nursing Care	82, 435	247, 469					6.00
7.00 8.00	Physical Therapy Occupational Therapy	73, 767 14, 110	221, 449 42, 358					7.00 8.00
9.00	Speech Pathol ogy	0	42, 330					9.00
10.00	Medical Social Services	0	0					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	32, 748 4, 755	98, 309 14, 275					11.00
13.00	Drugs	0	0					13.00
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.00
15.00	Home Dialysis Aide Services	0	0					15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0					16.00 17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0					20.00
22.00	Homemaker Service	0	Ö					22.00
23. 00 23. 50	All Others (specify) Telemedicine	0	0					23.00 23.50
	Total (sum of lines 1-23)		623, 860					24.00

COST ALLOCATION - HHA STATISTICAL BASIS Provider CCN: 15-1331 H4 CON: Peroid: 15-7242 Peroid: From 01/07/2017 Peroid: Permit 10 Source Peroid: From 01/07/2017 Peroid: From 01/07/2017 <th>Heal th</th> <th>Financial Systems</th> <th></th> <th>HARRI SON COUN</th> <th>TY HOSPITAL</th> <th></th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Heal th	Financial Systems		HARRI SON COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
Capital Related Costs Home Health PPS Bidgs & Fixtures Bidgs & Fixtures Movable (SQUARE FEET) Plant (SQUARE FEET) Transportation (MLEAGE) Transportation (MLEAGE) Record i ation (AcdMin is strative (AcCMM. COST) 1.00 2.00 3.00 4.00 5A.00 5.00 2.01 Capital Related - Bidg, & Fixtures 0 0 0 0 2.00 Capital Related - Bidg, & Fixtures 0 0 0 0 0 3.00 Plant Operation & Maintenance 0 0 0 0 2.00 3.00 Plant Operation & Maintenance 0 0 0 0 3.00 4.00 5.00 1.00 3.00 Plant Operation & Maintenance 0 0 0 0 3.00 4.00 3.00 3.00 Plant Operation & Maintenance 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <	COST A	NLLOCATION - HHA STATISTICAL BAS	SI S				From 01/01/2017	Part II Date/Time Pre	pared:
Early and the service Capital Related Costs Plant (SOUARE FEET) Transportation & Molentensor Transportation Reconcil I ation Administrative & General (ACCUM. COST) 1.00 Early 10E COST CENTERS 1.00 2.00 3.00 4.00 5A.00 5.00 1.00 Early targets 0 0 0 0 0 1.00 2.00 Capital Related - Bldg. & Capital Related - Movable Equipment 0 0 0 0 2.00 3.00 4.00 5A.00 5.00 2.00 3.00 Plant Operation & Maintenance 0 0 0 0 0 2.00 3.00 4.00 5A.00 5.00 3.00 4.00 Transportation (See Equipment 0 0 0 0 0 0 2.00 3.00 5.00 Hard Related - Movable Exercices 0 0 0 0 0 0 0 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 0 0 0 0									<u>/ piii</u>
Fixtures Equipment (SULAR Operation & Maintenance (SULAR (MILEAGE) & General (ACCUM. COST) 1.00 2.00 3.00 4.00 54.00 5.00 1.00 Capital Related - Bldg. & Extures 0 0 1.00 2.00 3.00 4.00 54.00 5.00 2.00 Capital Related - Movable Equipment 0 0 0 0 2.00 3.00 4.00 54.00 5.00 1.00 3.00 Plant Operation & Maintenance 0 0 0 0 3.00 4.00 3.00 4.00 Transportation (see 0 0 0 0 3.00 4.00 5.00 4HA REIMBURSABLE SERVICES 0 0 0 0 0 0 0 0 0 0 3.00 0.00 Coupational Therapy 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td></td> <td></td> <td>Capital Rel</td> <td>ated Costs</td> <td></td> <td></td> <td>, geney i</td> <td></td> <td></td>			Capital Rel	ated Costs			, geney i		
GENERAL SERVICE COST CENTERS Image: Control of the service of the servi			Fixtures	Equi pment	Operation & Maintenance		onReconciliation	& General	
1.00 Capital Related - Bldg. & 0 1.00 Fixtures 0 0 0 0 2.00 Capital Related - Movable 0 0 0 0 0 2.00 Subsect Equipment 0 0 0 0 0 0 3.00 4.00 Transportation (see 0 0 0 0 0 -207.815 416.045 5.00 Administrative and General 0 0 0 0 -207.815 416.045 6.00 Skilled Nursing Care 0 0 0 0 147.682 7.00 6.00 Speech Pathology 0			1.00	2.00	3.00	4.00	5A. 00	5.00	
Fixtures Construction									
Equipment o o o o o o o a.oo	1.00		0				0		1.00
3.00 Piant Operation & Maintenance 0 0 0 0 3.00 Piant Operation (see instructions) 3.00 4.00	2.00	•		0			0		2.00
5.00 Instructions) Administrative and General 0 0 0 -207,815 416,045 5.00 HAR ELFMBURSABLE SERVICES 5.00 Skilled Nursing Care 0 0 0 0 145,034 6.00 7.00 Physical Therapy 0 0 0 0 147,682 7.00 9.00 Speech Pathol ogy 0 0 0 0 0 0 9.00 10.00 Medical Social Services 0	3.00		0	0	C		0		3.00
5.00 Administrative and General 0 0 0 -207,815 416,045 5.00 HHA REIMBURSABLE SERVICES	4.00	Transportation (see	0	0	C		0		4.00
HHA REIMBURSABLE SERVICES Image: Constraint of the constraint									
6.00 Skilled Nursing Care 0 0 0 0 165,034 6.00 7.00 Physical Therapy 0 0 0 0 147,682 7.00 8.00 Occupational Therapy 0 0 0 0 147,682 7.00 8.00 Occupational Therapy 0 0 0 0 0 9.00 9.00 Speech Pathology 0 0 0 0 0 9.00 10.00 Medical Social Services 0 0 0 0 0 0 0 0 0 0 0 0 0 0 11.00 11.00 11.00 12.00 0 0 0 0 0 11.00 13.00 13.00 13.00 0 0 0 0 0 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 0 0	5.00		0	0	0)	0 -207, 815	416, 045	5.00
7.00 Physical Therapy 0 0 0 0 147,682 7.00 8.00 Occupational Therapy 0 0 0 0 28,248 8.00 9.00 Speech Pathology 0			1			1			
8.00 Occupational Therapy 0 0 0 0 0 28,248 8.00 9.00 Speech Pathology 0 <td< td=""><td></td><td></td><td>, o</td><td>Ũ</td><td>0</td><td>·</td><td>0</td><td></td><td></td></td<>			, o	Ũ	0	·	0		
9.00 Speech Pathology 0			0	0	0)	0 0		
10.00 Medical Social Services 0			0	0	0)	0 0		
11.00 Home Heal th Ai de 0 0 0 0 65,561 11.00 12.00 Supplies (see instructions) 0 0 0 0 0 9,520 12.00 13.00 Drugs 0 0 0 0 0 0 13.00 14.00 DME 0 0 0 0 0 0 14.00 HHA NONREI MBURSABLE SERVICES 15.00 Home Dialysis Aide Services 0 0 0 0 0 15.00 16.00 Respiratory Therapy 0 0 0 0 0 16.00 17.00 17.00 Private Duty Nursing 0 0 0 0 0 17.00 18.00 Clinic 0 0 0 0 0 0 18.00 19.00 Heal th Promotion Activities 0 0 0 0 0 20.00 21.00 Home Delivered Meals Program 0 0 0 0 0 20.00 22.00 Home Delivered Meal			0	0	0		0 0	-	
12.00 Supplies (see instructions) 0 0 0 0 0 0 0 0 13.00 13.00 Drugs 0 0 0 0 0 0 0 13.00 14.00 DME 0 0 0 0 0 0 0 0 14.00 HHA NONREI MBURSABLE SERVICES 15.00 Home Di al ysis A ide Services 0 0 0 0 0 0 14.00 16.00 Respiratory Therapy 0 0 0 0 0 0 15.00 16.00 Respiratory Therapy 0 0 0 0 0 16.00 17.00 Private Duty Nursing 0 0 0 0 0 17.00 18.00 Clinic 0 0 0 0 0 0 19.00 20.00 Day Care Program 0 0 0 0 0 0 20.00 21.00 Homemaker Service 0 0 0 0 20				0			0 0	-	
13.00 Drugs 0 0 0 0 0 13.00 14.00 DME 0 0 0 0 0 0 14.00 HHA NONREI MBURSABLE SERVICES				0	0		0 0		
14.00 DME 0 0 0 0 0 0 14.00 HHA NONREI MBURSABLE SERVI CES 15.00 Home Di al ysis A ide Servi ces 0 0 0 0 0 15.00 16.00 Respi ratory Therapy 0 0 0 0 0 0 16.00 17.00 Pri vate Duty Nursing 0 0 0 0 0 17.00 18.00 Cli ni c 0 0 0 0 18.00 18.00 18.00 19.00 Heal th Promotion Activities 0 0 0 0 0 19.00 20.00 Day Care Program 0 0 0 0 0 20.00 21.00 Home Del ivered Meals Program 0 0 0 0 21.00 22.00 Homemaker Service 0 0 0 0 22.00 23.00 All Others (speci fy) 0 0 0 0 23.00 23.50 Tel emedici ne 0 0 0 0 <				0	0	,	0 0		
HHA NONREIMBURSABLE SERVICES 15.00 Home Dialysis Aide Services 0 0 0 0 0 15.00 16.00 Respiratory Therapy 0 0 0 0 0 0 15.00 16.00 Respiratory Therapy 0 0 0 0 0 16.00 17.00 Private Duty Nursing 0 0 0 0 0 16.00 18.00 Clinic 0 0 0 0 0 18.00 0 0 0 19.00 19.00 19.00 19.00 19.00 19.00 19.00 0 0 0 0 0 0 19.00 19.00 19.00 19.00 19.00 0 0 0 0 0 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 <t< td=""><td></td><td>5</td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td></td><td></td></t<>		5		0	0		0 0		
15.00 Home Dialysis Aide Services 0 0 0 0 0 0 15.00 16.00 Respiratory Therapy 0 0 0 0 0 0 16.00 17.00 Private Duty Nursing 0 0 0 0 0 0 16.00 17.00 Private Duty Nursing 0 0 0 0 0 17.00 18.00 Clinic 0 0 0 0 0 18.00 19.00 Heal th Promotion Activities 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 21.00 22.00 Homemaker Service 0 0 0 0 22.00 23.00 All Others (specify) 0 0 0 0 23.00 23.00 Telemedicine 0 0 0 0 23.50 24.00 Total (sum of lines 1-23) 0	11.00		<u> </u>	U		1	<u> </u>	0	11.00
16.00 Respiratory Therapy 0 0 0 0 0 16.00 17.00 Private Duty Nursing 0 0 0 0 0 17.00 18.00 Clinic 0 0 0 0 0 17.00 18.00 Clinic 0 0 0 0 0 18.00 19.00 Heal th Promotion Activities 0 0 0 0 19.00 20.00 Day Care Program 0 0 0 0 0 20.00 21.00 Home Delivered Meals Program 0 0 0 0 0 21.00 22.00 Homemaker Service 0 0 0 0 22.00 23.00 All Others (specify) 0 0 0 0 23.00 23.50 Telemedicine 0 0 0 0 23.50 24.00 Total (sum of lines 1-23) 0 0 0 207, 815 24.00 25.00 Cost To Be Allocated (per 0 0 0 2	15.00		0	0	C)	0 0	0	15.00
18.00 Clinic 0 0 0 0 0 18.00 19.00 Health Promotion Activities 0 0 0 0 0 19.00 20.00 Day Care Program 0 0 0 0 0 0 20.00 21.00 Home Delivered Meals Program 0 0 0 0 0 20.00 22.00 Homemaker Service 0 0 0 0 0 22.00 23.00 All Others (specify) 0 0 0 0 23.00 23.50 Telemedicine 0 0 0 0 23.50 24.00 Total (sum of lines 1-23) 0 0 0 207,815 416,045 24.00 25.00 Cost To Be Allocated (per 0 0 0 207,815 25.00	16.00		0	0	C		0 0	0	16.00
19.00 Heal th Promotion Activities 0 0 0 0 19.00 20.00 Day Care Program 0 0 0 0 0 20.00 21.00 Home Delivered Meals Program 0 0 0 0 0 21.00 22.00 Homemaker Service 0 0 0 0 0 22.00 23.00 All Others (specify) 0 0 0 0 23.50 24.00 Total (sum of lines 1-23) 0 0 0 20.01 23.50 25.00 Cost To Be Allocated (per 0 0 0 20.7,815 24.00 Worksheet H-1, Part I) 0 0 0 0 20.7,815 25.00	17.00	Private Duty Nursing	0	0	C		0 0	0	17.00
20.00 Day Care Program 0 0 0 0 0 0 20.00 21.00 Home Delivered Meals Program 0 0 0 0 0 0 21.00 22.00 Homemaker Service 0 0 0 0 0 22.00 23.00 All Others (specify) 0 0 0 0 23.00 23.50 Telemedicine 0 0 0 0 23.50 24.00 Total (sum of lines 1-23) 0 0 0 0 20.01 25.00 Cost To Be Allocated (per 0 0 0 20.01 20.01 Worksheet H-1, Part I) 0 0 0 0 20.02 20.01	18.00	Clinic	0	0	C		0 0	0	18.00
21.00 Home Delivered Meals Program 0 0 0 0 0 21.00 22.00 Homemaker Service 0 0 0 0 0 22.00 23.00 All Others (specify) 0 0 0 0 0 23.00 23.50 Telemedicine 0 0 0 0 0 23.00 24.00 Total (sum of lines 1-23) 0 0 0 0 -207,815 416,045 24.00 25.00 Cost To Be Allocated (per 0 0 0 0 207,815 25.00 Worksheet H-1, Part I) 0 0 0 0 207,815 25.00	19.00	Health Promotion Activities	0	0	C)	0 0	0	19.00
22.00 Homemaker Service 0 0 0 0 0 22.00 23.00 All Others (specify) 0 0 0 0 0 23.00 23.50 Telemedicine 0 0 0 0 0 23.50 24.00 Total (sum of lines 1-23) 0 0 0 0 -207, 815 416,045 24.00 25.00 Cost To Be Allocated (per Worksheet H-1, Part I) 0 0 0 0 207,815 25.00	20.00		0	0	C		0 0	0	20.00
23.00 All Others (specify) 0 0 0 0 23.00 23.50 Telemedicine 0 0 0 0 0 23.50 24.00 Total (sum of lines 1-23) 0 0 0 0 -207,815 416,045 24.00 25.00 Cost To Be Allocated (per Worksheet H-1, Part I) 0 0 0 0 207,815 25.00			0	0	0		0 0	0	
23.50 Telemedicine 0 0 0 0 0 23.50 24.00 Total (sum of lines 1-23) 0 0 0 0 -207,815 416,045 24.00 25.00 Cost To Be Allocated (per Worksheet H-1, Part I) 0 0 0 0 207,815 25.00	22.00		0	0	0		0 0	0	
24.00 Total (sum of lines 1-23) 0 0 0 0 -207,815 416,045 24.00 25.00 Cost To Be Allocated (per Worksheet H-1, Part I) 0 0 0 0 0 25.00			0	0	0		0 0	0	
25.00 Cost To Be Allocated (per Worksheet H-1, Part I) 0 0 0 207,815 25.00			0	0	C		0 0	-	
Worksheet H-1, Part I			0	0	C		0 -207, 815		
26.00 Unit Cost Multiplier 0.000000 0.000000 0.000000 0.000000 0.499501 26.00	25.00		0	0	C		0	207, 815	25.00
	26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0.0000	00	0. 499501	26.00

	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider CC	N: 15-1331 15-7242	Period: From 01/01/2017 To 12/31/2017 Home Health	Worksheet H-2 Part I Date/Time Pre 5/22/2018 1:5 PPS	epare
			CAPI TAL			Agency I		
	Cost Center Description	HHA Trial	RELATED COSTS NEW BLDG &	MOB	AMB DEPR	NEW MVBLE	AMB EQUIP	
		Balance (1) 0	FI XT 1. 00	1.01	1.02	EQUI P 2. 00	2.01	
. 00	Administrative and General	0			1.02	0 0	() 1.
00	Skilled Nursing Care	247, 469	0	0		0 0	(2.
00	Physical Therapy	221, 449	0	0		0 0	() 3.
00	Occupational Therapy	42, 358	0	0		0 0	() 4.
00	Speech Pathology	0	0	0		0 0	() 5.
00	Medical Social Services	0	0	0		0 0	(
00	Home Health Aide	98, 309		0		0 0	(
00	Supplies (see instructions)	14, 275	0	0		0 0	(
00	Drugs	0	0	0		0 0	(
. 00	DME	0	0	0		0 0	(
. 00	Home Dialysis Aide Services	0	0	0		0 0	(
. 00	Respiratory Therapy	0	0	0		0 0	(
. 00	Private Duty Nursing Clinic	0	0	0		0 0		
. 00	Health Promotion Activities	0	0	0		0 0	(
. 00	Day Care Program		0	0		0 0) 16
. 00	Home Delivered Meals Program		0	0		0 0	(
. 00	Homemaker Service		0	0		0 0	(
. 00	All Others (specify)	0	0	0		0 0	(
. 50	Tel emedi ci ne	o o	0	0		0 0	(
0. 00	Total (sum of lines 1-19) (2)	623, 860	0	28, 744		0 0	(
I. 00	Unit Cost Multiplier: column							21
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	EMPLOYEE BENEFI TS	Subtotal	ADMI NI STRATI VE & GENERAL	ADMI TTI NG	CASHI ERI NG/ACC OUNTS	OPERATION OF PLANT	
		DEPARTMENT		& GENERAL		RECEIVABLE	PLANT	
		4.00	4A	5. 01	5.02	5. 03	7.00	-
00	Administrative and General	113, 541	142, 285	14, 148	2, 62	4, 993	() 1
00	Skilled Nursing Care	0	247, 469	24, 608		0 0	(2
00	Physical Therapy	0	221, 449			0 0	(
00	Occupational Therapy	0	42, 358	4, 212		0 0	(
00	Speech Pathology	0	0	0		0 0	(
00	Medical Social Services	0	0	0		0 0	(
00	Home Health Aide	0	98, 309			0 0	(
00	Supplies (see instructions)	0	14, 275			0 0	(1 9
00	Drugs	0	0	0		0 0	(
	DME	0	0	0		0 0		
. 00 . 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0		0 0	() 11) 12
. 00	Private Duty Nursing		0	0		0 0) 13
. 00	Clinic		0	0				14
00	Health Promotion Activities		0	0		0 0		15
00	Day Care Program	0	0	0		0 0		16
00	Home Delivered Meals Program	n	0	0		0 0		17
00	Homemaker Service	n	n 0	0		0 0		18
. 00	All Others (specify)	0	0	0		0 0		19
	Tel emedi ci ne	0	0	0		0 0		19
. 00	Total (sum of lines 1-19) (2)	113, 541	766, 145	76, 183	2,62	4, 993	(
. 00	Unit Cost Multiplier: column		0. 000000					21
	26, line 1 divided by the sum							1
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	of column 26, line 20 minus							

(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. 5/22/2018 1:57 pm

LLUCATION OF GENER	RAL SERVICE COSTS	IU HHA COST CEN	IERS	Provider CC HHA CCN:	CN: 15-1331 15-7242		riod: om 01/01/2017 12/31/2017	Worksheet H-2 Part I Date/Time Prep	pared:
							Home Health Agency I	5/22/2018 1:57 PPS	7 pm
Cost C	enter Description	AMB PLANT OPS	LINEN SERVICE	HOUSEKEEPING	DI ETARY		CAFETERI A	NURSI NG ADMI NI STRATI ON	
00 Administrati	vo. and Conoral	7.01	8.00	9.00	10.00	0	11.00	13.00	1.0
 Skilled Nurs Skilled Nurs Physical The OCcupational Speech Patho OSpeech Patho Medical Soci Home Health Supplies (see OD Drugs OD DME OD Home Dialysi OD Respiratory OD Private Duty OD Clinic OD Home Deliver OD Home Deliver OD All Others (sum OD Total (sum control of control 26, line 1 control 	erapy Therapy Al ogy al Services Aide e instructions) s Aide Services Therapy Nursing oftion Activities ogram red Meals Program ervice specify)								1. 0 2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 14. 0 15. 0 14. 0 17. 0 18. 0 19. 0 21. 0
6 decimal pl Cost C	<u>aces.</u> enter Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI	CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	17.00		24.00	25.00	
 Skilled Nurs Skilled Nurs Physical The OCcupational Speech Patho OSpeech Patho Medical Soci Home Health Supplies (see OD Drugs OD Drugs OD DME OD Home Dialysi OO Respiratory OO Private Duty OO Clinic OO Halth Promo OO Day Care Pro OO All Others (see OO All Others (see OO Total (sum control of control of control 26, line 1 control of control 26, line 1 control 	erapy Therapy Therapy ology al Services Aide e instructions) s Aide Services Therapy Nursing otion Activities ogram red Meals Program ervice (specify) of lines 1-19) (2) of lines 1-19) (2) of lines 1-19) (2) of lines 1, rounded to			742 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			164, 793 272, 077 243, 469 46, 570 0 108, 085 15, 694 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		11. 0 12. 0 13. 0 14. 0 15. 0

(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. 5/22/2018 1:57 pm

Health Financial Systems		HARRI SON COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO	O HHA COST CEN	TERS	Provider CC	CN: 15-1331 15-7242	Period: From 01/01/2017 To 12/31/2017	5/22/2018 1:5	pared:
					Home Health Agency I	PPS	
Cost Center Description	Subtotal 26.00	Allocated HHA A&G (see Part II) 27.00	Total HHA Costs 28.00		190107		-
 1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) (2) 21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places. 	164, 793 272, 077 243, 469 46, 570 0 108, 085 15, 694 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65, 368 58, 496 11, 189 0 25, 969 3, 771 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	337, 445 301, 965 57, 759 0 134, 054 19, 465 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 50\\ 20. \ 00\\ 21. \ 00\\ \end{array}$

	Financial Systems ATION OF GENERAL SERVICE COSTS		HARRISON COUNT		N. 15 1221	Period:	u of Form CMS-2 Worksheet H-2		
BASI S	ATTON OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS STATISTICAL	HHA CCN:	15-7242	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/22/2018 1:5	pared:	
	Home Heal th Agency I								
	CAPITAL RELATED COSTS								
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		
1 00		1.00	1.01	1.02	2.00	2.01	4.00	1.00	
1. 00 2. 00 3. 00 4. 00 5. 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. 50 20. 00 21. 00 22. 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) Total cost to be allocated Unit cost multiplier Cost Center Description	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 143 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	0.0000 CASHI ERI NG/A OUNTS RECEI VABLE (GROSS	CC OPERATION OF PLANT	485, 659 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\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\$	
		5A. 01	5.01	5.02	CHARGES) 5.03	7.00	7.01		
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 13.00\\ 14.00\\ 15.00\\ 15.00\\ 15.00\\ 19.50\\ 20.00\\ 20.00\\ 21.00\\ 22.00 \end{array}$	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) Total cost to be allocated Unit cost multiplier		142, 285 247, 469 221, 449 42, 358 0 98, 309 14, 275 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	567, 740 567, 740 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	567, 7 567, 7 4, 9	40 0 93 0		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 19.00 20.00 21.00	

Heal th	Financial Systems		HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA BASI S	TION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS STATISTICA	L Provider CC	N: 15-1331	Period: From 01/01/2017	Worksheet H-2 Part II	
BAST 5				HHA CCN:	15-7242	To 12/31/2017	Date/Time Pre 5/22/2018 1:5	pared: 7 pm
						Home Health Agency I	PPS	
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG (SQUARE	DI ETARY (TOTAL PATI ENT	CAFETERIA (HOURS OF	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	
		(POUNDS OF	FEET)	DAYS)	SERVI CE)		SUPPLY	
		LAUNDRY)				(DI RECT NRSI NG HRS)	(COSTED REQUIS.)	
1.00	Administrative and General	8.00	9.00	10.00	11.00	13.00 0 0	14.00 0	1.00
2.00	Skilled Nursing Care	0	0	0		0 0	0	
3.00	Physical Therapy	0	0	0		0 0	0	
4.00 5.00	Occupational Therapy	0	0	0		0 0	0	
5.00 6.00	Speech Pathology Medical Social Services	0	0	0		0 0	0	5.00 6.00
7.00	Home Health Aide	0	0	0		0 0	0	
8.00	Supplies (see instructions)	0	0	0		0 0	0	
9.00 10.00	Drugs DME	0	0	0		0 0 0 0	0	9.00 10.00
11.00	Home Dialysis Aide Services	0	0	0		0 0	0	11.00
12.00	Respiratory Therapy	0	0	0		0 0	0	
13.00 14.00	Private Duty Nursing Clinic	0	0	0		0 0	0	
14.00	Health Promotion Activities	0	0	0		0 0	0	
16.00	Day Care Program	0	0	0		0 0	0	16.00
17.00	Home Delivered Meals Program	0	0	0		0 0	0	
18.00 19.00	Homemaker Service All Others (specify)	0	0	0		0 0	0	
19.50	Tel emedi ci ne	0	0	0		0 0	0	
20.00	Total (sum of lines 1-19)	0	0	0		0 0	0	20.00
21.00 22.00	Total cost to be allocated Unit cost multiplier	0. 000000	0 0. 000000	0 0. 000000	0.0000	0 0 00 0.000000	0 0. 000000	21.00 22.00
22.00	Cost Center Description	PHARMACY		SOCI AL SERVI CE	0.0000	00 0.000000	0.000000	22.00
		(TIME SPENT)	RECORDS &					
			LI BRARY (GROSS	(TOTAL PATIENT DAYS)				
			CHARGES)	bittoj				
1 00		15.00	16.00	17.00				1.00
1.00 2.00	Administrative and General Skilled Nursing Care	0	567, 740 0	0				1.00 2.00
3.00	Physical Therapy	0	0	0				3.00
4.00	Occupational Therapy	0	0	0				4.00
5.00 6.00	Speech Pathology Medical Social Services	0	0	0				5.00 6.00
7.00	Home Heal th Ai de	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00 10.00	Drugs DME	0	0	0				9.00 10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing Clinic	0	0	0				13.00
14.00 15.00	Health Promotion Activities	0	0	0				14.00 15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00 19.00	Homemaker Service All Others (specify)	0	0	0				18.00 19.00
19.50	Tel emedi ci ne	0	0	0				19.50
20.00	Total (sum of lines 1-19)	0	567, 740	0				20.00
21.00	Total cost to be allocated Unit cost multiplier	0. 000000	742 0. 001307	0 0. 000000				21.00 22.00
22.00		1 0.000000	0.001307	0.000000				22.00

Heal th	Financial Systems		HARRISON COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider C	CN: 15-1331	Peri od:	Worksheet H-3	
				HHA CCN:	15-7242	From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/22/2018 1:5	pared: 7 pm
				Title	e XVIII	Home Health Agency I	PPS	•
	Cost Center Description	From, Wkst. H-2, Part I,	Facility Costs (from Wkst.	Shared Ancillary	Total HHA Costs (cols.	Total Visits	Average Cost Per Visit	
		col. 28, line		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
1.00	Skilled Nursing Care	2.00	337, 445		337, 44	1, 647	204, 88	1.00
2.00	Physical Therapy	3.00						
3.00	Occupational Therapy	4.00						
4.00	Speech Pathol ogy	5.00				0 0		
	Medical Social Services			L L		0 0		
5.00		6.00			104.00	-		•
6.00	Home Health Aide	7.00			134, 05			
7.00	Total (sum of lines 1-6)		831, 223	0				7.00
					Program Visit			1
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject 1 Deductibles Coinsurance	& Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation	-						
8.00	Skilled Nursing Care		31140	C) 1, 1*	15		8.00
8.01	Skilled Nursing Care		99915	(1	34		8.01
9.00	Physical Therapy		31140	C		30		9.00
9.00	Physical Therapy		99915	0		28		9.00
								•
10.00	Occupational Therapy		31140	C		56		10.00
10. 01	Occupational Therapy		99915	L C		32		10.01
11.00	Speech Pathology		31140	C		0		11.00
11.01	Speech Pathology		99915	C		0		11.01
12.00	Medical Social Services		31140	C		0		12.00
12.01	Medical Social Services		99915	C		0		12.01
13.00	Home Health Aide		31140	C) 7e	55		13.00
13.01	Home Health Aide		99915	C				13.01
	Total (sum of lines 8-13)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(14.00
14.00		From Wkst H_2	Facility Costs		Total HHA	Total Charges	Ratio (col 3	14.00
	cost center bescription	Part I, col.	(from Wkst.	Ancillary	Costs (col s.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from Part II)	+ 2)	Records)	÷ cor. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computa	ations						
15.00	Cost of Medical Supplies	8.00	19, 465	C	19, 46	55 0	0. 000000	15.00
16.00	Cost of Drugs	9.00	0	C		0 0	0. 000000	16.00
			Program Visits		Cost of Servi ces			
			Par	tВ	1	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
	soot contor boost ptron		Deductibles &			Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGOREGATE F	KUUKAW CUST, A	UNLUATE UF IF		TATION COST, UP	\	-
1 00	Skilled Nursing Care	0	1 200		1	0 204 / 27		1 00
1.00	5					0 286, 627		1.00
2.00	Physical Therapy	0				0 224, 804		2.00
3.00	Occupational Therapy	0				0 46, 858		3.00
4.00	Speech Pathology	0	-			0 0		4.00
5.00	Medical Social Services	0	0			0 0		5.00
6.00	Home Health Aide	0	939			0 81, 364		6.00
					1	0 639, 653		7.00
7.00	Total (sum of lines 1-6)	0	.1 .1 .1					1 / 1.11

PPORTIONMENT OF PATIENT SERVICE COS	TS		Provider CO	CN: 15-1331	Peri od:	Worksheet H-3	3
			HHA CCN:	15-7242	From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/22/2018 1:5	
			Title	XVIII	Home Health Agency I	PPS	
Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation	0.00	7.00	8.00	9.00	10.00	11.00	
.00Skilled Nursing Care.01Skilled Nursing Care.00Physical Therapy.01Physical Therapy.01Physical Therapy.00Occupational Therapy.01Occupational Therapy.01Speech Pathology1.01Speech Pathology2.00Medical Social Services2.01Medical Social Services							8. 9. 9. 10. 10. 11. 11. 12. 12.
3.00 Home Health Aide							13.
3.01 Home Health Aide							13.
4.00 Total (sum of lines 8-13)	Dura			Cost of			14.0
	Prog	ram Covered Cha	arges	Cost of Services			
		Par	t B		Part B		
Cost Center Description	Part A	Not Subject to Deductibles &	Deductibles &	Part A	Not Subject to Deductibles &	Subject to Deductibles &	
	6.00	Coi nsurance 7.00	Coi nsurance 8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
Supplies and Drugs Cost Comput		1100	0,00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100		
5.00 Cost of Medical Supplies	C				0 0	C	
6.00 Cost of Drugs	T 1 1 D	0	0		0	C) 16.
Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00	-					_
PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	!	
BENEFICIARY COST LIMITATION Cost Per Visit Computation							-
. 00 Skilled Nursing Care	286, 627	•					1 1.
.00 Physical Therapy	224, 804						2.
.00 Occupational Therapy	46, 858						3.
.00 Speech Pathology .00 Medical Social Services							4.
.00 Medical Social Services .00 Home Health Aide	81, 364						5. 6.
.00 Total (sum of lines 1-6)	639, 653						7.
Cost Center Description				-			
	12.00						
Limitation Cost Computation							
.00 Skilled Nursing Care .01 Skilled Nursing Care							8. 8.
. 00 Physical Therapy							9.
.01 Physical Therapy							9.
0.00 Occupational Therapy							10.
0.01 Occupational Therapy 1.00 Speech Pathology							10.
1.00 Speech Pathology 1.01 Speech Pathology							11.
							12.
2.00 Medical Social Services							
2.00 Medical Social Services 2.01 Medical Social Services							12.
2.01 Medical Social Services 3.00 Home Health Aide							12. 13.
2.01 Medical Social Services							

Health Financial Systems		HARRI SON COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COST	ΓS		Provider C	CN: 15-1331	Peri od:	Worksheet H-3	
			HHA CCN:	15-7242	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	narod
			TITA CON.	13-7242	10 12/31/2017	5/22/2018 1:5	
			Title	e XVIII	Home Health	PPS	
					Agency I		
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 SERVIO	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00 Physical Therapy	66.00	0. 281327	(0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 191678	(D	0 col. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0.047379	(D	0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	0. 314822	(D	0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 523130	()	0 col. 2, line 1	6. 00	5.00

^{5/22/2018 1:57} pm

th Financial Systems HARRISC CULATION OF HHA REIMBURSEMENT SETTLEMENT	N COUNTY HOSPITAL Provider CO	CN: 15-1331	Peri od:	u of Form CMS-2 Worksheet H-4	
	HHA CCN:	15-7242	From 01/01/2017 To 12/31/2017	Part I-II Date/Time Pre 5/22/2018 1:5	par
	Title	XVIII	Home Health	PPS	07 L
			Agency I	t B	
		Part A	Not Subject to		
			Deductibles &		
		1.00	Coi nsurance 2.00	Coi nsurance 3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST	OR CUSTOMARY CHARGE				
Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)		[0 0	0	
Total charges			0 0	0	
Customary Charges					
Amount actually collected from patients liable for pa	ayment for services		0 0	0	
on a charge basis (from your records) Amount that would have been realized from patients li	able for payment		0 0	0	
for services on a charge basis had such payment been with 42 CFR §413.13(b)					
Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	00 0. 000000	0.000000	
Total customary charges (see instructions)			0 0	0	
 Excess of total customary charges over total reasonab only if line 6 exceeds line 1) 	ole cost (complete		0 0	0	
Excess of reasonable cost over customary charges (con	nplete only if line		0 0	0	
1 exceeds line 6)					
) Primary payer amounts			0 0 Part A	Part B	
			Services	Services	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT	-		1.00	2.00	-
0 Total reasonable cost (see instructions)			0	0	1
00 Total PPS Reimbursement - Full Episodes without Outli	ers		0	371, 509	
00 Total PPS Reimbursement - Full Episodes with Outliers	5		0	29, 315	
0 Total PPS Reimbursement - LUPA Episodes 0 Total PPS Reimbursement - PEP Episodes			0	9, 007 5, 874	
0 Total PPS Outlier Reimbursement - Full Episodes with	Outliers		0	11, 128	
0 Total PPS Outlier Reimbursement - PEP Episodes			0	69	
00 Total Other Payments			0	0	
0 DME Payments 0 Oxygen Payments			0	0	
0 Prosthetic and Orthotic Payments			0	0	
00 Part B deductibles billed to Medicare patients (exclu	ude coi nsurance)			0	2
00 Subtotal (sum of lines 10 thru 20 minus line 21)			0	426, 902	
0 Excess reasonable cost (from line 8) 0 Subtotal (line 22 minus line 23)			0	426 002	
00 Subtotal (line 22 minus line 23) 00 Coinsurance billed to program patients (from your rec	cords)		0	426, 902 0	
00 Net cost (line 24 minus line 25)	(d)		0	426, 902	
00 Reimbursable bad debts (from your records)					2
00 Reimbursable bad debts for dual eligible beneficiarie				424 000	2
00 Total costs - current cost reporting period (line 26 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	prus rine 27)		0	426, 902 0	
50 Pioneer ACO demonstration payment adjustment (see ins	structions)		0	0	
9 Demonstration payment adjustment amount before seques	stration		0	0	
0 Subtotal (see instructions)			0	426, 902	
11 Sequestration adjustment (see instructions) 12 Demonstration payment adjustment amount after sequest	tration		0	8, 538 0	
0 Interim payments (see instructions)			0	418, 364	
00 Tentative settlement (for contractor use only)			0	0	
0 Balance due provider/program (line 31 minus lines 31.	01, 32, and 33)		0	0	3
00 Protested amounts (nonallowable cost report items) in			0	0	3

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED		Provider CCN: 15-1331			eri od:	Worksheet H-5	
PRO	IGRAM BENEFI CI ARI ES	HHA CCN: 15-7242			om 01/01/2017 12/31/2017	Date/Time Prep 5/22/2018 1:57	
					Home Health Agency I	PPS	/ piii
		I npati en	t Part A			t B	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
	Tabel interim neuments natid to specified	1.00	2.00		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 0		418, 364 0	1. 2.
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.
01				0		0	3.
02				0		0	3.
)3				0		0	3.
)4				0		0	3
)5				0		0	3
~	Provider to Program					0	~
0				0 0		0	3
2				0		0	3
53				0		0	3
54				õ		Ö	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		0	3
	3. 50-3. 98)						
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		418, 364	4
	TO BE COMPLETED BY CONTRACTOR						
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5
)1	Program to Provider			0		0	5
)2				0		0	5
3				0		0	5
	Provider to Program						
0				0		0	5
1				0 0		0	5 5
2	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		0	э 5
7	5. 50-5. 98)			0		0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)						6
)1	SETTLEMENT TO PROVIDER			0		0	6
2	SETTLEMENT TO PROGRAM			0		0	6
00	Total Medicare program liability (see instructions)			0		418, 364	7
					Contractor	NPR Date	
			2		Number 1.00	(Mo/Day/Yr) 2.00	
	Name of Contractor	()		1.00	2.00	8