HARRISON COUNTY HOSPITAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1331 Worksheet S Peri od. From 01/01/2018 Parts I-III AND SETTLEMENT SUMMARY 12/31/2018 Date/Time Prepared: То 5/30/2019 5:44 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/30/2019 Time: 5:44 pm use only Manually submitted cost report 2 []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

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

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

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION 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 ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARRISON COUNTY HOSPITAL (15-1331) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Si aned) Officer or Administrator of Provider(s) Title

Date

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	43, 612	-861, 877	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	-1, 693	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	41, 919	-861, 877	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.

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DA	TA	HOSPITA Provid		15-1331	Peri od:		Workshe	et S-2	2552 2
							From 01/01/ To 12/31/	/2018	Part I Date/Ti		
	1.00	2	. 00		3.00			4.00	5/30/20	019 5:4	14 pm
	Hospital and Hospital Health Care Co				0.00			1.00			
00	Street: 245 ATWOOD ST.	PO Box:		7. 0.1	47444						1.
0	City: CORYDON	State: I Component Na		Zip Cod CCN	CBSA		ty: HARRISON Date		nt Syst	em (P	2.
				Number	Numbe		Certified		0, or	N)	
		1.00		2.00	2.00	1.00	F 00	V	XVIII		-
	Hospital and Hospital-Based Componer	1.00 1.dentification:	I	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
0	Hospi tal	HARRI SON COUNTY		151331	31140) 1	12/15/2005	N	0	0	3
0	Subprovider - IPF	HOSPI TAL									4
0	Subprovider - IRF										5
0	Subprovider - (Other)										6
0	Swing Beds - SNF	HARRISON COUNTY BEDS	SWI NG	15Z331	15999)	08/14/2011	N	0	0	7
0	Swing Beds - NF	DEDS									8
0	Hospital-Based SNF										9
00 00	Hospital-Based NF Hospital-Based OLTC										10
00	Hospi tal -Based HHA	HARRI SON COUNTY	ННА	157242	15999)	12/23/1992	N	Р	N	12
00											13
00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14
00	Hospital -Based Health Clinic - FQHC										16
	Hospital-Based (CMHC) I										17
00 00	Renal Dialysis Other										18
			I				From:		То		
20	Cost Reporting Period (mm/dd/yyyy)						1.00		2.0		20
	Type of Control (see instructions)						9	010	12/ 51/	2010	21
						4 . 0.0					
	Inpatient PPS Information					1.00	2.00		3. (00	-
00	Does this facility qualify and is it					Ν	N				22
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo										
	facility subject to 42 CFR Section §										
01	hospital?) In column 2, enter "Y" fo	r yes or "N" for									
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03	cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the	mn 1, "Y" for yes riod occurring pr "for no for the er October 1. (se requires final up port settlement? "for no, for the er 1. Enter in cc le cost reporting ic reclassificati ds for delineatir solumn 1, "Y" for g period prior to no for the portio to for the portio 2.105)? Enter in edicaid days on li of admission, 2 i of identifying th method used in th	payments s or "N" oportion bee instru uncompens (see ins e portion blumn 2, period o on from ng statis yes or " o October on of the ee instru than 499 column 3 nes 24 a f census he days i "N" for In-Stat Medicai	for no f ctober 1 of the c ctions) ated car tructior of the "Y" for n or aft urban to tical ar N" for r 1. Ente cost ctions) beds (a , "Y" foc n this c cost n this c cost n. e In-S d Medi ys elig	or ost es) yes er eas o r s r s r s r s tate ble l ble l ble l aid p	N N Out-of State Medicaid	2 N Out-of State Medicaid		d 0 /s Mec c	ther li cai d	22
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00	cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me bel ow? In column 1, enter 1 if date if date of discharge. Is the method reporting period? In column 2, enter	mn 1, "Y" for yes riod occurring pr "for no for the er October 1. (se requires final up port settlement? "for no, for the er 1. Enter in cc le cost reporting dic reclassificati ds for delineatir olumn 1, "Y" for g period prior to no for the portic er October 1. (se 100 but not more 2.105)? Enter in edicaid days on li of admission, 2 i of identifying th method used in th tr "Y" for yes or , enter the in 1, in-state umn 2, olumn 3, d days in column	payments s or "N" fior to 0 portion ee instru uncompens (see ins e portion of umn 2, period o on from ng statis yes or " o October on of the ee instru than 499 col umn 3 nes 24 a f census ne prior "N" for In-Stat Medicai paid day	for no f ctober 1 of the c ctions) ated car tructior of the "Y" for n or aft urban tc tical ar N" for r 1. Ente cost ctions) beds (a , "Y" fc n this c cost days, c cost days days, c cost days, c cost days, c cost days, c cost days, c cost days, c cost days, c cost days days days days days days days days	r 3 ost r 3 ost r 3 ost r 3 ost r 4 r 4 r 4 r 4 r 4 r 4 r 4 r 4 r 4 r 4	N N Out-of State Medi cai d ai d days 3.00	2 N Out-of State Hedi cai d el i gi bl e unpai d	₩0 day	d 0 rs Mec c	ther li cai d lays o. 00	22

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		Provider CC		-		18 Par 18 Dat	rkshee rt l te/Tim 30/201	t S-2 e Pre	pared:
	In-State Medicaid paid days	In-State Medi cai d el i gi bl e unpai d days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	dMH e	i cai d days	Oth Medio day	cai d ys	
.00 If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	0	. 00	6.0	00	25.00
Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	lisbar	n/Rural			`oogr	25.0
					1. 00	3 Dat	2.00		
o.00 Enter your standard geographic classification (not wa		at the beg	jinning of t			2			26.00
 cost reporting period. Enter "1" for urban or "2" for CO Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi CO f this is a sole community hospital (SCH), enter the 	ige) status "2" for ri cation in i	ural. If ap column 2.	pplicable,			2			27. 0 35. 0
effect in the cost reporting period.									
					<u>i nni ng:</u> 1. 00		Endi no 2. 00		
0.00 Enter applicable beginning and ending dates of SCH st		cript line	36 for numb						36.00
of periods in excess of one and enter subsequent date 0.00 If this is a Medicare dependent hospital (MDH), enter		r of period	ls MDH statu	s		0			37.0
is in effect in the cost reporting period.									
7.01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)									37.0
3.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.									38. 0
					Y/N		Y/N		
0.00 Does this facility qualify for the inpatient hospital	payment a	djustment f	or low volu		1.00 N		2.00 N		39.00
hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	, (ii), or he mileage	(iii)? Ent requiremen	er in colum nts in	n					
0.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. Ente	r "Y" for y			N		N	<u></u>	40. 0
					1			XI X 3. 00	
Prospective Payment System (PPS)-Capital									
Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	it for disp	roporti onat	e share in a	accordan	ce	N	N	N	45.0
b. 00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					h	N	N	Ν	46.0
presented as a second	apital? F	nter "Y for	yes or "N"	for no.		N	N	Ν	47.0
.00 Is this a new hospital under 42 CFR §412.300(b) PPS c				no		N	N	N	48.0 56.0
 C. 00 Is this a new hospital under 42 CFR §412. 300(b) PPS c B. 00 Is the facility electing full federal capital payment Teaching Hospitals 	? Enter "				<u> </u>	N			0.0
2.00 Is this a new hospital under 42 CFR §412.300(b) PPS c B.00 Is the facility electing full federal capital payment	? Enter "				s	N			
7.00Is this a new hospital under 42 CFR §412.300(b) PPS c8.00Is the facility electing full federal capital paymentTeaching Hospitals0.00Is this a hospital involved in training residents in	2 Enter " approved G period duri yes or "N h of this ", complete	ME programs ng which re ' for no in cost report e Worksheet	? Enter "Y esidents in column 1. ing period?	" for yes approved If column Enter '	n 1 "Y"	N			57.0
 7.00 Is this a new hospital under 42 CFR §412.300(b) PPS c 8.00 Is the facility electing full federal capital payment Teaching Hospitals 9.00 Is this a hospital involved in training residents in or "N" for no. 9.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 8.00 If line 56 is yes, did this facility elect cost reimb 	approved G period durin yes or "N h of this ", complet , if appli pursement fo	ME programs ng which re 'for no in cost report e Worksheet cable. or physicia	? Enter "Y esidents in n column 1. ing period? : E-4. If co	" for yes approved If colum Enter ' lumn 2 is	n 1 "Y" s	N			57. 0 58. 0
 V.00 Is this a new hospital under 42 CFR §412.300(b) PPS c B.00 Is the facility electing full federal capital payment Teaching Hospitals D.00 Is this a hospital involved in training residents in or "N" for no. C.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II B.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 	Period durin eperiod durin yes or "N h of this ", complet , if applio pursement for complete W	ME programs ng which re 'for no in cost report e Worksheet cable. or physicia kst. D-5.	? Enter "Y esidents in column 1. ing period? E-4. If co uns' service	" for yes approved If colum Enter ' lumn 2 is	n 1 "Y" s	N			58.0
 7.00 Is this a new hospital under 42 CFR §412.300(b) PPS c 8.00 Is the facility electing full federal capital payment Teaching Hospitals 9.00 Is this a hospital involved in training residents in or "N" for no. 9.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 8.00 If line 56 is yes, did this facility elect cost reimb 	Period durin eperiod durin yes or "N h of this ", complet , if applio pursement for complete W	ME programs ng which re 'for no in cost report e Worksheet cable. or physicia kst. D-5.	? Enter "Y esidents in column 1. ing period? E-4. If co uns' service	" for yes approved If column Enter ' Iumn 2 is s as	n 1 "Y" s	N N A Pas Qua	ss-Thr I i fi ca teri on	ation	58. 0 59. 0
 V.00 Is this a new hospital under 42 CFR §412.300(b) PPS c B.00 Is the facility electing full federal capital payment Teaching Hospitals D.00 Is this a hospital involved in training residents in or "N" for no. C.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II B.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 	Period durin eperiod durin yes or "N h of this ", complet , if applio pursement for complete W	ME programs ng which re 'for no in cost report e Worksheet cable. or physicia kst. D-5.	Renter "Y esidents in column 1. ing period? E-4. If co nns' service Pt. I. NAHE 413.8	" for yes approved If column Enter ' lumn 2 is s as 35 Work L	n 1 "Y" s xsheet	N N A Pas Qua	l i fi ca	ation Code	58. 0 59. 0

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ТА	Provider CC		eriod: com 01/01/2018 o 12/31/2018	Worksheet S-2 Part I Date/Time Pre 5/30/2019 5:4	pared
		Y/N	IME	Direct GME	I ME	Direct GME	
	1	1.00	2.00	3.00	4.00	5.00	
1.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see	N			0.00	0. 00	61.0
1.02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
1. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
1.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	-
			1.00	2.00	3.00	4.00	
	Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61
						1.00	1
	ACA Provisions Affecting the Health Resources and Ser						
2.00 2.01	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ctions) a Teachi gram. (s	ng Health Cent see instruction	ter (THC) into			62.(62.(
3. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this co	67. (see instru	ictions)	N	63.
				Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	-
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base year	2.00	<u> </u>	
1. 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair a-primar all nor l non-pr n columr	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00	-		64.

IOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DA	TA Provider (eriod: ^om 01/01/2018		
			Тс	b 12/31/2018	Date/Time Pre 5/30/2019 5:4	pared: 4 pm
	Program Name	Program Code	Unwei ghted	Unweighted	Ratio (col. 3/	
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te			-
5.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						
4)). (see instructions)						
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te	Hospi tal	2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Y beginning on or after July 1, 201		n Nonprovider Setting				
56.00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	curring in all nonpr nweighted non-primar I. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00 Unweighted FTEs	0.00 Unweighted FTEsin	0.000000 Ratio (col. 3/ (col. 3 + col.	
-			Nonprovi der Si te	Hospi tal	4))	-
7.00 Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 0.000000	67.0
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
				1.0	0 2.00 3.00	
Inpatient Psychiatric Facility PP 0.00 Is this facility an Inpatient Psy		DE) or doos it cont	tain an IDE cube			70.00
Enter "Y" for yes or "N" for no.	5.					
1.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions) Inpatient Rehabilitation Facility	fore November 15, 20 umn 2: Did this faci 412.424 (d)(1)(iii) ate which program ye	DO4? Enter "Y" for y lity train residents (D)? Enter "Y" for y	/es or "N" for n s in a new teach /es or "N" for n	io. (see ii ng io.	0	71.0
5.00 Is this facility an Inpatient Reh	abilitation Facility	(IRF), or does it o	contain an IRF	N		75.0
Subprovider? Enter "Y" for yes a If line 75 is yes: Column 1: Did recent cost reporting period endi no. Column 2: Did this facility t	the facility have ar ng on or before Nove	ember 15, 2004? Enter	"Y" for yes or	"N" for	0	76.00

Heal th	Financial Systems HARRISON COUNT	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		Period:	Worksheet S-2	2
				From 01/01/2018 To 12/31/2018	Part I Date/Time Pre	epared.
					5/30/2019 5:4	44 pm
					1.00	_
	Long Term Care Hospital PPS				1.00	
80, 00	Is this a long term care hospital (LTCH)? Enter "Y" for yes	and "N" for	no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part of	or all of the	cost reporting	period? Enter	N	81.00
	"Y" for yes and "N" for no.					
	TEFRA Providers				1	_
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)				N	85.00
86.00	Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	ea uniτ) under	42 CFR Sectio	on		86.00
	Is this hospital an extended neoplastic disease care hospita	al classified	under section		N	87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					
				V	XI X	
				1.00	2.00	
	Title V and XIX Services					
	Does this facility have title V and/or XIX inpatient hospita	al services? E	nter "Y" for	N	Y	90.00
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through t	he cost repor	t either in	N	N	91.00
	full or in part? Enter "Y" for yes or "N" for no in the appl					/ // 00
	Are title XIX NF patients occupying title XVIII SNF beds (du		ion)? (see		N	92.00
	instructions) Enter "Y" for yes or "N" for no in the applica					
93.00	Does this facility operate an ICF/IID facility for purposes	of title V an	d XIX? Enter	N	N	93.00
94 00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94.00
	applicable column.		o ni tile	IN	IN IN	94.00
	If line 94 is "Y", enter the reduction percentage in the app	licable colum	n.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes	s or "N" for n	o in the	N	N	96.00
	applicable column.					
	If line 96 is "Y", enter the reduction percentage in the app			0.00	0.00	97.00
	Does title V or XIX follow Medicare (title XVIII) for the ir stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f			Y	Y	98.00
	column 1 for title V, and in column 2 for title XIX.	or yes or n				
	Does title V or XIX follow Medicare (title XVIII) for the re	porting of ch	arges on Wkst.	Y	Y	98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti	tle V, and in	column 2 for			
	title XIX.				N/	
	Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes c			Y	Y	98.02
	for title V, and in column 2 for title XIX.					
	Does title V or XIX follow Medicare (title XVIII) for a crit	ical access h	ospital (CAH)	Ν	N	98.03
	reimbursed 101% of inpatient services cost? Enter "Y" for ye	es or "N" for	no in column '	1		
	for title V, and in column 2 for title XIX.		1.4			
	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no ir			N	N	98.04
	in column 2 for title XIX.		title v, and			
	Does title V or XIX follow Medicare (title XVIII) and add ba	ack the RCE di	sallowance on	Y	Y	98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c	olumn 1 for t	itle V, and in	ו 🛛		
	column 2 for title XIX.					
98.06	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in columr			Y	Y	98.06
	column 2 for title XIX.	i i ioi titie	v, anu m			
	Rural Providers					
105.00	Does this hospital qualify as a CAH?			Y		105.00
	If this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of paymen	t N		106.00
	for outpatient services? (see instructions)		t for LOD	N		107 00
	If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in columr			N		107.00
	yes, the GME elimination is not made on Wkst. B, Pt. I, col.			t		
	reimbursed. If yes complete Wkst. D-2, Pt. II.		5			
	Is this a rural hospital qualifying for an exception to the	CRNA fee sche	dul e? See 42	N		108.00
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Dhunding		Crassi	Dessimuter	
		Physi cal 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	-
109 00	If this hospital qualifies as a CAH or a cost provider, are	N	¥	N	Y	109.00
	therapy services provided by outside supplier? Enter "Y"		· ·			
	for yes or "N" for no for each therapy.					
						_
110.00	Did this hospital participate in the Rural Community Hospita	Demonstrati	on project (S	1104	1.00 N	110.00
	Demonstration) for the current cost reporting period? Enter "					
	complete Worksheet E, Part A, lines 200 through 218, and Wor					
	appl i cabl e.					

Health Financial Systems HARRISON COUNTY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	N: 15-1331	Period: From 01/01		u of For Workshe Part I Date/Ti 5/30/20	et S-2 me Pre	2 epared:
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services.	t reporting p umn 1 is Y, e ∣cipating in	eriod? Enter enter the column 2.	1.00 N)	2. (00	111.00
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or " is yes, enter the method used (A, B, or E only) in column 2. I 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers) Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for	lf column 2 i for long ter) based on th	s "E", enter m care (incl e definition	in column udes	N		0	115.00
117.00 Is this facility legally-required to carry malpractice insurar no.			"N" for	N			117.00
118.00 Is the malpractice insurance a claims-made or occurrence polic claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 i	f the policy	is	1			118.00
		Premi ums	Losse	es	Insur	ance	
118.01 List amounts of malpractice premiums and paid losses:		1.00 607,7	2.00) 0	3. (0 118. 01
			1.00)	2. (00	-
 118. 02 Are mal practice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no. 	le listing co Harmless prov column 1, "Y" lifies for th	nst centers Mision in ACA for yes or Ne Outpatient			Ν		118. 02 119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	table devices	charged to	Y				121.00
122.00 Does the cost report contain healthcare related taxes as defir Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included.					5.0)1	122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N				125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter	er the certif	ication date					126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	r the certifi	cation date					127.00
128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	r the certifi	cation date					128.00
129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	the certific	ation date i	n				129.00
130.00 If this is a Medicare certified pancreas transplant center, er date in column 1 and termination date, if applicable, in colum		i fi cati on					130.00
131.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum	enter the ce	ertification					131.00
132.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.		cation date					132.00
133.00 If this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2.	r the certifi	cation date					133.00
134.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.	OPO number i	n column 1					134.00
All Providers 140.00 Are there any related organization or home office costs as def chapter 10? Enter "Y" for yes or "N" for no in column 1. If ye are claimed, enter in column 2 the home office chain number. (es, and home	office costs	, N				140. 00

	EX IDENTIFICATION DATA	JNTY HOSPITAL Provider CC	N: 15-1331		d: 01/01/2018		2
				То	12/31/2018	Date/Time Pro	
1.00	2	. 00			3.00	575072019 5.	
If this facility is part of a cha home office and enter the home of	in organization, enter or	n lines 141 throu		e name a		of the	
1.00 Name:	Contractor's Name:			ctor's M	Number:		141. (
12.00Street:	PO Box:						142. (
43.00 City:	State:		Zip Co	de:			143. (
						1.00	-
44.00 Are provider based physicians' cos	sts included in Worksheet	: A?				Y	144. (
					1.00	2.00	1.15
45.00 f costs for renal services are cl inpatient services only? Enter "Y"	almed on wkst. A, line /	4, are the costs	S TOP				145.
no, does the dialysis facility in							
period? Enter "Y" for yes or "N"			5				
46.00 Has the cost allocation methodolog					N		146.
Enter "Y" for yes or "N" for no in		15-2, chapter 4	0, §4020)	If			
yes, enter the approval date (mm/o							
						1.00	
47.00Was there a change in the statist						N	147.
48.00 Was there a change in the order of						N	148.
49.00 Was there a change to the simplifi	ea cost finding method?	Enter "Y" for ye Part A	es or "N" f Part B		Title V	N Title XIX	149.
		1.00	2.00	•	3.00	4.00	-
Does this facility contain a prov	ider that qualifies for a			cation			
or charges? Enter "Y" for yes or							
55.00Hospi tal		N	N		Ν	N	155.
56.00Subprovider - IPF		N	N		N	N	156.
57. 00 Subprovi der – IRF 58. 00 SUBPROVI DER		N	N		Ν	N	157. 158.
59. 00 S0BFROVIDER 59. 00 SNF		N	N		N	N	159.
60.00HOME HEALTH AGENCY		N	N		N	N	160. 0
61. 00 СМНС			N		N	N	161. (
						1.00	4
Multicampus						1.00	-
65.00 s this hospital part of a Multica		no or moro comp	isos in dif	Course to	2024-2	N	165. (
	ampus hospital that has c			rerent (UDDAS (I IN	
Enter "Y" for yes or "N" for no.	ampus hospital that has c			rerent	JBSAS ?	Ν	105.0
	Name	County	State	Zip Code	e CBSA	FTE/Campus	
Enter "Y" for yes or "N" for no.		•				FTE/Campus 5.00	_
Enter "Y" for yes or "N" for no. 66.00 f ine 165 is yes, for each	Name	County	State	Zip Code	e CBSA	FTE/Campus 5.00	_
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column	Name	County	State	Zip Code	e CBSA	FTE/Campus 5.00	_
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,	Name	County	State	Zip Code	e CBSA	FTE/Campus 5.00	_
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Name	County	State	Zip Code	e CBSA	FTE/Campus 5.00	_
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,	Name	County	State	Zip Code	e CBSA	FTE/Campus 5.00	_
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Name	County	State	Zip Code	e CBSA	FTE/Campus 5.00 0.0	_
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Name O	County 1.00	State 2.00	Zi p Code 3.00	CBSA 4.00	FTE/Campus 5.00	_
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user	Name 0 1) incentive in the Ameri r under §1886(n)? Enter	County 1.00 can Recovery and "Y" for yes or "	State 2.00 d Reinvestm N" for no.	Zip Code 3.00	e CBSA 4.00	FTE/Campus 5.00 0.0 1.00	0 166.
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10	Name 0 T) incentive in the Ameri r under §1886(n)? Enter D5 is "Y") and is a meani	County 1.00 can Recovery and "Y" for yes or " ngful user (line	State 2.00 d Reinvestm N" for no.	Zip Code 3.00	e CBSA 4.00	FTE/Campus 5.00 0.0 1.00	0 166. (
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the l	Name 0 T) incentive in the Ameri r under §1886(n)? Enter 55 is "Y") and is a meani HIT assets (see instructi	County 1.00 can Recovery and "Y" for yes or " ngful user (line ons)	State 2.00 A Reinvestm N" for no. 2.167 is "Y	Zip Coda 3.00 nent Act	e CBSA 4.00	FTE/Campus 5.00 0.0 1.00	0 166. (0 166. (167. (1168. (
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the l 68.01 If this provider is a CAH and is i	Name 0 1 0	County 1.00 can Recovery and "Y" for yes or " ngful user (line ons) bes this provider	State 2.00 d Reinvestm N" for no. e 167 is "Y	Zip Code 3.00 hent Act "), ente	e CBSA 4.00	FTE/Campus 5.00 0.0 1.00	0 166. (0 166. (167. (1168. (
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 11 reasonable cost incurred for the l exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful user (10, 10, 10, 10, 10, 10, 10, 10, 10, 10,	Name 0 1 0 1	County 1.00 <u>can Recovery and</u> "Y" for yes or " ngful user (line ons) pes this provider " for no. (see i	State 2.00 d Reinvestm N" for no. 167 is "Y qualify f nstruction	Zip Code 3.00 ment Act "), ente s)	e CBSA 4.00 er the rdshi p	FTE/Campus 5.00 0.0 1.00	0 166. (167. (168. (168. (
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)'	Name 0 1 0 1	County 1.00 <u>can Recovery and</u> "Y" for yes or " ngful user (line ons) pes this provider " for no. (see i	State 2.00 d Reinvestm N" for no. 167 is "Y qualify f nstruction	<u>Zip Coda</u> <u>3.00</u> nent Act "), ento s) s "N"),	e CBSA 4.00 er the rdship enter the	FTE/Campus 5.00 0.0 1.00 Y 9.9	0 166. (167. (1168. (168. (
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 11 reasonable cost incurred for the l exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful user (59.00 If this provider is a meaningful user (59.00 If this provider is a meaningful user (59.00 If this provider is a meaningful user (50.00 If thi	Name 0 1 0 1	County 1.00 <u>can Recovery and</u> "Y" for yes or " ngful user (line ons) pes this provider " for no. (see i	State 2.00 d Reinvestm N" for no. 167 is "Y qualify f nstruction	<u>Zip Coda</u> <u>3.00</u> nent Act "), ento s) s "N"),	e CBSA 4.00 er the rdship enter the Beginning	FTE/Campus 5.00 0.0 1.00 Y 9.9 Endi ng	0 166. (167. (1168. (168. (
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)' 69.00 If this provider is a meaningful user transition factor. (see instruction)	Name 0 1 0	County 1.00 can Recovery and "Y" for yes or " ngful user (line ons) pes this provider " for no. (see ind is not a CAH (State 2.00 A Reinvestm N" for no. e 167 is "Y qualify f nstruction (line 105 i	Zip Coda 3.00 hent Act "), ento s) s "N"), E	e CBSA 4.00 er the rdship enter the Beginning 1.00	FTE/Campus 5.00 0.0 1.00 Y 9.9 Endi ng 2.00	- 0 166. (167. (168. (168. (9 169. (-
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I	Name 0 1 0	County 1.00 can Recovery and "Y" for yes or " ngful user (line ons) pes this provider " for no. (see ind is not a CAH (State 2.00 A Reinvestm N" for no. e 167 is "Y qualify f nstruction (line 105 i	Zip Coda 3.00 hent Act "), ento s) s "N"), E	e CBSA 4.00 er the rdship enter the Beginning	FTE/Campus 5.00 0.0 1.00 Y 9.9 Endi ng	0 166. 0 167. 0 168. 0 168. 0 9 169. 0
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)' 69.00 If this provider is a meaningful user transition factor. (see instruction)	Name 0 1 0	County 1.00 can Recovery and "Y" for yes or " ngful user (line ons) pes this provider " for no. (see ind is not a CAH (State 2.00 A Reinvestm N" for no. e 167 is "Y qualify f nstruction (line 105 i	Zip Coda 3.00 hent Act "), ento s) s "N"), E	e CBSA 4.00 er the rdship enter the Beginning 1.00	FTE/Campus 5.00 0.0 1.00 Y 9.9 Endi ng 2.00	0 166. 0 167. 0 168. 0 168. 0 9 169. 0
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	Name 0 1) incentive in the Ameri r under §1886(n)? Enter D5 is "Y") and is a meani HIT assets (see instructi not a meaningful user, dc ? Enter "Y" for yes or "Nuser (line 167 is "Y") ar user (line 167 is "Y") ar pons)	County 1.00 <u>can Recovery and</u> "Y" for yes or " ngful user (line ons) pes this provider " for no. (see i nd is not a CAH (g date for the re	State 2.00 4 Reinvestm N" for no. e 167 is "Y qualify f nstruction line 105 i	Zip Coda 3.00 hent Act "), ento s) s "N"), E	e CBSA 4.00 4.00 er the rdship enter the 3egi nni ng 1.00 1/01/2018	FTE/Campus 5.00 0.0 1.00 Y 9.9 Endi ng 2.00 12/31/2018 2.00	167. (168. (168. (169. (170. (
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is nearingful of exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy) 71.00 If line 167 is "Y", does this provider is a provider provider is a provider provider provider provider provider is a provider pro	Name 0 11 12 13 14 14 14 14 15 15 14 14 15 15 16 17 18 18 19 10 10 10 10 10 10 10 10 11 12 13 14 14	County 1.00 <u>can Recovery and</u> "Y" for yes or " ngful user (line ons) pes this provider " for no. (see i nd is not a CAH (g date for the reconstruction nd viduals enrol	State 2.00 2.00 4 Reinvestm N" for no. e 167 is "Y qualify f nstruction line 105 i eporting led in	Zip Coda 3.00 ment Act "), ento for a han s) s "N"), E 0 0 0	e CBSA 4.00 er the rdship enter the Beginning 1.00 1/01/2018	FTE/Campus 5.00 0.0 1.00 Y 9.9 Endi ng 2.00 12/31/2018 2.00	- 0 166. (167. (168. (168. (9 169. (-
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	Name 0 1 0 1 assets (see instruction ta meaningful user, do entreta meaningful us	County 1.00 Can Recovery and "Y" for yes or " ngful user (line ons) bes this provider " for no. (see i nd is not a CAH (g date for the recover ndividuals enrol c. 1, line 2, col	State 2.00 2.00 4 Reinvestm N" for no. e 167 is "Y qualify f nstruction line 105 i eporting led in . 6? Enter	Zip Code 3.00 hent Act "), entr for a har s) s "N"), E 0 0	e CBSA 4.00 4.00 er the rdship enter the 3egi nni ng 1.00 1/01/2018	FTE/Campus 5.00 0.0 1.00 Y 9.9 Endi ng 2.00 12/31/2018 2.00	0 166. 1 167. 1 168. 1 168. 1 168. 1 170. 1 170. 1

iospi ti	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1331	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Pro 5/30/2019 5:4	epared:
		·		Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	TOT ALL NU TE	esponses. Ente	er all dates in t	ne	
	COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c	column 2. (see				
			Y/N 1.00	Date 2.00	V/I 3.00	_
2.00	Has the provider terminated participation in the Medicare F	Program? If	N 1.00	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.					
. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid	offices, drug	N			3. 0
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and other	of the board				
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
. 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,	N			4.0
. 00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconcisional statements of the statement of the stateme		N			5.0
				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	ne provider is	S N		6.0
. 00 . 00	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		7.0 8.0
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	Ν		9.0
0. 00	Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.	or renewed in t		Ν		10.0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	Y/N	11. C
				-	1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes		long		Y	110 /
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 0 13. 0
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement		*	1	Ν	14. 0
5.00	Did total beds available change from the prior cost reporti		-		N + P	15.0
		Y/N	-t A Date	Par Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
6. 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	N		N		16. C
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/18/2019	Y	04/04/2018	17. C
8.00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		Ν		18.0
9. 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	N		Ν		19.0

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-1331		Date/Time P 5/30/2019 5	repared:
		Descr	iption	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	Ν	20.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS I	HOSPI TALS)			
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, se				N	22.
23.00		e due to apprais	sals made du	ring the cost	N	23.
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	ed into during	this cost re	eporting period?	Ν	24.
	If yes, see instructions					
25.00	Have there been new capitalized leases entered into during instructions.	, the cost repo	rting period′	?lfyes, see	Ν	25.
26.00	_ · · · · · · · · · · · · · · · · · · ·	he cost report	ing period?	fyes, see	N	26.
	instructions.					
27.00	Has the provider's capitalization policy changed during th	ne cost reporti	ng period? I	r yes, submit	N	27.
	copy. Interest Expense					
20 00	Were new Loans, mortgage agreements or letters of credit e	ntorod into du	ring the cost	troporting	N	28.
∠o. UU	period? If yes, see instructions.		ing the cos	r reput ti tig	IN	28.
29.00		bond funds (D	eht Service I	Reserve Fund)	Ν	29.
29.00	treated as a funded depreciation account? If yes, see inst		ebt Service i		IN IN	27.
30.00			debt? If ve	s. see	Ν	30.
	instructions.		Jeneral Jen	-,		
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes	s, see	Ν	31.
	instructions.		<u> </u>			
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se	ervi ces furni sh	ed through co	ontractual	N	32.
	arrangements with suppliers of services? If yes, see instr		-			
22 00	If line 32 is ves were the requirements of Sec 2135.2 and					33

	Instructions.				
31.00	Has debt been recalled before scheduled maturity without is	ssuance of new debt? If yes,	see	Ν	31.00
	instructions.				
	Purchased Services				
32.00	Have changes or new agreements occurred in patient care ser		ractual	N	32.00
	arrangements with suppliers of services? If yes, see instru				
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 app	blied pertaining to competiti	ve bidding? If	N	33.00
	no, see instructions.				_
	Provi der-Based Physi ci ans				-
34.00	Are services furnished at the provider facility under an ar	rrangement with provider-base	d physi ci ans?	Y	34.00
05 00	If yes, see instructions.				05.00
35.00	If line 34 is yes, were there new agreements or amended exi	ovi der-based	Ν	35.00	
	physicians during the cost reporting period? If yes, see in		Y/N	Date	
			1.00	2.00	_
	Home Office Costs		1.00	2.00	
36.00	Were home office costs claimed on the cost report?		N		36.00
	If line 36 is yes, has a home office cost statement been pr	repared by the home office?	Ν		37.00
	If yes, see instructions.				
38.00	If line 36 is yes, was the fiscal year end of the home off	fice different from that of	N		38.00
	the provider? If yes, enter in column 2 the fiscal year end	d of the home office.			
39.00	If line 36 is yes, did the provider render services to othe	er chain components? If yes,	N		39.00
	see instructions.				
40.00	If line 36 is yes, did the provider render services to the	home office? If yes, see	N		40.00
	instructions.				
					_
		1.00	2.0	00	
	Cost Report Preparer Contact Information	lava	D.V.D.		
41.00		BKD	BKD		41.00
	held by the cost report preparer in columns 1, 2, and 3,				
40.00	respectively.				40.00

BKD

502-581-0435

42.00

43.00

LVCOSTREPORTS@BKD. COM

preparer.

42.00 Enter the employer/company name of the cost report

43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.

Heal th	Financial Systems HARRISON	COUNT	Y HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1331	Period:	Worksheet S-2	
				From 01/01/2018 To 12/31/2018		
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	B	KD			41.00
	held by the cost report preparer in columns 1, 2, and 3	3,				
	respectively.					
42.00	Enter the employer/company name of the cost report					42.00
	preparer.					
43.00	Enter the telephone number and email address of the cos	st				43.00
	report preparer in columns 1 and 2, respectively.					

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	HARRISON COUNT	Y HOSPITAL Provider CC	N. 1E 1001	In Lie Period:	u of Form CMS-2 Worksheet S-3	
HUSPII	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-1331	From 01/01/2018 To 12/31/2018	Part I	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
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)	30. 00	21	7,60	65 105, 312. 00	0	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0 0	5. 00 6. 00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,6	65 105, 312. 00	0	7.00
8.00 9.00 10.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	31.00	4	1, 4	60 7, 776. 00	0	8.00 9.00 10.00
11.00 12.00 13.00	SURGI CAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY	43.00				0	11.00 12.00 13.00
14.00 15.00 16.00	Total (see instructions) CAH visits SUBPROVIDER - IPF		25	9, 1:	25 113, 088. 00	0 0	14.00 15.00 16.00
17.00 18.00 19.00 20.00	SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY						17.00 18.00 19.00 20.00
21. 00 22. 00 23. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	101. 00				0	21.00 22.00 23.00
24.00 24.10 25.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	30. 00					24.00 24.10 25.00
26.00 26.25 27.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	89.00	25			0	26.00 26.25 27.00
28.00 29.00 30.00 31.00	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF					0	28.00 29.00 30.00 31.00
32. 0032. 0133. 00	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days		0		0		32.00 32.01 33.00
	LTCH site neutral days and discharges						33.00

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-1331	Period: From 01/01/2018 To 12/31/2018		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)	1, 972	81	4, 38	8		1.00
. 00	HMO and other (see instructions)	372	1, 172				2.00
. 00	HMO I PF Subprovi der	0	0				3.00
. 00	HMO I RF Subprovi der	0	0				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	54	0	F	4		5.00
. 00	Hospital Adults & Peds. Swing Bed NF	01	0		20		6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 026	81	4, 46	-		7.00
8. 00	INTENSIVE CARE UNIT	158	11	32	4		8.0
. 00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGICAL INTENSIVE CARE UNIT						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY		26	85	9		13.0
4.00	Total (see instructions)	2, 184	118	5, 64		462.11	14.0
5.00	CAH visits	2,101	0	0,0	0.00	102.11	15.0
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVI DER – I RF						17.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY	922	0	97	0.00	2.37	
3.00	AMBULATORY SURGICAL CENTER (D. P.)	/	Ű		0,000	2.07	23.0
4.00	HOSPI CE						24.0
4. 10	HOSPICE (non-distinct part)				0		24.1
5.00	CMHC - CMHC				-		25.0
6.00	RURAL HEALTH CLINIC						26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	
7.00	Total (sum of lines 14-26)	0	Ŭ		0.00		
8.00	Observation Bed Days		188	1, 10		101.10	28.0
9.00	Ambulance Trips	0	100	1, 10			29.0
0.00	Employee discount days (see instruction)	U U			0		30.0
1.00	Employee discount days - IRF				0		31.0
2.00	Labor & delivery days (see instructions)	o	0		0		32.0
2.00	Total ancillary labor & delivery room	0	0		0		32.0
2.01	outpatient days (see instructions)				5		32.0
3. 00	LTCH non-covered days	0					33.0
	LTCH site neutral days and discharges	0					33.0

HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1331	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Pre 5/30/2019 5:4	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 21.00 23.00 24.00 24.10	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part)	0.00	0	5	91 30 88 259 0 91 30	1, 417	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 23.00 24.00 24.00
25.00 26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00	CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room autortiest days (see instructions)	0. 00 0. 00					25. 0 26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		33. 0 33. 0

Health Financial Systems		HARRI SON COUN	TY HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOME HEALTH AGENCY STATIS	STICAL DATA		Provider C	CN: 15-1331 CCN: 15-7242	Period: From 01/01/2018 To 12/31/2018		
					Home Health	5/30/2019 5:4 PPS	4 pm
					Agency I		
0.00 County					HARRI SON	00	0.00
or oo poouncy		Title V	Title XVIII	Title XIX	Other	Total	
HOME HEALTH AGENCY	STATI STI CAL DATA	1.00	2.00	3.00	4.00	5.00	
1.00 Home Health Aide H	lours	0	0		0 0		
2.00 Unduplicated Censu	is Count (see instructions)	0.00	53.00		00 5.00 ployees (Full Ti		2.00
		Enter the number your normal		Staff	Contract	Total	
		your norman	WOLK WEEK				
	- NUMBER OF EMPLOYEES	0		1.00	2.00	3.00	
3.00 Administrator and	Assistant Administrator(s)		40.00				
4.00 Director(s) and As 5.00 Other Administrati	sistant Director(s)			0. 0.			
6.00 Direct Nursing Ser				0.	72 0.00	0.72	
7.00 Nursing Supervisor 8.00 Physical Therapy S				0. 0.			•
9.00 Physical Therapy S				0.			
10.00 Occupational Thera 11.00 Occupational Thera				0. 0.			
12.00 Speech Pathology S				0.			
13.00 Speech Pathology S 14.00 Medical Social Ser				0. 0.			
15.00 Medical Social Ser				0. 0.			
16.00 Home Health Aide	upor door			0.			
17.00 Home Health Aide S 18.00 Other (specify)	Super VI Sor			0. 0.			
HOME HEALTH AGENCY				1			10.00
you provided servi	the number of CBSAs where ces during the cost				2		19.00
reporting period. 20.00 List those CBSA co	de(s) in column 1 serviced			31140			20.00
during this cost r	reporting period (line 20			51140			20.00
contains the first	code).			99915			20.01
		Full Ep				-	
		Without Outliers	With Outliers	LUPA Epi sode	es PEP Only Epi sodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
21.00 Skilled Nursing Vi	sits	291	56		20 59	426	21.00
22.00 Skilled Nursing Vi	5	35, 965	7,000				
23.00 Physical Therapy V 24.00 Physical Therapy V		187 26, 622	15 2, 250		1 14 32 1, 986		
25.00 Occupational Thera		0	0		0 2	2	•
26.00 Occupational Thera 27.00 Speech Pathology V		0	0		0 267 0 0	267 0	
28.00 Speech Pathology V 29.00 Medical Social Ser	8	0	0		0 0	0	
	vice Visit Charges	0	0		0 0	0	
31.00 Home Health Aide V		163	67		0 47	277	
32.00 Home Health Aide V 33.00 Total visits (sum	of lines 21, 23, 25, 27,	8, 965 641	3, 685 138		0 2,585 21 122		
29, and 31) 34.00 Other Charges		6, 581	309	1	22 840	7, 852	34.00
35.00 Total Charges (sum	n of lines 22, 24, 26, 28,	78, 133	309 13, 244	1			•
30, 32, and 34) 36.00 Total Number of Ep	isodes (standard/non	45			10 6	61	36.00
outlier) 37.00 Total Number of Ou			4		0	4	
	Medical Supply Charges	915	247	1, 7	71 768		38.00

Heal th	Financial Systems HARRISON COUNTY H	OSPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 15-1331	Period: From 01/01/2018		0
				To 12/31/2018	Date/Time Pre 5/30/2019 5:4	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	i ded by	line 202 colum	n 8)	0. 238128	1,00
	Medicaid (see instructions for each line)	· uou oj	11110 202 001 01		01200120	
2.00	Net revenue from Medicaid				7, 147, 930	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 supplement			cai d?	N	4.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments fr Medicaid charges	om Medio	caid		-514, 704 33, 992, 489	
8.00 7.00	Medicaid charges Medicaid cost (line 1 times line 6)				8, 094, 563	
8.00	Difference between net revenue and costs for Medicaid program (line 7 m	ninus sum of li	nes 2 and 5 if	1, 461, 337	
0.00	< zero then enter zero)					0.00
9.00	Children's Health Insurance Program (CHIP) (see instructions fo Net revenue from stand-alone CHIP	r each i	The)		0	9.00
10.00	Stand-al one CHIP charges				0	1 1.00
	Stand-alone CHIP cost (line 1 times line 10)				0	
	Difference between net revenue and costs for stand-alone CHIP (line 11	minus line 9;	if < zero then	0	
	enter zero)					
10.00	Other state or local government indigent care program (see inst					1 4 9 9 9
	Net revenue from state or local indigent care program (Not incl Charges for patients covered under state or local indigent care				0	
14.00	10)	e prograi		1 III IIIles o ol	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
	Difference between net revenue and costs for state or local ind		are program (li	ne 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and st	ate/local indi	gent care progra	ms (see	
17.00	instructions for each line) Private grants, donations, or endowment income restricted to fu	indi na ch	parity care		0	17.00
	Government grants, appropriations or transfers for support of h				0	
	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)			ns (sum of lines	1, 461, 337	
			Uni nsured		Total (col. 1	
			patients 1.00	patients 2.00	+ col. 2) 3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire fac	ilitv	321, 4	180 885, 810	1, 207, 290	20.00
	(see instructions)					
21.00	Cost of patients approved for charity care and uninsured discount instructions)	ints (see	e 76, 5	553 885, 810	962, 363	21.00
22.00	Payments received from patients for amounts previously written charity care	off as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		76, 5	553 885, 810	962, 363	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patien	it davs b	pevond a length	n of stav limit	N 1.00	24.00
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th	program	?	3	0	25.00
20.00	stay limit	ie marge		in 3 rength of		20.00
26.00	Total bad debt expense for the entire hospital complex (see ins	tructior	ıs)		7, 537, 319	26.00
	Medicare reimbursable bad debts for the entire hospital complex				597, 783	
27.01	Medicare allowable bad debts for the entire hospital complex (s	ee instr	ructions)		919, 665	
	Non-Medicare bad debt expense (see instructions)	anac (a instruct!		6, 617, 654	
29.00 30.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp Cost of uncompensated care (line 23 column 3 plus line 29)	ense (se	ee instructions	»)	1, 897, 731 2, 860, 094	
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			4, 321, 431	
51.00	retar an ernou sea and ancompensated care cost (rine 17 plus li				1 1, 521, 451	1 01.00

ECLAS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CO	CN: 15-1331	Peri od:	Worksheet A	2552-
					From 01/01/2018 To 12/31/2018		
	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 CAP REL COSTS-BLDG & FIXT		1, 529, 216			1, 805, 470	
01	00101 MOB		657, 327			657, 327	
02	00102 AMB DEPR		0		0 64, 894	64, 894	
00 01	00200 CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP		1, 160, 867		0 171, 131	1, 160, 867 171, 131	
00	00400 EMPLOYEE BENEFITS DEPARTMENT	213, 900	1, 110, 666			7, 342, 419	
00	00590 ADMINI STRATI VE & GENERAL	1, 563, 579	4, 880, 438			6, 006, 520	
02	00570 ADMINISTRATIVE & GENERAL	482, 682	174, 020				
03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	425, 523	790, 822				
00	00700 OPERATI ON OF PLANT	254,001	1, 368, 750			1, 529, 920	
01	00701 AMB PLANT OPS	201,001	0		0 0	0	
00	00800 LAUNDRY & LINEN SERVICE	25, 464	250, 658	276, 12	-9,603	266, 519	
00	00900 HOUSEKEEPI NG	510, 270	306, 524	816, 79	4 -111, 519	705, 275	9.
0. 00	01000 DI ETARY	396, 755	453, 707	850, 46	-488, 633	361, 829	10.
. 00	01100 CAFETERI A	0	0		0 388, 116	388, 116	11.
3. 00	01300 NURSING ADMINISTRATION	621, 159	187, 037	808, 19	6 -136, 167	672, 029	13.
1.00	01400 CENTRAL SERVICES & SUPPLY	240, 784	2, 229, 912	2, 470, 69	6 -1, 717, 230	753, 466	14.
5.00	01500 PHARMACY	365, 525	1, 981, 828			722, 066	
b. 00	01600 MEDI CAL RECORDS & LI BRARY	594, 803	260, 201				
. 00	01700 SOCIAL SERVICE	298, 973	77, 316	376, 28	-49, 242	327, 047	17.
~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 4 47 407	0// 50/	1 014 00	4 000 507	0 704 504	
0.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	3, 147, 497	866, 594			2, 721, 504	
. 00 3. 00	04300 NURSERY	435, 690 0	119, 004 130			461, 259 347, 081	31. 43.
5. 00	ANCI LLARY SERVICE COST CENTERS	U	130	1 13	540, 951	347,001	43.
). 00	05000 OPERATI NG ROOM	993, 746	698, 908	1, 692, 65	-458, 518	1, 234, 136	50.
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 215, 716	215, 716	
3. 00	05300 ANESTHESI OLOGY	-618	1, 105, 218	1, 104, 60		1, 089, 096	
1.00	05400 RADI OLOGY-DI AGNOSTI C	1, 122, 079	1, 166, 845	2, 288, 92	4 -357,042	1, 931, 882	54.
0. 00	06000 LABORATORY	801, 763	1, 641, 055	2, 442, 81	8 -448, 125	1, 994, 693	60.
5.00	06500 RESPI RATORY THERAPY	0	538, 326	538, 32			
6. 00	06600 PHYSI CAL THERAPY	292, 848	93, 128				
. 00	06700 OCCUPATI ONAL THERAPY	0	39, 419				
3.00	06800 SPEECH PATHOLOGY	0	0		0 14, 171	14, 171	
9.00	06900 ELECTROCARDI OLOGY	526, 016	197, 758				
. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS	0	0		0 1, 144, 069		
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 002, 367 0 1, 555, 203	1, 002, 367 1, 555, 203	
. 00	OUTPATIENT SERVICE COST CENTERS	0	0		1, 555, 205	1, 555, 205	/3.
). 00	09000 CLINIC	19, 562	83, 439	103, 00	-34, 225	68, 776	90.
	09001 SENI OR CARE	129, 693	172, 535				
. 00	09100 EMERGENCY	1, 667, 831	809, 260				
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	2, 108, 214	1, 572, 829	3, 681, 04	-3 -861, 914	2, 819, 129	95.
01.00	10100 HOME HEALTH AGENCY	144, 384	78, 190	222, 57	4 -23, 448	199, 126	101.
	SPECIAL PURPOSE COST CENTERS			1			
	11300 I NTEREST EXPENSE		221, 921				113.
8.00		17, 382, 123	26, 823, 848	44, 205, 97	1, 708, 333	45, 914, 304	1118.
o	NONREI MBURSABLE COST CENTERS						1100
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0				190.
	19200 PHYSI CLANS PRI VATE OFFI CES	8, 845, 691	4, 639, 092				
	07950 MARKETI NG 07951 PHYSI CI AN BILLI NG	67, 102	329, 188			366, 233	
	07951 PHYSICIAN BILLING 07952 MOB	561, 609 0	205, 231			632, 419	194. 194.
'4. U2	07952 MOB 07953 FOUNDATI ON	0	0		0 0 0 0		194. 194.
01 03							

ECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CCN	: 15-1331	Period: From 01/01/2018	Worksheet A	
						Date/Time Prep 5/30/2019 5:44	bared 4 pm
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				•
		6.00	7.00				
	GENERAL SERVICE COST CENTERS						
. 00	00100 CAP REL COSTS-BLDG & FIXT	-26, 413					1. (
. 01	00101 MOB	0					1. (
. 02	00102 AMB DEPR	0					1.0
00	00200 CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP	-460					2. 2.
. 01 . 00	00201 AMB EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0					2. 4.
. 00	00590 ADMINISTRATIVE & GENERAL	-1, 404, 195					5.
. 02	00570 ADMI TTI NG	1, 101, 170	529, 470				5.
03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0					5.
00	00700 OPERATION OF PLANT	0	1, 529, 920				7.
. 01	00701 AMB PLANT OPS	0	0				7.
. 00	00800 LAUNDRY & LINEN SERVICE	0	266, 519				8. (
. 00	00900 HOUSEKEEPI NG	0					9.
D. 00	01000 DI ETARY	0					10.
1.00	01100 CAFETERI A	-134, 956					11.
	01300 NURSI NG ADMI NI STRATI ON	-8, 500					13.
	01400 CENTRAL SERVICES & SUPPLY	0					14.
		0	722,066				15.
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	-25, 286 0					16. 17.
1.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	527,047				17.
D. 00	03000 ADULTS & PEDIATRICS	0	2, 721, 504				30.
	03100 I NTENSI VE CARE UNI T	0					31.
	04300 NURSERY	0					43.
	ANCILLARY SERVICE COST CENTERS						
0.00	05000 OPERATING ROOM	0	1, 234, 136				50.
2.00	05200 DELIVERY ROOM & LABOR ROOM	0					52.
3.00	05300 ANESTHESI OLOGY	-1,072,382					53.
4.00	05400 RADI OLOGY-DI AGNOSTI C	0	.,				54.
0.00		-660					60.
5.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0					65.
6.00 7.00	06700 OCCUPATI ONAL THERAPY	-182					66. 67.
B. 00	06800 SPEECH PATHOLOGY	- 102					68.
	06900 ELECTROCARDI OLOGY	0					69.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	0					72.
	07300 DRUGS CHARGED TO PATIENTS	0	1, 555, 203				73.
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0					90.
	09001 SENI OR CARE	0					90.
	09100 EMERGENCY	0	2, 127, 149				91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.
5 00	OTHER REIMBURSABLE COST CENTERS	24 750	2 704 270				05
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	-24, 759 0					95. 101.
	SPECIAL PURPOSE COST CENTERS	0	177,120				101.
13.00	11300 I NTEREST EXPENSE	0	0				113.
18.00		-2, 697, 793					118.
	NONREI MBURSABLE COST CENTERS		· · · · ·				
90.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0				190.
	19200 PHYSICIANS PRIVATE OFFICES	0	11, 940, 928				192.
	07950 MARKETI NG	0	366, 233				194.
	07951 PHYSICIAN BILLING	0	632, 419				194.
94.02	07952 MOB 07953 FOUNDATI ON	0	0				194. 194.

	Financial Systems SIFICATIONS		HARRI SON COUNT	Y HOSPITAL Provider CCN:	Period:	ieu of Form CMS Worksheet A	
					From 01/01/201 To 12/31/201	8 Date/Time Pr	repared:
		Increases				5/30/2019 5	:44 pm
	Cost Center	Line #	Salary	Other			
	2.00 A - EMPLOYEE BENEFITS	3.00	4.00	5.00			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6, 017, 853			1.00
2.00	ANESTHESI OLOGY	53.00	0	164			2.00
3.00 4.00		0.00 0.00	0	0			3.00 4.00
5.00		0.00	Ö	0			5.00
6.00		0.00	0	0			6.00
7.00 8.00		0.00 0.00	0	0			7.00 8.00
9.00		0.00	0	Ő			9.00
10.00		0.00	0	0			10.00
11. 00 12. 00		0.00 0.00	0	0			11.00 12.00
13.00		0.00	0	0			13.00
14.00		0.00	0	0			14.00
15. 00 16. 00		0.00 0.00	0	0			15.00 16.00
17.00		0.00	0	0			17.00
18. 00 19. 00		0.00 0.00	0	0			18.00 19.00
20.00		0.00	0	0			20.00
21.00		0.00	0	0			21.00
22.00 23.00		0.00 0.00	0	0			22.00 23.00
23.00 24.00		0.00	0	0			23.00
25.00		0.00	О	0			25.00
26.00 27.00		0.00 0.00	0	0			26.00 27.00
27.00	0	0.00	0	6, 018, 017			27.00
1 00	B - EKG	(0.00	44 272				1 00
1.00 2.00	ELECTROCARDI OLOGY	69.00 0.00	44, 273 0	55, 011 0			1.00
3.00		0.00	0	0			3.00
4.00		0.00					4.00
	C - LDRP		44, 273	55,011			-
1.00	NURSERY	43.00	328, 325	18, 642			1.00
2.00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	<u>204, 126</u> 532, 451	1 <u>1, 590</u> 30, 232			2.00
	D - CAFETERIA		332, 431				
1.00	CAFETERI A	<u>11.00</u>	205, 331	182, 785			1.00
	e - Therapy		205, 331	182, 785			
1.00	OCCUPATI ONAL THERAPY	67.00	1, 013	665			1.00
2.00	SPEECH PATHOLOGY		<u>14, 072</u> 15, 085	<u>99</u> 764			2.00
	F - AMBULANCE CAPITAL		13,003				
1.00	AMB DEPR	1.02	0	64, 894			1.00
2.00	AMB EQUI P	2.01	0	<u>171, 131</u> 236, 025			2.00
	G - MEDICAL SUPPLIES		-1				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2, 382, 461			1.00
2.00		0.00	0	0			2.00
3.00 4.00		0.00 0.00	0	0			3.00 4.00
4.00 5.00		0.00	0	0			4.00 5.00
6.00		0.00	0	0			6.00
7.00 8.00		0.00 0.00	0	0			7.00 8.00
8.00 9.00		0.00	0	0			9.00
10.00		0.00	о	0			10.00
11. 00 12. 00		0.00 0.00	0	0			11.00 12.00
12.00		0.00	0	o			13.00
14.00		0.00	0	0			14.00
	0 H - DRUGS		0	2, 382, 461			-
1.00	DRUGS_CHARGED_TO_PATIENTS	73.00	0	<u>1, 555, 2</u> 03			1.00
	O I – CAPITAL		0	1, 555, 203			-
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	221, 921			1.00
2.00	CAP REL COSTS-BLDG & FIXT	<u>1.00</u>	0	5 <u>4, 333</u> 276, 254			2.00
	0		U	210, 254			

Heal th	Financial Systems		HARRISON COUN	ITY HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLASS	SI FI CATI ONS			Provider (CCN: 15-1331	Period: From 01/01/2018	Worksheet A-	6
						To 12/31/2018	Date/Time Pr 5/30/2019 5:	epared: 44 pm
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	J - IMPLANTABLE DEVICES							
1.00	IMPL. DEV. CHARGED TO	72.00	0	1,002,367				1.00
	PATI ENTS							
	TOTALS		0	1,002,367				
	K – ANESTHESIA SALARY							
1.00	ANESTHESI OLOGY	53.00	618	0				1.00
	TOTALS	+	618					
500.00	Grand Total: Increases		797, 758	11, 739, 119				500.00

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
. 00	ADMI NI STRATI VE & GENERAL	5.01	0	383, 164	0	1. (
. 00	ADMI TTI NG	5.02	0	127, 232		2.0
00	CASHI ERI NG/ACCOUNTS	5.03	0	120, 823	0	3. (
	RECEIVABLE					
00	OPERATION OF PLANT	7.00	0	92, 831	0	4. (
00	LAUNDRY & LINEN SERVICE	8.00	0	9, 603	0	5.
00	HOUSEKEEPING	9.00	0	111, 519		6.
00	DI ETARY	10.00	0	100, 517	0	7.
00	NURSING ADMINISTRATION	13.00	0	136, 167	o	8.
00	CENTRAL SERVICES & SUPPLY	14.00	0		0	9.
			-	46, 904		
. 00	PHARMACY	15.00	0	68, 900	0	10.
. 00	MEDICAL RECORDS & LIBRARY	16.00	0	176, 750	0	11.
. 00	SOCI AL SERVI CE	17.00	0	49, 242		12.
			-			
. 00	ADULTS & PEDIATRICS	30.00	0	707, 659		13.
. 00	INTENSIVE CARE UNIT	31.00	0	91, 846	0	14.
. 00	OPERATING ROOM	50.00	0	262, 585		15.
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	258, 030	0	16.
. 00	LABORATORY	60.00	0	189, 783	0	17.
00	PHYSI CAL THERAPY	66.00	0	85, 004	0	18.
			-			
00	ELECTROCARDI OLOGY	69.00	0	106, 753		19.
00	CLINIC	90.00	0	1, 495	0	20.
. 00	SENI OR CARE	90.01	0	20, 104	0	21.
00	EMERGENCY	91.00	0	340, 065		22.
. 00	AMBULANCE SERVICES	95.00	0	799, 260	0	23.
. 00	HOME HEALTH AGENCY	101.00	0	23, 448	o	24.
			0			
. 00	PHYSICIANS PRIVATE OFFICES	192.00	0	1, 543, 855		25.
. 00	MARKETING	194.00	0	30, 057	0	26.
. 00	PHYSICIAN BILLING	194.01	0	134, 421	o	27.
			— — — o			
	-		0	6, 018, 017		
	B – EKG					
0C	INTENSIVE CARE UNIT	31.00	17	0	0	1.
00	LABORATORY	60.00	40, 615	0	0	2.
00	RESPI RATORY THERAPY	65.00	0	55, 011		3.
00	EMERGENCY	91.00	3, 641	0	0	4.
	0		44, 273	55, 011		
	C - LDRP					
00	ADULTS & PEDIATRICS	30.00	532, 451	30, 232	0	1.
	ADULIS & PEDIATRICS		552,451	30, 232		
0C		0.00	0	0	0	2.
	0		532, 451	30, 232		
	D – CAFETERIA				L	
~~		10.00	005 004	100 705		
00	DI ETARY		205, 331	<u>182, 7</u> 85		1.
	0		205, 331	182, 785		
	E – THERAPY					
00	PHYSICAL THERAPY	66.00	15, 085	764	0	1.
	PHISICAL INERAPT		15,065			
00		0.00	0	0	0	2.
	0		15, 085	764		
	F - AMBULANCE CAPITAL	L			·	
00	MEDICAL SUPPLIES CHARGED TO	71.00	0	236, 025	9	1.
50		/1.00	U	230, 025	9	1.
	PATI ENT					
00		0.00	0	0	9	2.
		†	<u>0</u>	236, 025		
	G - MEDI CAL SUPPLI ES		0	_00, 020	I	
~~			-1	4 (70.07)		
00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 670, 326		1.
00	PHARMACY	15.00	0	1, 184	0	2.
00	ADULTS & PEDIATRICS	30.00	0	22, 245		3.
00	INTENSIVE CARE UNIT	31.00	0	1, 572		4.
00	NURSERY	43.00	0	16	0	5.
00	OPERATING ROOM	50.00	0	195, 933		6.
00	ANESTHESI OLOGY	53.00	0	15, 668		7.
00	RADI OLOGY-DI AGNOSTI C	54.00	0	99, 012	0	8.
00	LABORATORY	60.00	0	217, 727		9.
			0			
00	RESPI RATORY THERAPY	65.00	0	30, 478		10.
. 00	ELECTROCARDI OLOGY	69.00	0	26, 680	0	11.
00	CLINIC	90.00	Ö	32, 730		12.
00	EMERGENCY	91.00	0	6, 236		13.
00	AMBULANCE SERVICES	95.00	0	62, 654	0	14.
			— — — ö	2, 382, 461		
			U	2, 302, 401		
	H – DRUGS					
00	PHARMACY	15.00	0	1, 555, 203	0	1.
		+		1, 555, 203		

0

1, 555, 203 1, 555, 203

Decreases

Health Financial Systems RECLASSIFICATIONS

In Lieu of Form CMS-2552-10 Worksheet A-6

Provider CCN: 15-1331

Period: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/30/2019 5:44 pm

0

Heal th	Financial Systems		HARRISON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-1331	Period:	Worksheet A-	5
						From 01/01/2018 To 12/31/2018	Date/Time Pre 5/30/2019 5:4	epared: 44 pm
		Decreases						
	Cost Center	Line #	Salary	0ther	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	I – CAPITAL							
1.00	ADMI NI STRATI VE & GENERAL	5.01	0	54, 333	1	1		1.00
2.00	INTEREST EXPENSE	113.00	0	221, 921	1	2		2.00
	0		0	276, 254				
	J - IMPLANTABLE DEVICES							
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1,002,367		0		1.00
	PATI ENT							
	TOTALS		0	1,002,367				
	K - ANESTHESIA SALARY							
1.00	ANESTHESI OLOGY	53.00	0	618		0		1.00
	TOTALS		0	618				
500.00	Grand Total: Decreases		797, 140	11, 739, 737				500.00

	Financial Systems	HARRI SON COUN	TY_HOSPITAL		. In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2018 To 12/31/2018		pared:
				Acquisition	S		
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES		_		_	
1.00	Land	3, 001, 138	0		0 0	0	1.00
2.00	Land Improvements	3, 379, 433	0		0 0	0	2.00
3.00	Buildings and Fixtures	40, 406, 678	842, 583		0 842, 583	0	3.00
4.00	Building Improvements	4, 309, 403	0		0 0	704, 268	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	28, 124, 986	0		0 0	744, 750	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	79, 221, 638	842, 583		0 842, 583	1, 449, 018	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	79, 221, 638	842, 583		0 842, 583	1, 449, 018	10.00
		Endi ng Bal ance	Fully				
		-	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE			-			
1.00	Land	3, 001, 138	0				1.00
2.00	Land Improvements	3, 379, 433	0				2.00
3.00	Buildings and Fixtures	41, 249, 261	0				3.00
4.00	Building Improvements	3, 605, 135	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	27, 380, 236	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	78, 615, 203	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	78, 615, 203	0				10.00

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	F	Period: From 01/01/2018 To 12/31/2018		pared:
		SL	JMMARY OF CAPI	ΓAL		
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 V	WORKSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FIXT	1, 529, 216	0	(0 0	0	1.00
1.01 MOB	275, 756	74, 035	115, 435	5 13, 725	0	1.01
1.02 AMB DEPR	0	0	0	0 0	0	1.02
2.00 CAP REL COSTS-MVBLE EQUIP	1, 160, 867	0	0	0 0	0	2.00
2.01 AMB EQUIP	0	0	0	0 0	0	2.01
3.00 Total (sum of lines 1-2)	2, 965, 839		115, 435	5 13, 725	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
	Capi tal -Rel ate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM V	NORKSHEET A, COLUN					
1.00 CAP REL COSTS-BLDG & FIXT	0	1, 529, 216				1.00
1.01 MOB	178, 376	657, 327				1.01
1.02 AMB DEPR	0	0				1.02
2.00 CAP REL COSTS-MVBLE EQUIP	0	1, 160, 867				2.00
2.01 AMB EQUIP	170.07/	0				2.01
3.00 Total (sum of lines 1-2)	178, 376	3, 347, 410				3.00

Heal th	Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provider C			Date/Time Prep 5/30/2019 5:44	bared:
		COME	PUTATION OF RA	FI OS	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 CE				1		
1.00 1.01 1.02	CAP REL COSTS-BLDG & FIXT MOB AMB DEPR	43, 690, 436 7, 544, 531 0		7, 544, 53		0	1. 00 1. 01 1. 02
2. 00 2. 01	CAP REL COSTS-MVBLE EQUIP AMB EQUIP	27, 380, 236 0	C	27, 380, 23	6 0. 348282 0 0. 000000	0 0	2. 00 2. 01
3.00	Total (sum of lines 1-2)	78, 615, 203 ALLOCA ⁻	CTION OF OTHER	78, 615, 20 CAPI TAL		0 DF CAPITAL	3.00
	Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum or cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS			-		
1.00 1.01 1.02	CAP REL COSTS-BLDG & FIXT MOB AMB DEPR	0 0 0			0 1, 519, 989 0 275, 756 0 64, 894	74, 035	1. 00 1. 01 1. 02
2.00 2.01 3.00	CAP REL COSTS-MVBLE EQUIP AMB EQUIP Total (sum of lines 1-2)	0			0 1, 160, 407 0 171, 131 0 3, 192, 177	0	2.00 2.01 3.00
0.00			SI	JMMARY OF CAPI		11,000	0.00
	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	
1.00	PART III - RECONCILIATION OF CAPITAL COSTS CE CAP REL COSTS-BLDG & FIXT	ENTERS 204, 735	54, 333		0 0	1, 779, 057	1.00
1. 01 1. 02	MOB AMB DEPR	115, 435 0	13, 725		0 178, 376 0 0	657, 327 64, 894	1. 01 1. 02
2.00 2.01 3.00	CAP REL COSTS-MVBLE EQUIP AMB EQUIP Total (sum of lines 1-2)	0 0 320, 170	0 0 68, 058		0 0 0 0 0 178, 376	1, 160, 407 171, 131 3, 832, 816	2.00 2.01 3.00
5.00		320, 170	00,050	1	o _l 170, 370	J 5, 052, 010	5.00

	Financial Systems MENTS TO EXPENSES		HARRI SON COUN	Provider CCN: 15-1331	In Lie Period: From 01/01/2018	u of Form CMS-2 Worksheet A-8	
					To 12/31/2018	Date/Time Prep 5/30/2019 5:44	
				Expense Classification or To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-17, 186	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - MOB (chapter 2)		0	МОВ	1.01	0	1.01
1.02	Investment income - AMB DEPR (chapter 2)		0	AMB DEPR	1.02	0	1. 02
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	COSTS-MVBLE EQUIP (chapter 2) Investment income - AMB EQUIP		0	AMB EQUIP	2.01	0	2. 01
3.00	(chapter 2) Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time	В	_1 255	ADMI NI STRATI VE & GENERAL	5.01	0	4.00
	discounts (chapter 8)	U					
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service		0		0.00	0	8.00
9. 00 10. 00	(chapter 21) Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -19, 882		0.00	0 0	
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
12. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	0			0	12.00
	Laundry and linen service Cafeteria-employees and guests Rental of quarters to employee	В	0 -134, 956 0	CAFETERI A	0.00 11.00 0.00	0	14.00
	and others Sale of medical and surgical supplies to other than		0		0.00		
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
	patients Sale of medical records and	в	-25 286	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
	abstracts	D					
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	
	Vending machines Income from imposition of		0 0		0.00		
	interest, finance or penalty charges (chapter 21)						
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26. 01	COSTS-BLDG & FIXT Depreciation - MOB		0	МОВ	1.01	0	26. 01
26. 02	Depreciation - AMB DEPR Depreciation - CAP REL		0	AMB DEPR CAP REL COSTS-MVBLE EQUIP	1.02 2.00	0	26. 02
	COSTS-MVBLE EQUIP Depreciation - AMB EQUIP Non-physician Anesthetist Physicians' assistant			AMB EQUIP *** Cost Center Deleted ***	2. 01 19. 00 0. 00		27.01 28.00 29.00

Heal th Financial			HARRISON COUN			u of Form CMS-2	
ADJUSTMENTS TO I	EXPENSES			Provider CCN: 15-1331	Period: From 01/01/2018	Worksheet A-8	
					To 12/31/2018	Date/Time Pre	nared
					10 12/01/2010	5/30/2019 5:4	
				Expense Classification of	on Worksheet A		
				To/From Which the Amount i	s to be Adjusted		
2							
COS	t Center Description	Basi s/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
20.00 A I'		1.00	2.00	3.00	4.00	5.00	00.00
	nt for occupational	A-8-3	- 182	OCCUPATI ONAL THERAPY	67.00		30.00
	costs in excess of on (chapter 14)						
			0	ADULTS & PEDIATRICS	30, 00		30.99
i nstructi	(non-distinct) (see		0	ADULIS & PEDIATRICS	30.00		30.99
	nt for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	costs in excess of	A-0-3	0	SPEECH PATHOLOGY	00.00		31.00
	on (chapter 14)						
	Adjustment for		0		0.00	0	32.00
	tion and Interest		Ŭ		0.00		02.00
	COME - A&G	В	-81,944	ADMI NI STRATI VE & GENERAL	5.01	0	33.00
33.01 MISC. INC		В		LABORATORY	60,00		•
33.02 MISC. INC	COME - AMBULANCE	В	-12,759	AMBULANCE SERVICES	95.00	0	33.02
34.00 PATIENT 1	FELEPHONES -	A	-460	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.00
DEPRECI AT	TI ON						
34.01 PATIENT 1	TELEPHONES - EXPENSES	A	-7, 825	ADMI NI STRATI VE & GENERAL	5.01	0	34.01
35.00 CRNA		A	-1,073,000	ANESTHESI OLOGY	53.00	0	35.00
36.00 I HA & AHA	A DUES	A	-5, 403	ADMI NI STRATI VE & GENERAL	5.01	0	36.00
37.00 HAF FEES		A	-1, 307, 668	ADMI NI STRATI VE & GENERAL	5.01	0	37.00
38.00 UNECESSAF	RY BORROWING	A	-9, 227	CAP REL COSTS-BLDG & FIXT	1.00	9	38.00
50.00 TOTAL (su	um of lines 1 thru 49)		-2, 697, 793				50.00
	to Worksheet A,						
column 6,	line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

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

PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CDN: 15-1331 Period: From 01/01/201 To 12/31/2018 Worksheet A-8-2 bate/Time Prepared: To 12/31/2019 Worksheet A-8-2 Date/Time Prepared: To 12/31/2019 1.00 13.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 1.00 13.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 1.00 13.00 0.00 6.00 7.00 1.00	Heal th	Financial Syste	ems	HARRI SON COU	NTY HOSPITAL		In Lie	eu of Form CMS-	2552-10
To 12/31/2018 Date/Time Prepared: 5/30/2019 5: 44 pm Wkst. A Line # Cost Center/Physician Total Identifier Professional Remuneration Provider Component Provider RCE Amount Physician/Provider 1.00 1:00 2:00 3:00 4:00 5:00 6:00 Physician/Provider 1.00 1:00 2:00 3:00 4:00 5:00 6:00 0							Period:	Worksheet A-8	
West: A Line Cost Center/Physic ian Identifier Total Remuneration Proviessional Component Proviessional Component Proviessional Component RCE Amount Component Proviessional Hours 1.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 2.00 53.00 AMESTHESI OLOGY -618 -618 0 0 0 0 2.00 3.00 4.00 43.335 0 0.03.00 0.00 <								B Date/Time Pre	
Identifier Remuneration Component Component Ider Component 1.00 2.00 3.00 4.00 5.00 6.00 7.00 2.00 53.00/MESTIR STOLOGY -618 0 0 0 2.00 3.00 60.00 0.01/MINISTRATION 8.500 -618 0 0 0 2.00 2.00 3.00 4.03.335 0 0.01/MINISTRATION 2.00 3.00 4.00 3.00 0		Wkst Aline #	Cost Center/Physician	Total	Professional	Provi der	RCE Amount		
Image: constraint of the stress of									
1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 13.00 NURSI K ADININI STRATION 8,500 0 0 0 0 1.00 3.00 60.00 NURSI KG ADININI STRATION 8,500 0									
2.00 53.00 AUSTHEST IOLOGY -618 -618 0 0 0 2.00 3.00 60.00 LABORATORY 43,335 0 43,335 0 0 3.00 4.00 91.00 EMERGENCY 319,696 0 319,696 0 <t< td=""><td></td><td>1.00</td><td>2.00</td><td>3.00</td><td>4.00</td><td>5.00</td><td>6.00</td><td></td><td></td></t<>		1.00	2.00	3.00	4.00	5.00	6.00		
3.00 4.00 60.00 LABORATORY 91.00 EMERGENCY 43,335 319,696 0 319,696 43,335 0 319,696 0 319,696 0 0 0 0 <t< td=""><td>1.00</td><td>13.00</td><td>NURSING ADMINISTRATION</td><td>8, 500</td><td>8, 500</td><td>0</td><td>0</td><td>0</td><td>1.00</td></t<>	1.00	13.00	NURSING ADMINISTRATION	8, 500	8, 500	0	0	0	1.00
4.00 91.00 DEREGENCY 319,696 0 319,696 0	2.00	53.00	ANESTHESI OLOGY	-618	-618	0	0	0	2.00
5.00 95.00 AMBULANCE SERVICES 12,000 12,000 0	3.00	60.00	LABORATORY	43, 335	c	43, 335	0	0	3.00
5.00 95.00 AMBULANCE SERVICES 12,000 12,000 0	4.00				C			0	4,00
6.00 0.00 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>0</td><td></td></th<>								0	
7.00 0.00 0.00 0								0	
8.00 0.00 0.00 0				0				0	
9.00 0.00 0.00 0.00 <				0	0		0	0	
10.00 0.00 0 0 0 0 0 10.00 200.00 10.00 263,031 0 0 200.00 200.00 10.00 200.00 10.00 200.00 10.00 200.00 2				0	0		0	0	
200.00 382,913 19,882 363,031 0 0 200.00 Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit 5 Percent of Unadjusted RCE Limit Cost of Continuing Education Provider Share of col. Physician Cost of Mal practice Insurance Physician Cost of Mal practice Insurance 1.00 2.00 8.00 9.00 12.00 13.00 14.00 2.00 53.00 ANESTHESI OLOGY 0 0 0 0 0 0 0 2.00 3.00 60.00 DLABORATORY 0 0 0 0 0 0 0 2.00 3.00 4.00 91.00 EMERGENCY 0 <t< td=""><td></td><td></td><td></td><td>0</td><td></td><td></td><td>0</td><td>, s</td><td></td></t<>				0			0	, s	
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit 5 Percent of Unadjusted RCE Limit Cost of Memberships & Limit Provider Component Share of col. Physician Cost of Malpractice Insurance 1.00 2.00 8.00 9.00 12.00 13.00 14.00 1.00 13.00 NURSI NG ADMI NI STRATI ON 2.00 0 0 0 0 0 1.00 2.00 53.00 ANESTHESI OLOGY 0 0 0 0 0 0 2.00 3.00 60.00 LABORATORY 0 0 0 0 0 0 3.00 4.00 91.00 EMERGENCY 0 0 0 0 0 0 4.00 5.00 0.00 0 </td <td></td> <td>0.00</td> <td></td> <td>382 913</td> <td>19 882</td> <td>363 031</td> <td>0</td> <td>, s</td> <td></td>		0.00		382 913	19 882	363 031	0	, s	
Identifier Limit Unadjusted RCE Memberships & Continuing Education Component Share of col. 12 of Mal practice Insurance 1.00 2.00 8.00 9.00 12.00 14.00 1.00 13.00 NURSING ADMINISTRATION 0 0 0 0 10.00 2.00 53.00 ANESTHESI OLOGY 0 0 0 0 0 0 1.00 3.00 60.00 LABORATORY 0 0 0 0 0 0 2.00 4.00 91.00 EMERGENCY 0 0 0 0 0 0 0 0 4.00 5.00 95.00 AMBULANCE SERVICES 0	200.00	Wkst Aline#	Cost Center/Physician						
Image: Constraint of the second sec									
Image: Note of the image in the image. Education in the image intervalue in the image in the im									
1.00 2.00 8.00 9.00 12.00 13.00 14.00 1.00 13.00 NURSI NG ADMI NI STRATI ON 0					2			i nour anoo	
1.00 13.00 NURSI NG ADMI NI STRATI ON 0 0 0 0 0 1.00 2.00 53.00 ANESTHESI OLOGY 0 0 0 0 0 2.00 3.00 60.00 LABORATORY 0 0 0 0 0 3.00 4.00 91.00 EMERGENCY 0 0 0 0 0 3.00 5.00 95.00 AMBULANCE SERVICES 0 0 0 0 0 5.00 6.00 0.00 0 0 0 0 0 0 6.00 7.00 0.00 0 0 0 0 0 0 6.00 7.00 0.00 0 0 0 0 0 0 7.00 8.00 0.00 0 0 0 0 0 0 9.00 10.00 0.00 0<		1.00	2,00	8,00	9,00			14.00	
3.00 60.00 LABORATORY 0 0 0 0 0 3.00 4.00 91.00 EMERGENCY 0	1.00								1.00
3.00 60.00 LABORATORY 0 0 0 0 0 3.00 4.00 91.00 EMERGENCY 0	2.00			0	C		0	0	2,00
4.00 91.00 EMERGENCY 0 0 0 0 0 0 4.00 5.00 95.00 AMBULANCE SERVICES 0 0 0 0 0 0 5.00 6.00 0.00 0 0 0 0 0 0 0 6.00 7.00 0.00 0 0 0 0 0 0 7.00 8.00 0.00 0 0 0 0 0 0 8.00 0 0 0 9.00 0 9.00 0 9.00 0 0 9.00 0 9.00 0 0 0 9.00 0 0 0 9.00 0				0			0	0	3,00
5.00 95.00 AMBULANCE SERVICES 0 0 0 0 0 0 0 6.00 0 <td< td=""><td>4.00</td><td>91.00</td><td>EMERGENCY</td><td>0</td><td></td><td></td><td>0</td><td>0</td><td>4,00</td></td<>	4.00	91.00	EMERGENCY	0			0	0	4,00
6.00 0.00 <th< td=""><td></td><td></td><td></td><td>0</td><td></td><td></td><td>0</td><td>0</td><td></td></th<>				0			0	0	
7.00 0.00 <th< td=""><td></td><td></td><td></td><td>0</td><td>0</td><td></td><td>0</td><td>0</td><td></td></th<>				0	0		0	0	
8.00 0.00 <th< td=""><td></td><td></td><td></td><td>0</td><td>-</td><td>-</td><td>0</td><td>0</td><td></td></th<>				0	-	-	0	0	
9.00 0.00 <th< td=""><td></td><td></td><td></td><td>0</td><td>u u</td><td></td><td>0</td><td>0</td><td></td></th<>				0	u u		0	0	
10.00 0.00 0.00 0 0 0 0 0 0 10.00 200.00 Wkst. A Line # Cost Center/Physician I dentifier Provider Component Share of col. 14 Adj usted RCE Limit RCE Disal I owance Adj ustment Adj ustment Adj ustment Disal I owance Adj ustment Image: Component Share of col. 14 Disal I owance Adj ustment Image: Component Share of col. 14 Disal I owance Adj ustment Image: Component Share of col. 14 Disal I owance Image: Component Share of col. 14 Image: Component Share of col. 14 </td <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>-</td> <td>0</td> <td></td>				0			-	0	
200.00 <td></td> <td></td> <td></td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> <td>0</td> <td></td>				-	-	-	-	0	
Wkst. A Line #Cost Center/Physician I dentifierProvider Component Share of col.Adjusted RCE LimitRCE DisallowanceAdjustment1.002.0015.0016.0017.0018.00		0.00		0	-		-	, s	
I denti fi er Component Share of col. Li mi t Di sal I owance 1.00 2.00 15.00 16.00 17.00 18.00	200.00	Wkst Aline #	Cost Center/Physician	Provi der			-	0	200.00
Share of col. 14 1.00 2.00 15.00 16.00 17.00 18.00		WRSt. A EINC #			, ,		Aujustillerre		
14 14 1.00 2.00 15.00 16.00 17.00 18.00			i denti i i ei			Di Sal i Owaliee			
1.00 2.00 15.00 16.00 17.00 18.00									
		1.00	2.00		16,00	17.00	18.00		
	1.00								1.00
2. 00 53. 00 ANESTHESI OLOGY 0 0 -618 2. 00				0					
3. 00 60. 00 LABORATORY 0 0 0 0 3. 00									
				0	-	-	-		
5. 00 95. 00 AMBULANCE SERVICES 0 0 12, 000 5. 00				0					
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7.00 0.00 0 0 0 7.00				0			-		
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200.00 0 19,882 200.00		0.00		-					
	200.00	I	I	1 0			17,002	I	200.00

	Financial Systems IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	HARRI SON COUN FURNI SHED BY	TY HOSPITAL Provider CCN:	F	In Lie Period: From 01/01/2018 To 12/31/2018 Respiratory Therapy	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Prep 5/30/2019 5:44 Cost	-3 pared:
						1.00	
1.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide	s) (see instruc	tions)			52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervi					0	3.00
4.00	Number of unduplicated days in which therapy nor therapist was on provider site (see inst		on provider site	but neitner	supervisor	0	4.00
5.00	Number of unduplicated offsite visits - supe	rvisors or ther				0	5.00
6.00	Number of unduplicated offsite visits - therassistant and on which supervisor and/or the					0	6.00
	instructions)		present during t		(366		
7.00	Standard travel expense rate					0.00	
8.00	Optional travel expense rate per mile	Supervi sors	Therapists	Assi stants	Ai des	0.00 Trai nees	8.00
	1	1.00	2.00	3.00	4.00	5.00	
9.00 10.00	Total hours worked AHSEA (see instructions)	0. 00 74. 96	12, 500. 80 65. 18	0.00 48.89		0.00 0.00	
11.00	Standard travel allowance (columns 1 and 2,	32.59	32.59	24.45		0.00	11.00
	one-half of column 2, line 10; column 3,						
12.00	one-half of column 3, line 10) Number of travel hours (provider site)	0	o	C)		12.00
12. 01	Number of travel hours (offsite)		-				12.01
13.00 13.01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0	(13.00 13.01
13.01		<u> </u>					13.01
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00	Supervisors (column 1, line 9 times column 1	, line 10)				0	14.00
15.00	Therapists (column 2, line 9 times column 2,					814, 802	15.00
16.00 17.00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a		ratory therapy o	r lines 14-1	6 for all	0 814, 802	16.00 17.00
17.00	others)	nu is ioi respi	ratory therapy o	1 111163 14-1		014, 002	17.00
18.00	Aides (column 4, line 9 times column 4, line					0	18.00
19.00 20.00	Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f		therapy or lines	17 and 18 f	or all others)	0 814, 802	19.00 20.00
20.00	If the sum of columns 1 and 2 for respirator	y therapy or co	lumns 1-3 for phy	ysical thera	py, speech path	ology or	20100
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		no entries on li	nes 21 and 2	2 and enter on	line 23	
21.00	Weighted average rate excluding aides and tra		divided by sum	of columns 1	and 2, line 9	0.00	21.00
22.00	for respiratory therapy or columns 1 thru 3,					0	22.00
22.00 23.00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)	ees (line 2 tim	es line 21)			0 814, 802	22.00 23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	VANCE AND TRAVE	L EXPENSE COMPUT	ATION - PROV	IDER SITE		
24.00	Standard Travel Allowance					0	24 00
25.00	Assistants (line 3 times column 2, line 11)					0	
26.00	Subtotal (line 24 for respiratory therapy or					0	26.00
27.00	Standard travel expense (line 7 times line 3 others)	for respirator	y therapy or sum	of lines 3	and 4 for all	0	27.00
28.00	Total standard travel allowance and standard	travel expense	at the provider	site (sum c	flines 26 and	0	28.00
	27) Optional Travel Allowance and Optional Travel	Evnense					
29.00	Therapists (column 2, line 10 times the sum		d 2, line 12)			0	29.00
30.00	Assistants (column 3, line 10 times column 3					0	30.00
31.00 32.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column				or sum of	0	31.00 32.00
52.00	columns 1-3, line 13 for all others)			ory therapy	or sum or	0	52.00
33.00	Standard travel allowance and standard trave			21)		0	33.00
34.00 35.00	Optional travel allowance and standard trave Optional travel allowance and optional trave					0	34.00 35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW				CES OUTSIDE PRO		
36.00	Standard Travel Expense Therapists (line 5 times column 2, line 11)				1	0	36.00
	Assistants (line 6 times column 3, line 11)					0	
37.00	Subtotal (sum of lines 36 and 37)	6 J ·				0	38.00
37. 00 38. 00	Standard travel expense (line 7 times the su		d 6)			0	39.00
37.00						0	40.00
37. 00 38. 00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.)		2, line 10)				
 37. 00 38. 00 39. 00 40. 00 41. 00 	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12, Assistants (column 3, line 12.01 times colum	01 times column	2, line 10)			0	41.00
37.00 38.00 39.00 40.00 41.00 42.00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12, Assistants (column 3, line 12.01 times colum Subtotal (sum of lines 40 and 41)	01 times column n 3, line 10)				0 0	42.00
 37. 00 38. 00 39. 00 40. 00 41. 00 	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12, Assistants (column 3, line 12.01 times colum	D1 times column n 3, line 10) m of columns 1-	3, line 13.01)	of the follo	wing three line	0 0 0	
37.00 38.00 39.00 40.00 41.00 42.00 43.00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12, Assistants (column 3, line 12.01 times colum Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	01 times column n 3, line 10) <u>n of columns 1-</u> Offsite Service:	3, line 13.01) s; Complete one d			0 0 s 44, 45,	42.00

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	URNI SHED BY	Provider C	CN: 15-1331	Period: From 01/01/2018 To 12/31/2018	Worksheet A-8 Parts I-VI Date/Time Pre 5/30/2019 5:4	pared:
					Respi ratory Therapy	Cost	
						1.00	
5.00	Optional travel allowance and standard travel					0	
6.00	Optional travel allowance and optional travel					0	46.0
	-	Therapists 1.00	Assistants 2.00	Ai des 3.00	Trai nees 4.00	<u> </u>	
	PART V - OVERTIME COMPUTATION	1.00	2.00	5.00	4.00	5.00	
	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. C	0.00	0.00	47.0
8. 00	Overtime rate (see instructions)	0.00	0.00				48.0
	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00	0.0	0.00		49.0
	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. C	0.00	0.00	50.0
	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	O. C	0.00	0.00	51.0
	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	65. 18	0.00	36.6	0.00		52.0
	(see instructions) Overtime cost limitation (line 51 times line	05. 18	0.00		0 0		52.0
	52) Maximum overtime cost (enter the lesser of	О	0		0 0		54. C
5. 00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.0
6. 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	0	0		0 0	0	56. C
	for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)	ND EXCESS COST	ADJUSTMENT			814, 802	57. C
3. 00 9. 00 0. 00 1. 00 2. 00 3. 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	es (from lines)		814, 802 0 0 0 814, 802 814, 802	58.0 59.0 60.0 61.0 62.0 63.0
5.00	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	- if negative,		ll others		0	65. C
)0. 01)0. 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 LINE 34 CALCULATION				others	0	100. 0 100. 0 100. 0
01.00 01.01 01.02	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. C 101. C 101. C
02.00	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				umns 1-3. line		102. (102. (

1.00 Tc 2.00 Li 3.00 Nu 4.00 Nu 5.00 Nu 6.00 Nu 6.00 Nu 8.00 Op 9.00 Tc 10.00 AF 11.00 AF 11.00 AF 11.00 Nu 13.00 Nu 13.01 Nu 13.01 Nu 14.00 Su 15.00 Tr 16.00 As 17.00 Su 18.00 Ai	ART 1 - GENERAL INFORMATION otal number of weeks worked (excluding aides ine 1 multiplied by 15 hours per week umber of unduplicated days in which supervis umber of unduplicated offsite visits - super umber of unduplicated offsite visits - super umber of unduplicated offsite visits - thera ssistant and on which supervisor and/or ther nstructions) tandard travel expense rate ptional travel expense rate per mile otal hours worked HSEA (see instructions) tandard travel allowance (columns 1 and 2, ne-half of column 3, line 10) umber of travel hours (provider site) umber of travel hours (offsite) umber of miles driven (provider site) umber of miles driven (offsite) art 11 - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 3, line 9 times column 2, ssistants (column 3, line 9 times column 2, ubtotal allowance amount (sum of lines 14 ar	Supervisors Supervisors 1.00 0.00 90.39 39.30 0 0 0 0 0 0 0 0 0 0 0 0 0	t was on provide on provider site apists (see inst (include only vi	e but neither : cructions) sits made by	supervi sor therapy	1.00 26 390 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
1.00 Tc 2.00 Li 3.00 Nu 4.00 Nu 5.00 Nu 6.00 Nu 6.00 Nu 8.00 Op 9.00 Tc 10.00 AF 11.00 AF 11.00 AF 11.00 Nu 13.00 Nu 13.01 Nu 13.01 Nu 14.00 Su 15.00 Tr 16.00 As 17.00 Su 18.00 Ai	otal number of weeks worked (excluding aides ine 1 multiplied by 15 hours per week umber of unduplicated days in which supervis umber of unduplicated days in which therapy or therapist was on provider site (see instr umber of unduplicated offsite visits - super umber of unduplicated offsite visits - super umber of unduplicated offsite visits - thera ssistant and on which supervisor and/or ther nstructions) tandard travel expense rate ptional travel expense rate per mile otal hours worked HSEA (see instructions) tandard travel allowance (columns 1 and 2, ne-half of column 2, line 10; column 3, ne-half of column 3, line 10) umber of travel hours (provider site) umber of miles driven (provider site) umber of miles driven (offsite) art 11 - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	Supervisors Supervisors 1.00 0.00 90.39 39.30 0 0 0 0 0 0 0 0 0 0 0 0 0	t was on provide on provider site apists (see inst (include only vi present during t Therapists 2.00 499.20 78.60 39.30 0 0	e but neither rructions) sits made by the visit(s)) Assistants 3.00 0.00 58.95 29.48 0 0 0 0 0 0 0 0 0 0 0 0 0	supervi sor therapy (see <u>Ai des</u> <u>4. 00</u> 0. 00	390 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 12.01 13.00
2.00 Li 3.00 Nu 4.00 Nu 5.00 Nu 6.00 Nu 6.00 St 8.00 Op 9.00 Tc 10.00 AH 11.00 St 12.00 Nu 13.01 Nu 13.01 Nu 14.00 St 15.00 Tr 16.00 As 17.00 St 18.00 Ai 18.00 Ai	<pre>ine 1 multiplied by 15 hours per week umber of unduplicated days in which supervis umber of unduplicated days in which therapy or therapist was on provider site (see instr umber of unduplicated offsite visits - super umber of unduplicated offsite visits - thera ssistant and on which supervisor and/or ther nstructions) tandard travel expense rate ptional travel expense rate per mile otal hours worked HSEA (see instructions) tandard travel allowance (columns 1 and 2, ne-half of column 2, line 10; column 3, ne-half of column 3, line 10) umber of travel hours (provider site) umber of travel hours (offsite) umber of miles driven (provider site) umber of miles driven (offsite) art 11 - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 3, line 9 times column 2, ssistants (column 3, line 9 times column 3,</pre>	Supervisors Supervisors 1.00 0.00 90.39 39.30 0 0 0 0 0 0 0 0 0 0 0 0 0	t was on provide on provider site apists (see inst (include only vi present during t Therapists 2.00 499.20 78.60 39.30 0 0	e but neither rructions) sits made by the visit(s)) Assistants 3.00 0.00 58.95 29.48 0 0 0 0 0 0 0 0 0 0 0 0 0	supervi sor therapy (see <u>Ai des</u> <u>4. 00</u> 0. 00	390 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 12.01 13.00
3.00 Nu 4.00 Nu 5.00 Nu 6.00 Nu 6.00 St 8.00 Op 9.00 Tc 10.00 AH 11.00 St 12.00 Nu 12.01 Nu 13.00 Nu 13.00 Nu 13.00 Nu 13.00 Tc 14.00 St 15.00 Tr 16.00 As 17.00 St 18.00 Ai	umber of unduplicated days in which supervis umber of unduplicated days in which therapy or therapist was on provider site (see instr umber of unduplicated offsite visits - super umber of unduplicated offsite visits - thera ssistant and on which supervisor and/or ther nstructions) tandard travel expense rate ptional travel expense rate per mile otal hours worked HSEA (see instructions) tandard travel allowance (columns 1 and 2, ne-half of column 2, line 10; column 3, ne-half of column 3, line 10) umber of travel hours (provider site) umber of travel hours (offsite) umber of miles driven (provider site) umber of miles driven (offsite) art 11 - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 3, line 9 times column 2, ssistants (column 3, line 9 times column 3,	assistant was of ructions) rvisors or thera apy assistants apist was not p Supervisors 1.00 0.00 90.39 39.30 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	on provider site apists (see inst (include only vi present during t Therapists 2.00 499.20 78.60 39.30 0 0 0	e but neither rructions) sits made by the visit(s)) Assistants 3.00 0.00 58.95 29.48 0 0 0 0 0 0 0 0 0 0 0 0 0	supervi sor therapy (see <u>Ai des</u> <u>4. 00</u> 0. 00	0 0 0 0 0.00 0.00 0.00 0.00 0.00	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 12.01 13.00
5. 00 6. 00 8. 00 9. 00 10. 00 11. 00 11. 00 12. 00 12. 00 13. 01 14. 00 15. 00 14. 00 15. 00 17. 00 16. 00 17. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 19. 00 10. 00 10	or therapist was on provider site (see instrumber of unduplicated offsite visits - super umber of unduplicated offsite visits - thera ssistant and on which supervisor and/or ther nstructions) tandard travel expense rate ptional travel expense rate per mile otal hours worked HSEA (see instructions) tandard travel allowance (columns 1 and 2, ne-half of column 2, line 10; column 3, ne-half of column 3, line 10) umber of travel hours (provider site) umber of travel hours (offsite) umber of miles driven (provider site) umber of miles driven (offsite) art 11 - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	Line 10) Line 10) Line 10) Line 10) Lisson of the second Line 10 bits Line 10 bits	apists (see inst (include only vi present during t Therapists 2.00 499.20 78.60 39.30 0 0	Assistants 3.00 0.00 58.95 29.48 0 0 0 0	therapy (see <u>Ai des</u> <u>4. 00</u> 0. 00	0.00 0.00 <u>Trai nees</u> 5.00 0.00 0.00 1.00	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 01 13. 00
5.00 Nu 6.00 Au 9.00 St 8.00 Op 9.00 To 10.00 Al 11.00 St 11.00 St 12.01 Nu 12.01 Nu 13.00 Nu 13.01 Nu 13.01 Nu 14.00 Su 15.00 Tr 16.00 As 17.00 Su 18.00 Ai	umber of unduplicated offsite visits - super umber of unduplicated offsite visits - thera ssistant and on which supervisor and/or ther nstructions) tandard travel expense rate ptional travel expense rate per mile otal hours worked HSEA (see instructions) tandard travel allowance (columns 1 and 2, ne-half of column 2, line 10; column 3, ne-half of column 3, line 10) umber of travel hours (provider site) umber of travel hours (offsite) umber of miles driven (provider site) umber of miles driven (offsite) art 11 - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	Supervisors or thera apy assistants apist was not p <u>Supervisors</u> <u>1.00</u> 0.00 90.39 39.30 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(include only vi present during t 2.00 499.20 78.60 39.30 0 0 0	sits made by the visit(s)) Assistants 3.00 0.00 58.95 29.48 0 0 0 0	(see <u>Ai des</u> <u>4. 00</u> 0. 00	0.00 0.00 Trai nees 5.00 0.00 0.00	6.00 7.00 8.00 9.00 10.00 11.00 12.00 12.01 13.00
as r 8.00 9.00 10.00 AH 11.00 S1 07 07 07 11.00 12.00 Nu 13.00 Nu 13.01 Nu 14.00 5.00 17.00 18.00 Ai	ssistant and on which supervisor and/or ther nstructions) tandard travel expense rate ptional travel expense rate per mile otal hours worked HSEA (see instructions) tandard travel allowance (columns 1 and 2, ne-half of column 2, line 10; column 3, ne-half of column 3, line 10) umber of travel hours (provider site) umber of travel hours (offsite) umber of miles driven (provider site) umber of miles driven (offsite) art 11 - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 3, sistants (column 3, line 9 times column 3,	Supervi sors 1.00 0.00 90.39 39.30 0 0 0 0 0 0 0 0 0 0 0 0 0	Therapi sts 1 2.00 499.20 78.60 39.30 0 0 0 0	Assi stants 3.00 0.00 58.95 29.48 0 0 0 0 0	(see <u>Ai des</u> <u>4. 00</u> 0. 00	0.00 0.00 <u>Trai nees</u> 5.00 0.00 0.00	7.00 8.00 9.00 10.00 11.00 12.00 12.01 13.00
7.00 S1 8.00 Op 9.00 Tc 10.00 AH 11.00 S1 9.2.00 Nu 12.00 Nu 13.00 Nu 13.01 Nu 14.00 Su 15.00 Tr 16.00 As 17.00 Su 18.00 Ai	nstructions) tandard travel expense rate ptional travel expense rate per mile otal hours worked HSEA (see instructions) tandard travel allowance (columns 1 and 2, ne-half of column 2, line 10; column 3, ne-half of column 3, line 10) umber of travel hours (provider site) umber of travel hours (offsite) umber of miles driven (provider site) umber of miles driven (offsite) art 11 - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	Supervi sors 1.00 0.00 90.39 39.30 0 0 0 0 0 0 0 1 i ne 10) l i ne 10) l i ne 10) l i ne 10)	Therapi sts 2.00 499.20 78.60 39.30 0 0 0 0	Assi stants 3. 00 0. 00 58. 95 29. 48 0 0 0 0 0	Ai des 4.00 0.00	0.00 Trai nees 5.00 0.00 0.00	8.00 9.00 10.00 11.00 12.00 12.01 13.00
8.00 Op 9.00 Tc 10.00 At 11.00 St 11.00 Nu 12.01 Nu 13.00 Nu 13.01 Nu 14.00 Su 15.00 Tr 16.00 As 17.00 Su 18.00 Ai	ptional travel expense rate per mile otal hours worked HSEA (see instructions) tandard travel allowance (columns 1 and 2, ne-half of column 2, line 10; column 3, ne-half of column 3, line 10) umber of travel hours (provider site) umber of travel hours (offsite) umber of miles driven (provider site) umber of miles driven (offsite) art 11 - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	1.00 0.00 90.39 39.30 0 0 0 0 0 0 1 i ne 10) 1 i ne 10) 1 i ne 10)	2.00 499.20 78.60 39.30 0 0 0	3.00 0.00 58.95 29.48 0 0 0	4.00 0.00	0.00 Trai nees 5.00 0.00 0.00	8.00 9.00 10.00 11.00 12.00 12.01 13.00
9.00 To 10.00 AH 11.00 St 11.00 St 12.00 Nu 12.01 Nu 13.00 Nu 13.01 Nu 14.00 Su 15.00 Tr 16.00 As 17.00 Su 18.00 Ai	otal hours worked HSEA (see instructions) tandard travel allowance (columns 1 and 2, ne-half of column 2, line 10; column 3, ne-half of column 3, line 10) umber of travel hours (provider site) umber of travel hours (offsite) umber of miles driven (provider site) umber of miles driven (offsite) art 11 - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	1.00 0.00 90.39 39.30 0 0 0 0 0 0 1 i ne 10) 1 i ne 10) 1 i ne 10)	2.00 499.20 78.60 39.30 0 0 0	3.00 0.00 58.95 29.48 0 0 0	4.00 0.00	Trai nees 5. 00 0. 00 0. 00 1. 00	9.00 10.00 11.00 12.00 12.01 13.00
10. 00 AH 11. 00 St or 12. 00 Nu 12. 01 Nu 13. 01 Nu 13. 01 Nu 14. 00 Su 15. 00 Th 16. 00 As 17. 00 Su 17. 00 Su 18. 00 Ai	HSEA (see instructions) tandard travel allowance (columns 1 and 2, ne-half of column 2, line 10; column 3, ne-half of column 3, line 10) umber of travel hours (provider site) umber of travel hours (offsite) umber of miles driven (provider site) umber of miles driven (offsite) art 11 - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	1.00 0.00 90.39 39.30 0 0 0 0 0 0 1 i ne 10) 1 i ne 10) 1 i ne 10)	2.00 499.20 78.60 39.30 0 0 0	3.00 0.00 58.95 29.48 0 0 0	4.00 0.00	5.00 0.00 0.00	10. 00 11. 00 12. 00 12. 01 13. 00
10. 00 AH 11. 00 St or 12. 00 Nu 12. 01 Nu 13. 01 Nu 13. 01 Nu 14. 00 Su 15. 00 Th 16. 00 As 17. 00 Su 17. 00 Su 18. 00 Ai	HSEA (see instructions) tandard travel allowance (columns 1 and 2, ne-half of column 2, line 10; column 3, ne-half of column 3, line 10) umber of travel hours (provider site) umber of travel hours (offsite) umber of miles driven (provider site) umber of miles driven (offsite) art 11 - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	90. 39 39. 30 0 0 0 0 0 1 i ne 10) 1 i ne 10) 1 i ne 10)	78.60 39.30 0 0	58. 95 29. 48 0 0 0		0.00	10. 00 11. 00 12. 00 12. 01 13. 00
11. 00 S1 or or 12. 00 Nu 12. 01 Nu 13. 01 Nu 13. 01 Nu 13. 01 Su 14. 00 Su 15. 00 Th 16. 00 As 17. 00 Su 18. 00 Ai	<pre>tandard travel allowance (columns 1 and 2, ne-half of column 2, line 10; column 3, ne-half of column 3, line 10) umber of travel hours (provider site) umber of travel hours (offsite) umber of miles driven (provider site) umber of miles driven (offsite) art 11 - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,</pre>	39.30 0 0 0 0 1 i ne 10) 1 i ne 10) 1 i ne10)	39.30 0 0	29.48 0 0 0	44.21	1.00	11.00 12.00 12.01 13.00
0 or 0 or 0 or 12.00 Nu 13.00 Nu 13.01 Nu 13.01 Nu 14.00 Su 15.00 Tr 16.00 As 17.00 Su 18.00 Ai	ne-half of column 2, line 10; column 3, ne-half of column 3, line 10) umber of travel hours (provider site) umber of miles driven (provider site) umber of miles driven (offsite) art 11 - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	0 0 0 1 i ne 10) 1 i ne 10) 1 i ne 10)	0 0 0	0 0			12.00 12.01 13.00
12.00 Nu 12.01 Nu 13.00 Nu 13.01 Nu 13.01 Nu 14.00 Su 15.00 Tr 16.00 As 17.00 Su 18.00 Ai	umber of travel hours (provider site) umber of travel hours (offsite) umber of miles driven (provider site) umber of miles driven (offsite) art II - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	l i ne 10) l i ne 10) l i ne10)	0	0 0			12. 01 13. 00
12. 01 Nu 13. 00 Nu 13. 01 Nu 14. 00 Su 15. 00 Th 16. 00 As 17. 00 Su 18. 00 Ai	umber of travel hours (offsite) umber of miles driven (provider site) umber of miles driven (offsite) art II - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	l i ne 10) l i ne 10) l i ne10)	0	0 0			12. 01 13. 00
13. 01 Nu Pa 14. 00 Su 15. 00 Th 16. 00 As 17. 00 Su 01 18. 00 Ai	umber of miles driven (offsite) art II - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	0 line 10) line 10) line 10)	-				•
Pa 14. 00 Su 15. 00 Th 16. 00 As 17. 00 Su 01 18. 00 Ai	art II - SALARY EQUIVALENCY COMPUTATION upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	line 10) line 10) line 10) line10)	U	0			13.01
14.00 Su 15.00 Th 16.00 As 17.00 Su 01 18.00 Ai	upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	line 10) line10)					
14.00 Su 15.00 Th 16.00 As 17.00 Su 01 18.00 Ai	upervisors (column 1, line 9 times column 1, herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	line 10) line10)				0	
15.00 Th 16.00 As 17.00 Su 01 18.00 Ai	herapists (column 2, line 9 times column 2, ssistants (column 3, line 9 times column 3,	line 10) line10)				0	14.00
17.00 Su ot 18.00 Ai						39, 237	
ot 18.00 Ai	ubtotal allowance amount (sum of lines 14 ar				C 11	0	
18.00 Ai	thers)	iu io ioi respir	ratory therapy o	or lines 14-16	TOT ALL	39, 237	17.00
19 00 ITr	ides (column 4, line 9 times column 4, line					0	
	rainees (column 5, line 9 times column 5, li otal allowance amount (sum of lines 17–19 fo		therany or lines	: 17 and 18 fo	r all others)	0 39, 237	
	f the sum of columns 1 and 2 for respiratory						20.00
	ccupational therapy, line 9, is greater thar he amount from line 20. Otherwise complete		no entries on li	nes 21 and 22	and enter on	line 23	
	eighted average rate excluding aides and tra		divided by sum	of columns 1	and 2, line 9	0.00	21.00
	for respiratory therapy or columns 1 thru 3,						22.00
23.00 To	eighted allowance excluding aides and traine otal salary equivalency (see instructions)					0 39, 237	
	ART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	L EXPENSE COMPUT	ATION - PROVI	DER SITE		
	tandard Travel Allowance herapists (line 3 times column 2, line 11)					0	24.00
25.00 As	ssistants (line 4 times column 3, line 11)					0	•
	ubtotal (line 24 for respiratory therapy or				nd 4 for all	0	•
	tandard travel expense (line 7 times line 3 thers)	Tor respiratory	y the apy of Sun	I UI ITTIES 3 a		0	27.00
	otal standard travel allowance and standard	travel expense	at the provider	site (sum of	lines 26 and	0	28.00
	7) otional Travel Allowance and Optional Travel	Expense					
29.00 Tł	herapists (column 2, line 10 times the sum o	of columns 1 and	d 2, line 12)			0	•
	ssistants (column 3, line 10 times column 3, ubtotal (line 29 for respiratory therapy or		0 and 20 for all	othors)		0	30.00
	ptional travel expense (line 8 times columns				r sum of	0	•
1	olumns 1-3, line 13 for all others)		20)				
	tandard travel allowance and standard travel ptional travel allowance and standard travel			31)		0	
35.00 Op	ptional travel allowance and optional travel	expense (sum o	of lines 31 and	32)		0	
	art IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	NCE AND TRAVEL	EXPENSE COMPUTA	TION - SERVIC	ES OUTSIDE PRO	VIDER SITE	
	tandard Travel Expense herapists (line 5 times column 2, line 11)					0	36.00
37.00 As	ssistants (line 6 times column 3, line 11)					0	37.00
	ubtotal (sum of lines 36 and 37) tandard travel expense (line 7 times the sum	n of lines 5 and	d 6)			0	•
	ptional Travel Allowance and Optional Travel						
	herapists (sum of columns 1 and 2, line 12.0		2, line 10)			0	•
	ssistants (column 3, line 12.01 times columr ubtotal (sum of lines 40 and 41)	13, IINE 10)				0	
43.00 Op	ptional travel expense (line 8 times the sum					0	•
	otal Travel Allowance and Travel Expense - C r 46, as appropriate.	offsite Services	s; Complete one	of the follow	ing three line	es 44, 45,	
	tandard travel allowance and standard travel	expense (sum o	of lines 38 and	39 - see inst	ructions)	0	44.00

					From 01/01/2018 To 12/31/2018	Parts I-VI Date/Time Pre 5/30/2019 5:4	pared: 4 pm
					Occupational Therapy	Cost	
						1.00	
5.00	Optional travel allowance and standard travel					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	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
	Overtime rate (see instructions)	0.00	0.00				48.00
	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00	0.0	0.00		49.00
60.00	(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
	Adjusted hourly salary equivalency amount	78.60	58.95	44.2	0.00		52.00
	(see instructions) Overtime cost limitation (line 51 times line	0	0		0 0		53.00
4.00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.00
6.00	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.)	O	0		0 0	0	56.00
		I					
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST				1.00	
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	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) 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 LINE 33 CALCULATION	(from lines 33 es (from lines your records)	, 34, or 35)) 44, 45, or 46)		39, 237 0 0 0 0 39, 237 39, 419 182	58.00 59.00 60.00 61.00 62.00 63.00
00. 00 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 LINE 34 CALCULATION	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 01.02	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
02.00	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line 13 for all others	sum of lines 2 13 for respira	9 and 30 for a tory therapy o	ll others or sum of colu	umns 1-3, line		102. 00 102. 01

From 0.107(3) Cost Center Description Not Expense Not Expense (from 0.107) District (from 0.107) Not Expense (from 0.107) 1.00 00110 (from 0.107) 0.1070 </th <th></th> <th>ancial Systems ATION - GENERAL SERVICE COSTS</th> <th>HARRISON COUN</th> <th>Provider CO</th> <th>N· 15-1331</th> <th>Peri od:</th> <th>u of Form CMS- Worksheet B</th> <th>2552-1</th>		ancial Systems ATION - GENERAL SERVICE COSTS	HARRISON COUN	Provider CO	N· 15-1331	Peri od:	u of Form CMS- Worksheet B	2552-1
Line Cost Conter Description Not Expenses for Cost All Cost Al	JST ALLOU	ATTON - GENERAL SERVICE COSTS			N. 10-1351	From 01/01/2018	Part I Date/Time Pre	epared:
Local Center Description Net Expenses from Cash (col. 7). BLGG & FLXT MOB ANB DEPR MVBLE EQUIP 1.00 00100 (AB REL COST-SELDE & FLXT 1.00 1.01 1.02 2.00 1.00 00100 (AB REL COST-SELDE & FLXT 1.770 (ST) 1.779 (ST) 6.77, 327 6.7, 327 6.4, 894 1.00 00100 (AB REL COST-SHUELE EQUIP 1.64, 407 6.7, 327 6.4, 894 1.1, 160, 407 0.00 00000 (AB REL COST-SHUELE EQUIP 1.64, 407 0.00 0.00 0.00 0.00 0.01, 7.01 0.00					CAPI TAL	RELATED COSTS	573072019 5:4	4 pm
O 1.00 0.01 1.01 1.02 2.00 0001001 CAP FEL COST SENEG & FLIXT 1.770,057 1.770,057 0 0.677,327 0 0.677,327 0 0.677,327 0 0.677,327 0 0.677,327 0 0.677,327 0 0.677,327 0 0.677,327 0 0.677,327 0 0.677,327 0 0.677,327 0 0.677,327 0 0.677,327 0 0.677,327 0.070 0.677,327 0.070 0.070 0.0757,0408 EDU P 1.171,151 1.100,070 0 0.070 0		Cost Center Description	for Cost Allocation (from Wkst A	BLDG & FIXT			MVBLE EQUIP	
1.00 OCIOD CAP REL. COSTS-BLIDG & FLXT 1.779, 0.67 1.779, 0.67 1.00 OCIOD MAB 657, 327 667, 327 0.00 OCIOD CAMB FCDUP 1.160, 407 0 0.0100 CAMB FCDUP T1, 160, 407 0 0 0.0100 CAMB FCDUP T1, 171, 131 2, 660, 0 0 0 0.0100 CAMB FCDUP T1, 160, 407 0 0 0 0 0.0100 CAMB FCDUP T1, 160, 407 0				1.00	1.01	1. 02	2.00	
1.01 00101 M0B 657, 327 0 657, 327 2.00 00200 CAP REL COSTS-INGLE EQUIP 1, 160, 407 0 0 2.00 00200 CAP REL COSTS-INGLE EQUIP 1, 171, 131 2, 666 0 0 1, 160, 407 2.00 00200 CAP REL COSTS-INGLE EQUIP 1, 171, 131 2, 666 0 0 1, 700, 407 2.01 00200 CAP REL COSTS-INGLE EQUIP 5, 94, 475 0			4 770 057	4 770 057				
1.02 COTOZ ÁNB EERR 64.894 0 64.894 0.00 COZO CAR PELL COSTS -UNBLE EQUIP 1,160.407 1,160.407 2.01 COZOTA ANB EQUIP 1,11,131 0 1,060.407 0.00 COZOTA ANB EQUIP 1,11,131 0 0 0,00 0.00 COSTO ANMINISTRATIVE & CENERAL 4,602.325 2,99,453 3,834 0 1,92,20 0.00 COSTO ANMINITIM CACCOUNTS RECEIVABLE 1,055,22 0 <t< td=""><td></td><td></td><td></td><td></td><td>657 3</td><td>27</td><td></td><td>1.00</td></t<>					657 3	27		1.00
2.00 CO2001 CAP REL COSTS-MUELE EQUIP 1, 160, 407 1, 160, 407 0.00 CO2001 AMB EOUIP 171, 131 0				0	007,0			1.02
0.00 00400 EMPLOYEE BENEFITS DEPARTMENT 7,342,419 2,000 0 1,701 0.10 005070 ADMINISTRATULY & GENERAL 4,602,325 259,433 3,834 0 169,230 0.20 005070 ADMINISTRATULY & GENERAL 1,529,920 204,568 0							1, 160, 407	
10 00590 ADMINISTRATIVE & GENERAL 4,602,325 259,453 3,834 0 169,230 0.30 00580 CASHI ERING/ACCOUNTS RECEIVABLE 1,095,522 0							-	
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0.000 OPERATION OF PLANT 1, 529, 920 204, 568 0 0 133, 429 0.0000 LAUNDRY & LINEN SERVICE 266, 519 11, 944 0 0 7, 79 0.0000 DOUSEKLEFING 361, 829 74, 444 0 0 46, 557 0.0000 DETRATION SERVICE 266, 519 11, 944 0 0 46, 557 0.0000 DETRATION 663, 529 6, 259 0 0 4, 063 1.000 DISOC PHARMACY 753, 466 0<				0		0 0	-	
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0.00 00900 MUSEREEPI NG 705, 275 25, 584 0 0 16, 687 10.00 01000 CARFETERI A 253, 160 37, 189 0 0 24, 257 11.00 01400 CARFETERI A 253, 160 37, 189 0 0 24, 257 15.00 01500 MESI NG ADMINI ISTRATION 663, 529 6, 259 0 0 0 0 15.00 01500 MENI CAR, RECORDS & LI BRARY 722, 066 0 0 0 1, 633 10.00 01000 ADULTS & FEDUTI RE SERVICE COST CENTERS 327, 047 2, 504 0 0 17, 349 10.00 03100 INTERSI VE CARE UNI T 461, 259 37, 776 0 0 0 17, 349 10.00 03100 INTERSI VE CARE UNI T 441, 254 347, 081 7, 824 0 0 150, 731 10.00 05200 DELI VERY ROM & LABOR ROM 1, 234, 136 231, 074 0 0 0 76, 76, 76 10.00 05200 DELI VERY ROM & LABOR ROM 1, 234, 136 64, 852	01 0070	DI AMB PLANT OPS	0	0		0 0		
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11.00 CARETERIA 253, 160 37, 189 0 24, 257 13.00 01300 UNESING AGMINI STRATION 663, 529 6, 259 0 0 4, 083 14.00 O1400 CENTRAL SERVICES & SUPPLY 753, 466 0 0 0 0 0 15.00 01500 HENICAL, RECORDS & LI BRARY 652, 968 41, 532 0 0 77, 089 10.01 01400 SERVICE 327, 047 2, 504 0 0 77, 089 10.00 03000 NULTS & PEDIATRICS 2, 721, 504 302, 563 0 197, 349 10.00 05000 OFFRATING ROOM 1, 234, 136 231, 091 0 25, 731 10.00 05000 OFFRATING ROOM 1, 234, 136 231, 091 0						0 0		
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6 00 0 1600 MEDI CAL RECORDS & LI BRARY 652,968 41,532 0 0 77,063 100 0 3000 ADUTI NE SERVICE 0 0 17,049 0 1,633 100 0 3000 ADUTS & PEDI ATRICS 2,721,504 302,563 0 0 24,640 100 0 3100 NURSERY 347,081 7,824 0 0 24,640 3000 ADULTS & PEDI ATRICS 347,081 7,824 0 0 5103 ANCILLARY SERVICE COST CENTERS						0 0	-	
INPART ENT. ROUTINE SERVICE COST CENTERS						0 0	27, 089	
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7.00 06700 CCUPATI ONAL THERAPY 40,915 0 0 00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
8.00 06800 SPECH PATHOLOGY 14,171 0 0 0 0 9.00 06900 ELECTROCARDI OLOGY 68,625 23,785 0 0 15,514 1.00 70100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 1,144,069 56,801 0 0 37,049 2.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1,555,203 15,987 0 0 0 0 0.01 09000 CLI NI C 68,776 0 31,552 0 0 0 0.00 09000 CLI NI C 282,124 0 22,886 0						0 0		
1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 1,144,069 56,801 0 0 37,049 2.00 07300 DRU. DEV. CHARGED TO PATIENTS 1,002,367 0				0		0 0	0	68.0
12.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,002,367 0 0 0 0.0 0UTPATIENT SERVICE COST CENTERS 1,555,203 15,987 0 0 10,428 0UTPATIENT SERVICE COST CENTERS 68,776 0 31,552 0 0 0 0.01 09001 CLINIC 68,776 0 31,552 0						0 0		
'3.00 OT300 DRUGS CHARGED TO PATIENTS 1,555,203 15,987 0 0 10,428 OUTPATIENT SERVICE COST CENTERS U U 0 000 01,102 0 0 000 000 000 CLINIC 0				56, 801		0 0		
OUTPATIENT SERVICE COST CENTERS 00.00 09000 CLINIC 68,776 0 31,552 0 0 0 00.01 09100 EKERGENCY 282,124 0 22,886 0 0 0.00 09100 EKERGENCY 2,127,149 85,528 31,552 0 55,786 09200 OBSERVATION BEDS (NON-DISTINCT PART 2 2,794,370 0 64,894 0 0 05.00 09500 MBURSABLE COST CENTERS 2,794,370 0 9,311 0 0 0 64,894 0 0 SUBTORIALS (SUM OF LINES 1 through 117) 43,216,511 1,672,848 99,135 64,894 1,091,131 NORREL MBURSABLE COST CENTERS SUBTORIALS (SUM OF LINES 1 through 117) 43,216,511 1,672,848 99,135 64,894 1,091,131 NORREL MBURSABLE COST CENTERS 90.00 10,06,227 0 0 NOREL MBURSABLE COST CENTERS <				15 097		0 0		
0.00 09000 CLINIC 68,776 0 31,552 0 0 0 0.01 09001 SENIOR CARE 28,124 0 22,886 0 0 0.020 09200 0BSERVATION BEDS (NON-DISTINCT PART 2,127,149 85,528 31,552 0 55,786 0 09200 09200 005ERVATION BEDS (NON-DISTINCT PART 2,127,149 85,528 31,552 0 55,786 0 09200 09500 AMBULANCE SERVICES 2,794,370 0 0 0 64,894 0 01100 10100 HOME HEALTH AGENCY 199,126 0 9,311 0 0 0 SPECIAL PURPOSE COST CENTERS 2 13.00 11300 INTEREST EXPENSE 5 13.00 11000 FOR KEST EXPENSE 5 13.00 11000 O IFT FLOWER COFFEE SHOP & CANTEEN 7 90.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 7 90.00 19000 O IFT FLOWER COFFEE SHOP & CANTEEN 7 90.00 19000 PHYSICIANS PRIVATE OFFICES 11,940,928 86,271 0 0 6,932 7 91.00 07950 MARKETING 056,233 2,791 0 0 7,820 7 94.01 07951 PHYSICIAN BILLING 632,419 6,520 0 0 4,253 7 94.02 07952 MOB 0 0 0 558,192 0 0 4,253 7 94.03 07953 FOUNDATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1, 555, 205	10, 907		0 0	10, 420	/3.0
0.01 09001 SENI OR CARE 282, 124 0 22, 886 0 0 1.00 09100 EMERGENCY 2, 127, 149 85, 528 31, 552 0 55, 786 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 64, 894 0 0100 FEI MBURSABLE COST CENTERS 2, 794, 370 0 0 64, 894 0 5.00 09500 AMBULANCE SERVICES 2, 794, 370 0 9, 311 0 0 SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 99, 126 99, 135 64, 894 1, 091, 131 NOREI MBURSABLE COST CENTERS 11, 672, 848 99, 135 64, 894 1, 091, 131 NOREI MBURSABLE COST CENTERS 11, 940, 928 86, 271 0 6, 932 92.00 19000 GFT FLOWER COFFEE SHOP & CANTEEN 11, 940, 928 86, 271 0 0 1, 820 94.00 07950 MARKETI NG 632, 419 6, 520 0 0 4, 253 94.02 0			68, 776	0	31, 5	52 0	0	90.0
D2.00 OBSERVATION BEDS (NON-DISTINCT PART OTHER REI MBURSABLE COST CENTERS 0THER REI MBURSABLE COST CENTERS 2, 794, 370 0 0 64, 894 0 01.00 10100 HOME HEALTH AGENCY 199, 126 0 9, 311 0 0 SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 13.00 INTEREST EXPENSE NONREI MBURSABLE COST CENTERS 90.00 FT FLOWER COFFEE SHOP & CANTEEN 0 10, 627 0 0 6, 932 92.00 19200 PHYSI CI ANS PRI VATE OFFICES 11, 940, 928 86, 271 0 0 1, 820 94.00 07950 MARKETI NG 366, 233 2, 791 0 0 1, 820 94.01 07951 PHYSI CI AN BI LLI NG 632, 419 6, 520 0 0 4, 253 94.02 07953 FOUNDATION 0 0 0 0 0 0 0 0 0 0 0	0900 01 00	D1 SENI OR CARE					0	90.0
OTHER REI MBURSABLE COST CENTERS 5.00 09500 AMBULANCE SERVICES 2, 794, 370 0 0 64, 894 0 01.00 10100 HOME HEALTH AGENCY 199, 126 0 9, 311 0 0 0 SPECIAL PURPOSE COST CENTERS 743, 216, 511 1, 672, 848 99, 135 64, 894 1, 091, 131 NONREI MBURSABLE COST CENTERS 70 0 6, 932 90.00 GI FT FLOWER COFFEE SHOP & CANTEEN 0 10, 627 0 0 6, 932 92.00 19200 PHYSI CI ANS PRI VATE OFFICES 11, 940, 928 86, 271 0 0 1, 820 94.00 07950 MARKETI NG 632, 419 6, 520 0 0 4, 253 94.02 07952 MOB 0 0 0 0 0 0 0 94.03 07953			2, 127, 149	85, 528	31, 5	52 0	55, 786	
D5.00 09500 AMBULANCE SERVICES 2,794,370 0 0 64,894 0 01.00 10100 HOME HEALTH AGENCY 199,126 0 9,311 0 0 SPECIAL PURPOSE COST CENTERS TI300 INTEREST EXPENSE 99,135 64,894 1,091,131 NONREL MBURSABLE COST CENTERS TOWE NOTALS (SUM OF LINES 1 through 117) 43,216,511 1,672,848 99,135 64,894 1,091,131 NONREL MBURSABLE COST CENTERS 90.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 10,627 0 0 6,932 92.00 19200 PHYSI CI ANS PRI VATE OFFICES 11,940,928 86,271 0 0 1,820 94.00 07950 MARKETI NG 632,419 6,520 0 0 4,253 94.02 07952 MOB 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								92.00
01 100 HOME HEALTH AGENCY 199, 126 0 9, 311 0 0 SPECIAL PURPOSE COST CENTERS 5			2 704 270	0		0 64 904	0	95.00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 43, 216, 511 1, 672, 848 99, 135 64, 894 1, 091, 131 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0 10, 627 0 0 6, 932 190.00 IFT FLOWER COFFEE SHOP & CANTEEN 0 10, 627 0 0 56, 271 192.00 19200 PHYSI CI ANS PRI VATE OFFICES 11, 940, 928 86, 271 0 0 1, 820 194.00 07950 MARKETI NG 632, 419 6, 520 0 0 4, 253 194.02 07953 FOUNDATI ON 0<					0 3			101.00
113.00 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 43, 216, 511 1, 672, 848 99, 135 64, 894 1, 091, 131 NONREI MBURSABLE COST CENTERS 190.00 GI FT FLOWER COFFEE SHOP & CANTEEN 0 10, 627 0 0 66, 932 192.00 19200 PHYSI CI ANS PRI VATE OFFICES 11, 940, 928 86, 271 0 0 56, 271 194.00 07950 MARKETI NG 366, 233 2, 791 0 0 1, 820 194.01 07951 PHYSI CI AN BI LLI NG 632, 419 6, 520 0 0 4, 253 194.02 07952 MOB 0 0 558, 192 0 0 194.03 07953 FOUNDATI ON 0 0 0 0 0 0 0 194.02 07952 MOB 0 0 0 0 0 0 0 194.03 07953 FOUNDATI ON 0 0 0 0			177,120		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	101.00
NONREI MBURSABLE COST CENTERS 190.00 GI FT FLOWER COFFEE SHOP & CANTEEN 0 10, 627 0 0 6, 932 192.00 192.00 PHYSI CI ANS PRI VATE OFFICES 11, 940, 928 86, 271 0 0 56, 271 194.00 07950 MARKETI NG 366, 233 2, 791 0 0 1, 820 194.01 07951 PHYSI CI AN BILLI NG 632, 419 6, 520 0 0 4, 253 194.02 07952 MOB 0 0 558, 192 0 0 194.03 07953 FOUNDATI ON 0 0 0 0 0 194.02 07952 MOB 0	13.001130	DO INTEREST EXPENSE						113.00
190.00 GIFT FLOWER COFFEE SHOP & CANTEEN 0 10, 627 0 0 6, 932 192.00 19200 PHYSI CI ANS PRI VATE OFFICES 11, 940, 928 86, 271 0 0 56, 271 194.00 07950 MARKETI NG 366, 233 2, 791 0 0 1, 820 194.02 07952 MARKETI NG 632, 419 6, 520 0 0 4, 253 194.02 07952 MOB 0 0 558, 192 0			43, 216, 511	1, 672, 848	99, 1	35 64, 894	1, 091, 131	118.00
92.00 19200 PHYSI CI ANS PRI VATE OFFICES 11,940,928 86,271 0 0 56,271 94.00 07950 MARKETI NG 366,233 2,791 0 0 1,820 94.01 07951 PHYSI CI AN BILLI NG 632,419 6,520 0 0 4,253 94.02 07952 MOB 0 0 558,192 0 0 94.03 07953 FOUNDATI ON 0				10 / 07		0	(000	100 0
94.00 07950 MARKETING 366, 233 2, 791 0 0 1,820 94.01 07951 PHYSICIAN BILLING 632, 419 6,520 0 0 4,253 94.02 07952 MOB 0 0 558, 192 0 0 0 94.03 07953 FOUNDATION 0 <td< td=""><td></td><td></td><td>11 040 020</td><td></td><td></td><td></td><td></td><td></td></td<>			11 040 020					
94.01 07951 PHYSI CI AN BILLING 632,419 6,520 0 0 4,253 94.02 07952 MOB 0 0 558,192 0 0 94.03 07953 FOUNDATI ON 0								
94.02 07952 MOB 0 0 558, 192 0 0 94.03 07953 FOUNDATI ON 0 0 0 0 0 00.00 Cross Foot Adjustments 0 0 0 0 0 01.00 Negative Cost Centers 0 0 0 0 0						0 0		
94.03 07953 FOUNDATION 0			0	0, 320	558. 1	92 0		194.0
201.00 Negative Cost Centers 0 0 0 0			0	0		0 0		194. 03
								200.00
202 UUL LIULAL (SUM LINES 118 through 201) I 56 156 AQ1L 1 770 A57L 657 207L 67 Q0AL 1 160 407				0		0 0		201.00
1, 100, 100, 100, 100, 100, 100, 100, 1	02.00	TOTAL (sum lines 118 through 201)	56, 156, 091	1, 779, 057	657, 3	64, 894	1, 160, 407	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	HARRI SON COUNT	Provider CC	1	Period: From 01/01/2018 To 12/31/2018	u of Form CMS- Worksheet B Part I Date/Time Pre 5/30/2019 5:4	pared:
	Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	ADMI TTI NG	
		2.01	4.00	4A	5. 01	5.02	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	I I					1.00
1.01 1.02 2.00 2.01	00101 MOB 00102 AMB DEPR 00200 CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP	171, 131	7 044 700				1. 01 1. 02 2. 00 2. 01
4.00 5.01 5.02 5.03	00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE	0 0 0 0	7, 346, 728 431, 149 133, 097 117, 336	5, 465, 99 662, 56 1, 212, 85	7 71, 446	734, 013 0	
7.00 7.01 8.00	00700 OPERATI ON OF PLANT 00701 AMB PLANT OPS 00800 LAUNDRY & LINEN SERVICE	0 0 0	70, 040 0 7, 022	1, 937, 96 293, 27	0 208, 974 0 0 6 31, 625	0 0 0	7. 01 8. 00
9.00 10.00 11.00 13.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0 0 0	140, 704 52, 784 56, 619 171, 281	888, 25 537, 61 371, 22 845, 15	4 57, 972 5 40, 030	0 0 0 0	10. 00 11. 00
14.00 15.00 16.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0 0 0	66, 395 100, 792 164, 014	819, 86 822, 85 885, 60	8 88, 730 3 95, 496	0 0 0	15.00 16.00
17.00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	82, 440	413, 62	4 44, 602	0	17.00
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY	0 0 0	721, 086 120, 135 90, 534	3, 942, 50 643, 81 450, 54	0 69, 423	48, 686 3, 680 7, 126	31.00
F0 00	ANCI LLARY SERVICE COST CENTERS		074 000	1 000 07			1 50 00
50.00 52.00 53.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0 0 0	274, 020 56, 287 0	1, 889, 97 272, 00 16, 71	3 29, 331	52, 702 4, 458 10, 678	52.00 53.00
54.00 60.00 65.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY	0	309, 408 209, 883 0	2, 441, 33 2, 309, 05 475, 71	6 248, 990	179, 290 119, 029 14, 306	60.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	76, 592 279	439, 12 41, 19	7 47, 352 4 4, 442	11, 222 1, 145	66. 00 67. 00
68.00 69.00 71.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	3, 880 157, 254 0	18, 05 886, 17 1, 237, 91	8 95, 558 9 133, 487	262 47, 642 30, 335	69.00 71.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	00	0 0	1, 002, 36 1, 581, 61		14, 649 38, 505	
90. 00 90. 01 91. 00	09000 CLINIC 09001 SENIOR CARE 09100 EMERGENCY	0 0 0	5, 394 35, 762 458, 892	105, 72 340, 77 2, 758, 90	2 36, 746	1, 043 3, 514 102, 088	
92.00 95.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	171, 131	581, 329		0 389, 459	42, 806	92.00 95.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	0	39, 813				101.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	171, 131	4, 734, 221	39, 870, 32	· · · ·	734, 013	
192.00 194.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES 07950 MARKETING	0 0 0	0 2, 439, 143 18, 503	389, 34	3 1, 565, 982 7 41, 984	0 0	190.00 192.00 194.00
194.02	07951 PHYSICIAN BILLING 07952 MOB 07953 FOUNDATION	0 0 0	154, 861 0 0	798, 05 558, 19		0	194. 01 194. 02 194. 03
200.00 201.00 202.00	Negative Cost Centers	0 171, 131	0 7, 346, 728		0 0 0 1 5, 465, 991	0 734, 013	200.00 201.00 202.00

COST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	HARRI SON COUN	Provider C		Period: From 01/01/2018 To 12/31/2018		epared:
	Cost Center Description	CASHI ERI NG/ACC OUNTS RECEI VABLE	OPERATION OF PLANT	AMB PLANT OPS	5 LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	L	5.03	7.00	7.01	8.00	9.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02	00102 AMB DEPR						1.02
2.00	00200 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						4.00
5.01	00570 ADMINISTRATIVE & GENERAL						5.01
5.02 5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 343, 643					5.02
5.03 7.00	00700 OPERATI ON OF PLANT	1, 343, 043	2, 146, 934				7.00
7.00	00701 AMB PLANT OPS	0	2, 140, 934		0		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	19, 539		0 344, 440		8.00
9.00	00900 HOUSEKEEPING	0	41, 852		0 25		
10.00	01000 DI ETARY	0	121, 779		0 5,422		
11.00	01100 CAFETERI A	0	60, 836		0 0, 122		
13.00	01300 NURSI NG ADMI NI STRATI ON	0	10, 239		0 0	5, 037	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	1
15.00	01500 PHARMACY	0	0		0 0	o o	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	67, 940		0 0	-	
	01700 SOCIAL SERVICE	0	4, 096		0 0		
	INPATIENT ROUTINE SERVICE COST CENTERS		.,	1	-	_,	
30.00	03000 ADULTS & PEDIATRICS	89, 130	494, 944		0 152, 715	243, 471	30.00
31.00	03100 I NTENSI VE CARE UNI T	6,738			0 0		
43.00	04300 NURSERY	13,046			0 0		
	ANCILLARY SERVICE COST CENTERS			•			
50.00	05000 OPERATING ROOM	96, 483	378, 030		0 23, 992	185, 958	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 162	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	19, 549	0		0 32	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	328, 106	198, 059		0 44, 483	97, 428	54.00
60.00	06000 LABORATORY	217, 908	104, 096		0 0	51, 206	60.00
65.00	06500 RESPI RATORY THERAPY	26, 189	22, 654		0 523	11, 144	65.00
66.00	06600 PHYSI CAL THERAPY	20, 544	76, 643		0 5, 353	37, 702	66.00
67.00	06700 OCCUPATI ONAL THERAPY	2, 097	0		0 0	0	
68.00	06800 SPEECH PATHOLOGY	479	0		0 0	-	
69.00	06900 ELECTROCARDI OLOGY	87, 220	38, 908		0 517	19, 139	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	55, 535	92, 918		0 0	45, 708	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	26, 817	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	70, 491	26, 152		0 0	12, 865	73.00
	OUTPATIENT SERVICE COST CENTERS	·		1	al		
	09000 CLINIC	1,909	0		0 2, 207		
	09001 SENI OR CARE	6, 432			0 108		
	09100 EMERGENCY	186, 893	139, 911		0 83, 449	68, 824	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
05 00	OTHER REIMBURSABLE COST CENTERS	70.0/5	0		0 44 707		05 00
	09500 AMBULANCE SERVICES	78, 365			0 14, 787		
101.00	10100 HOME HEALTH AGENCY	1, 550	0		0 0	0	101.00
112 00	SPECIAL PURPOSE COST CENTERS			1			112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	1, 343, 643	1, 973, 191		0 333, 613	940, 442	113.00
110.00	NONREIMBURSABLE COST CENTERS	1, 343, 643	1, 973, 191	I	0 333, 613	940, 442	1110.00
100 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	17, 385		0 0	0 550	190.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES		141, 127		0 10, 827		190.00
	07950 MARKETING		4, 565		0 10, 827	07,422 2 242	192.00
	07950 MARKETING 07951 PHYSICIAN BILLING	0			0 0		
		0	10, 666				194.01
		0	0		0 0		194.02
	07953 FOUNDATION	0	0		0		194.03
200.00		_	^		0		200.00
201 00		0	0		0 0		
202.00	TOTAL (sum lines 118 through 201)	1, 343, 643	2, 146, 934		0 344, 440	1, 025, 909	

	Financial Systems	HARRI SON COUNT				u of Form CMS-2	2552-10
COST #	ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2018 o 12/31/2018	Worksheet B Part I Date/Time Pre 5/30/2019 5:4	
	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	
$\begin{array}{c} 1. \ 00\\ 1. \ 01\\ 1. \ 02\\ 2. \ 00\\ 2. \ 01\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 7. \ 00\\ 7. \ 01\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS OD100 CAP REL COSTS-BLDG & FIXT OD101 MOB OD102 AMB DEPR OD200 CAP REL COSTS-MVBLE EQUI P OD201 AMB EQUI P OD400 EMPLOYEE BENEFITS DEPARTMENT OD590 ADMINISTRATIVE & GENERAL OD570 ADMITTING OD580 CASHIERING/ACCOUNTS RECEIVABLE OO700 OPERATION OF PLANT OO701 AMB PLANT OPS O0800 LAUNDRY & LINEN SERVICE OO900 HOUSEKEEPING 01000 DIETARY O1100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	782, 692 0 0 0	502, 017 14, 737 12, 372	966, 299	920, 640		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
15.00	01500 PHARMACY	0	6, 345		1, 602	919, 535	
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	27, 527 7, 347		4, 665 330	0	
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	1, 347	0	330	0	17.00
30.00	03000 ADULTS & PEDIATRICS	729, 706	84, 589	390, 624		0	30.00
31.00	03100 I NTENSI VE CARE UNI T	52, 986	9, 770			0	
43.00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	9, 361	43, 227	29	0	43.00
50.00	05000 OPERATING ROOM	0	27, 086	125, 079	28, 837	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	5, 820			0	
53.00	05300 ANESTHESI OLOGY	0	26			0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	37, 288		39, 119	0	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	26, 350	0	179, 400 2, 391	0	
66.00	06600 PHYSI CAL THERAPY	0	7, 975	0	1, 278	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	
68.00	06800 SPEECH PATHOLOGY	0	C	0	0	0	
69.00	06900 ELECTROCARDI OLOGY	0	17, 294	79, 861	3, 610	0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	346, 772 251, 861	0	
72.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		919, 535	
/01/00	OUTPATIENT SERVICE COST CENTERS					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
90.00	09000 CLI NI C	0	575			0	
90.01	09001 SENI OR CARE	0	3, 864			0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	50, 893	235, 019	16, 833	0	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	0	0	0	14, 945	0	95.00
	10100 HOME HEALTH AGENCY	0	C	0		0	101.00
	SPECIAL PURPOSE COST CENTERS			1	I		
	11300 INTEREST EXPENSE	702 (02	240.210	0// 200	000 (40	010 525	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	782, 692	349, 219	966, 299	920, 640	919, 535	1118.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.00	19200 PHYSICIANS PRIVATE OFFICES	0	126, 680				192.00
	19200 PHISICIANS PRIVATE OFFICES					0	194. OC
192.00 194.00	07950 MARKETI NG	0	1, 718		0		
192.00 194.00 194.0	07950 MARKETI NG 07951 PHYSI CI AN BILLI NG	0 0	1, 718 24, 400		0	0	194. 01
192.00 194.00 194.01 194.02	07950 MARKETING 07951 PHYSICIAN BILLING 207952 MOB	0 0 0			0	0 0	194. 01 194. 02
192.00 194.00 194.02 194.02 194.03	07950 MARKETI NG 07951 PHYSI CI AN BILLI NG 207952 MOB 307953 FOUNDATI ON	0 0 0			0 0 0	0 0	194. 01 194. 02 194. 03
192.00 194.00 194.01 194.02	07950 MARKETING 07951 PHYSICIAN BILLING 207952 MOB 307953 FOUNDATION Cross Foot Adjustments	0 0 0 0			000000000000000000000000000000000000000	0 0 0	194. 01 194. 02

Heal th	Financial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider CC	1	Period: From 01/01/2018 Fo 12/31/2018		
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS		1				1
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01							1.01
1.02 2.00	00102 AMB DEPR 00200 CAP REL COSTS-MVBLE EQUIP						1.02
2.00	00201 AMB EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590 ADMINI 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 8.00	00701 AMB PLANT OPS 00800 LAUNDRY & LINEN SERVICE						7.01 8.00
8.00 9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						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 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 114, 651 0	472 014				16.00 17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	472, 014				17.00
30.00	03000 ADULTS & PEDI ATRI CS	73, 938	440,060	7, 135, 71	5 0	7, 135, 716	30.00
31.00	03100 I NTENSI VE CARE UNI T	5, 589	31, 954	966, 84	4 0	966, 844	1
43.00	04300 NURSERY	10, 822	0	601, 83	1 0	601, 831	43.00
F0 00	ANCI LLARY SERVICE COST CENTERS	00.027		2 001 00		2 001 002	
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	80, 037 6, 770		3, 091, 98 353, 41		3, 091, 982 353, 419	1
53.00	05300 ANESTHESI OLOGY	16, 216		67, 48		67, 489	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	272, 220		3, 900, 58		3, 900, 583	1
60.00	06000 LABORATORY	180, 764	0	3, 436, 79	9 0	3, 436, 799	60.00
65.00	06500 RESPI RATORY THERAPY	21, 725		625, 94		625, 948	1
66.00	06600 PHYSI CAL THERAPY	17,042		664, 23		664, 238	1
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 740 397		50, 61 21, 13		50, 618	
69.00	06900 ELECTROCARDI OLOGY	72, 352		1, 348, 27		21, 135 1, 348, 279	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	46,068	-	1, 988, 74		1, 988, 742	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	22, 246		1, 426, 02		1, 426, 027	
73.00	07300 DRUGS CHARGED TO PATIENTS	58, 476	0	2, 878, 19	1 0	2, 878, 191	73.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS					107.111	
	09000 CLINIC 09001 SENIOR CARE	1,584		127, 41		.=.,	
	09100 EMERGENCY	5, 336 155, 036		414, 98 4, 095, 35			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	155, 656	Ŭ	4,070,00	0		92.00
	OTHER REIMBURSABLE COST CENTERS		ΙΙ.				
	09500 AMBULANCE SERVICES	65,007		4, 217, 09			
101.00	10100 HOME HEALTH AGENCY	1, 286	0	278, 70	2 0	278, 702	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)	1, 114, 651	472, 014	37, 691, 38	6 0	37, 691, 386	113.00
110.00	NONREIMBURSABLE COST CENTERS	1, 114, 031	472,014	37,071,30	5 0	37, 071, 300	1110.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	45, 38	9 0	45, 389	190. 00
192.00	19200 PHYSI CLANS PRI VATE OFFI CES	0		16, 436, 65		16, 436, 651	
194.00	07950 MARKETI NG	0	0	439, 86		439, 860	
	07951 PHYSI CI AN BILLI NG	0	0	924, 42		924, 422	1
		0	0	618, 38		618, 383	
194.03 200.00	07953 FOUNDATION Cross Foot Adjustments	0					194. 03 200. 00
200.00		0	0		0		200.00
202.00		1, 114, 651	472, 014	56, 156, 09			

	Financial Systems TION OF CAPITAL RELATED COSTS	HARRISON COUN	Provider CC	CN: 15-1331	Period:	u of Form CMS- Worksheet B	∠00Z-1
NEL007	HOR OF ON THE RELATED COSTS			N. 10 1001	From 01/01/2018 To 12/31/2018	Part II	epared: 14 pm
				CAPI TAL	RELATED COSTS	10,00,201, 011	
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MOB	AMB DEPR	MVBLE EQUIP	
		Related Costs 0	1.00	1.01	1.02	2.00	
	GENERAL SERVICE COST CENTERS						
1.00 1.01	00100 CAP REL COSTS-BLDG & FIXT 00101 MOB						1.00
1.01	00102 AMB DEPR						1.02
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2. 01	00201 AMB EQUIP						2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2,608		0 0	1, 701	
5.01	00590 ADMINI STRATI VE & GENERAL	0	259, 453	3, 8		169, 230	
5.02 5.03	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0		0 0 0 0	0	
7.00	00700 OPERATI ON OF PLANT	0	204, 568		0 0	133, 432	
7.01	00701 AMB PLANT OPS	0	0		0 0	0	1
3.00	00800 LAUNDRY & LINEN SERVICE	0	11, 944		0 0	7, 791	8.0
9.00	00900 HOUSEKEEPI NG	0	25, 584		0 0	16, 687	
10.00	01000 DI ETARY	0	74, 444		0 0	48, 557	
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	37, 189		0 0 0 0	24, 257	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	6, 259 0		0 0	4, 083 0	
15.00	01500 PHARMACY	0	0		0 0	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	41, 532		0 0	27, 089	
7.00	01700 SOCIAL SERVICE	0	2, 504		0 0	1, 633	17.0
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDIATRICS	0			0 0		
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0			0 0 0 0		
43.00	ANCI LLARY SERVICE COST CENTERS	0	7,024		0 0	5, 103	43.00
50.00	05000 OPERATING ROOM	0	231, 091		0 0	150, 731	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	1
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	40, 757	121,074		0 0	78, 972	
50.00 55.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	63, 634		0 0 0 0	41, 506	
55.00 56.00	06600 PHYSI CAL THERAPY	3, 607	13, 848 46, 852		0 0	9, 033 30, 560	
57.00	06700 OCCUPATI ONAL THERAPY	0	40, 032		0 0	0	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0	23, 785		0 0	15, 514	69.0
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	56, 801		0 0	37, 049	
2.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	15, 987		0 0	10, 428	73.0
90.00	09000 CLINIC	47, 639	0	31, 5	52 0	0	90.0
90.00	09001 SENI OR CARE	20, 536		22, 8		0	
91.00	09100 EMERGENCY	77,054				55, 786	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.0
	OTHER REIMBURSABLE COST CENTERS	1				F	
	09500 AMBULANCE SERVICES	0			0 64, 894		
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	10, 818	0	9, 3	11 0	0	101.00
13 00	11300 INTEREST EXPENSE						113. 0
118.00		200, 411	1, 672, 848	99, 1	35 64, 894	1, 091, 131	
	NONREI MBURSABLE COST CENTERS		,,			, , ,	
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	10, 627		0 0		190. 0
	19200 PHYSICIANS PRIVATE OFFICES	921, 523			0 0	56, 271	
	07950 MARKETI NG	0	2, 791		0 0		194.0
	07951 PHYSICIAN BILLING	0	6, 520		0 0		194.0
		0	0	558, 1	92 0		194.0
	07953 FOUNDATION Cross Foot Adjustments	0	0		0	0	200.00
200 00					1		1200.01
200.00 201.00	5		0		0 0	^	201.00

Heal th	Financial Systems	HARRI SON COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ITION OF CAPITAL RELATED COSTS		Provider CC	F	Period: From 01/01/2018 Fo 12/31/2018	Worksheet B Part II Date/Time Pre 5/30/2019 5:4	pared:
		CAPI TAL				373072017 3.4	
	Cost Center Description	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	
	GENERAL SERVICE COST CENTERS						
$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 2.\ 00\\ 2.\ 01\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 7.\ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00101 MOB 00102 AMB DEPR 00200 CAP REL COSTS-MVBLE EQUI P 00201 AMB EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINISTRATIVE & GENERAL 00570 ADMINISTRATIVE & GENERAL 00570 ADMINISTRATIVE & GENERAL 00580 CASHI ERING/ACCOUNTS RECEIVABLE 00700 OPERATION OF PLANT	0 0 0 0 0	4, 309 432, 517 0 338, 000	4, 30 25 78 64 4	3 432, 770 3 5, 657 9 10, 355 1 16, 546	5, 735 0 0	5. 03 7. 00
7.01 8.00	00701 AMB PLANT OPS 00800 LAUNDRY & LINEN SERVICE	0	0 19, 735	(0 0 4 2,504	0	7.01 8.00
9.00 10.00	00900 HOUSEKEEPING 01000 DI ETARY	0	42, 271 123, 001	83	3 7, 584	0	9.00 10.00
11.00	01100 CAFETERI A	0	61, 446	33		0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	10, 342	101		0	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0	39 59		0	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	68, 621	96		0	16.00
17.00	01700 SOCIAL SERVICE	0	4, 137	48	3, 532	0	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	499, 912	424	4 33, 661	378	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	62, 416	7		29	31.00
43.00	04300 NURSERY	0	12, 927	53	3 3, 847	55	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	0	381, 822	16	1 16, 137	409	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	33		35	
53.00	05300 ANESTHESI OLOGY	0	0	(83	53.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	240, 803 105, 140	182 123		1, 427 924	54.00 60.00
65.00	06500 RESPI RATORY THERAPY	0	22, 881	125		111	65.00
66.00	06600 PHYSI CAL THERAPY	0	81, 019	45		87	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	(9	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0 39, 299	92	2 154 2 7, 566	2 370	68.00 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	93, 850	(236	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(114	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	26, 415	(13, 504	299	73.00
90.00	09000 CLINIC	0	79, 191		3 903	8	90.00
90.01	09001 SENI OR CARE	0	43, 422	21	1 2, 910	27	90.01
91.00	09100 EMERGENCY	0	249, 920	270	23, 556	793	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0				92.00
95.00	09500 AMBULANCE SERVICES	171, 131	236, 025	342	2 30, 837	332	95.00
101.00	10100 HOME HEALTH AGENCY	0	20, 129	23	3 2, 120	7	101. 00
113 00	SPECIAL PURPOSE COST CENTERS						113.00
118.00		171, 131	3, 299, 550	2, 780	293, 747	5, 735	118.00
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	17, 559	() 150	0	190.00
	19200 PHYSI CLANS PRI VATE OFFI CES	0	1, 064, 065	1, 42			192.00
	07950 MARKETING 07951 PHYSICIAN BILLING	0	4, 611 10, 773	1 ⁻ 9 ⁻			194.00 194.01
	07951 MOB	0	558, 192	9	4, 766		194.01
194.03	07953 FOUNDATI ON	0	0	(0 0		194. 03
200.00			0	,		_	200. 00 201. 00
201.00 202.00	ů, s	0 171, 131	4, 954, 750		0 0 9 432, 770		201.00
							•

	Financial Systems	HARRI SON COUN				u of Form CMS-	2552-10
ALLOCA	TI ON OF CAPITAL RELATED COSTS		Provider C	F	veriod: rom 01/01/2018 o 12/31/2018	5/30/2019 5:4	
	Cost Center Description	CASHI ERI NG/ACC OUNTS RECEI VABLE	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	1	5.03	7.00	7.01	8.00	9.00	
1 00	GENERAL SERVICE COST CENTERS	1			1		1 1 00
1.00 1.01	00100 CAP REL COSTS-BLDG & FIXT 00101 MOB						1.00
1.01	00102 AMB DEPR						1.01
2.00	00200 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		10, 10,					5.02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00700 OPERATI ON OF PLANT	10, 424	254 507				5.03
7.00 7.01	00701 AMB PLANT OPS	0	354, 587	0			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	3, 227		25, 470		8.00
9.00	00900 HOUSEKEEPI NG	0	6, 912	0	20, 110	56, 852	
10.00	01000 DI ETARY	0	20, 113		401	3, 320	10.00
11.00	01100 CAFETERI A	0	10, 048	0	0	1, 658	11.00
13.00	01300 NURSING ADMINISTRATION	0	1, 691	0	0	279	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
15.00		0	11 221	0		0	
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	11, 221 676		0	1, 852 112	
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0/0		0	112	17.00
30.00	03000 ADULTS & PEDIATRICS	693	81, 748	0	11, 293	13, 491	30.00
31.00	03100 I NTENSI VE CARE UNI T	52	10, 206	0		1, 685	1
43.00	04300 NURSERY	101	2, 114	0	0	349	43.00
	ANCI LLARY SERVICE COST CENTERS	750	(0.405			10.005	1
50.00	05000 OPERATING ROOM	750	62, 435			10, 305	1
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	63 152	0	0	0	0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	2, 530	32, 711		3, 289	5, 399	
60.00	06000 LABORATORY	1, 694	17, 192		0,20,	2,838	1
65.00	06500 RESPI RATORY THERAPY	204	3, 741	0	39	618	
66.00	06600 PHYSI CAL THERAPY	160	12, 658	0	396	2, 089	66.00
67.00	06700 OCCUPATIONAL THERAPY	16	0	0	0	0	
68.00	06800 SPEECH PATHOLOGY	4	0	0	0	0	
69.00	06900 ELECTROCARDI OLOGY	678	6, 426		38	1, 061	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	432 208	15, 346		0	2, 533 0	1
	07300 DRUGS CHARGED TO PATIENTS	548	4, 319		0	713	
10100	OUTPATIENT SERVICE COST CENTERS	010		<u> </u>		, 10	10100
90.00	09000 CLI NI C	15	0	0	163	0	
	09001 SENI OR CARE	50		-	-	0	
	09100 EMERGENCY	1, 453	23, 108	0	6, 171	3, 814	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	609	0	0	1, 093	0	95.00
	10100 HOME HEALTH AGENCY	12					101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113.00
118.00		10, 424	325, 892	0	24, 669	52, 116	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0		0	-		190.00
	19200 PHYSICIANS PRIVATE OFFICES	0	23, 308		801		192.00
	07950 MARKETI NG 07951 PHYSI CLAN BILLI NG		754		0		194.00 194.01
	07951 PHYSICIAN BILLING 07952 MOB		1, 762				194.01
	07953 FOUNDATI ON	0	0	0	0		194.02
				Ĭ	l ő	Ű	200.00
200.00							
200.00 201.00 202.00	Negative Cost Centers	0 10, 424	0 354, 587	0	0 25, 470		201. 00 202. 00

	Financial Systems TION OF CAPITAL RELATED COSTS	HARRI SON COUNT	Provider C		eri od:	u of Form CMS-: Worksheet B	
				Fr Tc	com 01/01/2018 0 12/31/2018	Part II Date/Time Pre 5/30/2019 5:4	
	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	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 1.01	00100 CAP REL COSTS-BLDG & FIXT 00101 MOB						1.00
1.01	00102 AMB DEPR						1.01
2.00	00200 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	00570 ADMI TTI NG						5.02
5.03	00580 CASHI ERING/ACCOUNTS RECEIVABLE 00700 OPERATION OF PLANT						5.03
7.00 7.01	00700 OPERATION OF PLANT 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	151, 456					10.00
11.00	01100 CAFETERI A	0	76, 355				11.00
13.00	01300 NURSING ADMINISTRATION	0	2, 242				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1, 882		8, 921		14.00
15.00	01500 PHARMACY	0	965		16	8, 066	
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	4, 187 1, 117		45 3	0	
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	1, 117	0	<u> </u>	0	17.00
30.00	03000 ADULTS & PEDI ATRI CS	141, 203	12, 866	8, 842	196	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	10, 253	1, 486		54	0	
43.00	04300 NURSERY	0	1, 424	978	0	0	43.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	0	4, 120		279	0	
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	885 4		0 24	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	5, 671	0	379	0	
60.00	06000 LABORATORY	0	4,008	0	1, 739	0	
65.00	06500 RESPI RATORY THERAPY	0	0		23	0	1
66.00	06600 PHYSI CAL THERAPY	0	1, 213	0	12	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	
69.00	06900 ELECTROCARDI OLOGY	0	2, 630		35	0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	-	3, 360 2, 441	0	
	07200 IMPL. DEV. CHARGED TO PATTENTS	0	0	0	2, 441	8, 066	
70.00	OUTPATIENT SERVICE COST CENTERS	0	0		0	0,000	, 0. 00
90.00	09000 CLI NI C	0	87	60	3	0	90.00
90. 01	09001 SENI OR CARE	0	588		4	0	90.01
	09100 EMERGENCY	0	7, 741	5, 319	163	0	
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
05 00	OTHER REIMBURSABLE COST CENTERS	0			145	0	
	10100 HOME HEALTH AGENCY	0	0		145 0	0	95.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS	U	0	0	V	0	101.00
113.00	11300 I NTEREST EXPENSE						113.00
118.00		151, 456	53, 116	21, 871	8, 921	8, 066	118.00
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	19, 267		0		192.00
	07950 MARKETI NG	0	261		0		194.00
	07951 PHYSICIAN BILLING	0	3, 711		0		194.01
	07952 MOB 07953 FOUNDATI ON	0	0	0	0		194. 02 194. 03
		0	0	0	0	0	
	Cross Foot Adjustments	1			I		1200 00
200.00		0	0	0	0	0	200.00 201.00

ALLOC	Financial Systems	HARRISON COUN	Provi der CCI	N: 15-1331	Period: From 01/01/2018 To 12/31/2018	u of Form CMS- Worksheet B Part II Date/Time Pre 5/30/2019 5:4	epared:
	Cost Center Description	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		Г Г				1 1 00
1.00 1.01	00100 CAP REL COSTS-BLDG & FIXT 00101 MOB						1.00
1.02	00102 AMB DEPR						1.02
2.00	00200 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	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
B. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11.00	01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	93, 583					16.00
17.00	01700 SOCIAL SERVICE	0	9, 625				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 205		819, 88		819, 885	
31.00	03100 I NTENSI VE CARE UNI T	469		93, 89		93, 891	
43.00		908	0	22, 75	56 0	22, 756	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	6, 717	0	487, 74	40 0	487, 740	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	568		487, 72		487, 740	
53.00	05300 ANESTHESI OLOGY	1, 361	0	1, 76		1, 769	
54.00	05400 RADI OLOGY-DI AGNOSTI C	22, 883	-	336, 11		336, 118	
60.00	06000 LABORATORY	15, 171	0	168, 54		168, 544	
65.00	06500 RESPI RATORY THERAPY	1, 823	0	33, 50	02 0	33, 502	65.00
66.00	06600 PHYSI CAL THERAPY	1, 430	0	102, 85	58 0	102, 858	66.00
67.00	06700 OCCUPATI ONAL THERAPY	146		52		523	
68.00	06800 SPEECH PATHOLOGY	33		19		195	
69.00	06900 ELECTROCARDI OLOGY	6, 072		66, 07		66, 075	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	3,866		130, 19		130, 192	
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	1, 867 4, 908		13, 18 58, 77		13, 188 58, 772	
/ 5. 00	OUTPATIENT SERVICE COST CENTERS	4, 700	U0	50, 71	0	50,772	/ 3. 00
90.00	09000 CLINIC	133	0	80, 56	56 0	80, 566	90.00
	09001 SENI OR CARE	448		47, 88		47, 882	
	09100 EMERGENCY	13, 011		335, 31		335, 319	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	5, 456		274, 83		274, 839	
101.00	0 10100 HOME HEALTH AGENCY	108	0	22, 39	99 0	22, 399	101.00
112 00	SPECIAL PURPOSE COST CENTERS		<u>г</u>				112 00
113.00 118.00	SUBTOTALS (SUM OF LINES 1 through 117)	93, 583	9, 625	3, 101, 52	27 0	3, 101, 527	113.00
110.00	NONREI MBURSABLE COST CENTERS	43, 303	9,025	5, 101, 52	27 0	3, 101, 527	
190 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	21, 05	54 0	21 054	190.00
	19200 PHYSICIANS PRIVATE OFFICES	0		1, 236, 68		1, 236, 684	
	07950 MARKETI NG	0	o	9, 08			194.00
	07951 PHYSICIAN BILLING	0	0	23, 44		23, 442	
	2 07952 MOB	0	0	562, 95	58 0	562, 958	
	3 07953 FOUNDATI ON	0	0		0 0		194. 03
200.00					0 0		200. 00
201.00	5	0	0		0 0		201.00
202.00) TOTAL (sum lines 118 through 201)	93, 583	9, 625	4, 954, 75	50 0	4, 954, 750	1202 0

	Financial Systems LOCATION - STATISTICAL BASIS	HARRISON COUN	TY HOSPITAL Provider CO	N· 15-1331 ₽	In Lie eriod:	u of Form CMS- Worksheet B-1	
SUSI ALI	LUGATION - STATISTICAL DASIS				rom 01/01/2018		
						5/30/2019 5:4	4 pm
			CAP	ITAL RELATED CO	JSTS		
	Cost Center Description	BLDG & FI XT	MOB	AMB DEPR	MVBLE EQUIP	AMB EQUI P	
		(SQUARE FEET) 1.00	(SQUARE FEET) 1.01	(SQ_UARE_FEET) 1.02	2. 00	2. 01	
	ENERAL SERVICE COST CENTERS	10/ 100					
	00100 CAP REL COSTS-BLDG & FIXT 00101 MOB	136, 433 0	33, 604				1.0
1.02 0	00102 AMB DEPR	0	0	11, 032			1.0
	00200 CAP REL COSTS-MVBLE EQUIP				136, 433		2.0
	00201 AMB EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	200	0	0	0 200		
5.01 0	00590 ADMI NI STRATI VE & GENERAL	19, 897	196	0	19, 897	0	
	00570 ADMITTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	0	0	
	00700 OPERATION OF PLANT	15, 688	0	0	15, 688	-	
	00701 AMB PLANT OPS	0	0	0	0	0	
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	916 1, 962	0	0	916 1, 962	0	
	01000 DI ETARY	5, 709	0	0	5, 709	-	
		2,852	0	0	2, 852		
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	480	0	0	480	0	
15.00 0	1500 PHARMACY	0	0	0	0	0	
	1600 MEDICAL RECORDS & LIBRARY	3, 185 192	0	0	-,		
	01700 SOCIAL SERVICE NPATIENT ROUTINE SERVICE COST CENTERS	192	0	0	192	0	17.0
30.00 0	03000 ADULTS & PEDIATRICS	23, 203		-			
)3100 I NTENSI VE CARE UNI T)4300 NURSERY	2, 897 600	0				
	NCI LLARY SERVICE COST CENTERS	800	0	0	000	0	43.0
50.00 0	05000 OPERATING ROOM	17, 722	0	0		0	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0	0	0	0	
	05400 RADI OLOGY-DI AGNOSTI C	9, 285	0	0	9, 285		
	06000 LABORATORY	4, 880	0	0	4, 880		
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1,062 3,593	0	0	1, 062 3, 593	0	
	06700 OCCUPATI ONAL THERAPY	0	0	0	0,070	0	
	06800 SPEECH PATHOLOGY	0	0	0	0	0	
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	1,824 4,356	0	0	1, 824 4, 356	0	
72.00 0	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0			
	07300 DRUGS CHARGED TO PATIENTS	1, 226	0	0	1, 226	0	73.0
90.00 C	DUTPATIENT SERVICE COST CENTERS	0	1, 613	0	0	0	90.0
90.01 0	99001 SENI OR CARE	0	1, 170	0	0	0	90.0
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	6, 559	1, 613	0	6, 559	0	91.00
	THER REIMBURSABLE COST CENTERS					<u> </u>	92.0
	09500 AMBULANCE SERVICES	0					
	0100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	476	0	0	0	101. 0
	1300 INTEREST EXPENSE						113. 0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	128, 288	5, 068	11, 032	128, 288	11, 032	118. 0
	IONREI MBURSABLE COST CENTERS	815	0	0	815	0	190. 00
192.001	9200 PHYSICIANS PRIVATE OFFICES	6, 616		0	6, 616		190.00
	07950 MARKETI NG	214		0	214		194.0
)7951 PHYSI CLAN BILLING)7952 MOB	500	0 28, 536	0	500 0		194. 0 194. 0
	07953 FOUNDATI ON	0	20, 330	0	0		194.0
200.00	Cross Foot Adjustments						200.0
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B, Post 1)	1, 779, 057	657, 327	64, 894	1, 160, 407	171, 131	201. 0 202. 0
203.00 204.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	13. 039785	19. 560975	5. 882342	8. 505325	15. 512237	203. 0 204. 0
205.00	Part II) Unit cost multiplier (Wkst. B, Part II)						205. 0
-00.00		1				1	1
205.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 0

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	HARRI SON COUNT	TY HOSPITAL Provider CC		<u>In Lie</u> u riod: om 01/01/2018	u of Form CMS-: Worksheet B-1	
			То		Date/Time Pre 5/30/2019 5:4	
Cost Center Description	EMPLOYEE F BENEFITS DEPARTMENT (GROSS	Reconciliation.	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	ADMI TTI NG (GROSS CHARGES)	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS	
	SALARI ES)	54.01	5.01		CHARGES)	
GENERAL SERVI CE COST CENTERS	4.00	5A. 01	5.01	5.02	5.03	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 MOB 1.02 00102 AMB DEPR 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.01 00201 AMB EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00590 ADMI NI STRATI VE & GENERAL	26, 643, 243 1, 563, 579	-5, 465, 991	50, 690, 100			1. 01 1. 02 2. 00 2. 01 4. 00 5. 01
5. 02 00570 ADMI TTI NG	482, 682	0,100,771	662, 567	158, 281, 966		5.02
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	425, 523	0	1, 212, 858	0	158, 281, 966	5.03
7.00 00700 OPERATION OF PLANT	254, 001	0	1, 937, 960	0	0	7.00
7. 01 00701 AMB PLANT OPS 8. 00 00800 LAUNDRY & LINEN SERVICE	0 25, 464	0	0 293, 276	0	0	7.01 8.00
9. 00 00900 HOUSEKEEPING	510, 270	0	888, 250	0	0	9.00
10. 00 01000 DI ETARY	191, 424	0	537, 614	0	0	10.00
	205, 331	0	371, 225	0	0	11.00
13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY	621, 159 240, 784	0	845, 152 819, 861	0	0	13.00 14.00
15. 00 01500 PHARMACY	365, 525	0	822, 858	0	0	14.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	594, 803	Ö	885, 603	0	0	16.00
17.00 01700 SOCIAL SERVICE	298, 973	0	413, 624	0	0	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 O30000 ADULTS & PEDI ATRI CS	2 615 046	0	2 042 502	10, 499, 505	10, 499, 505	30.00
31. 00 03100 NTENSI VE CARE UNI T	2, 615, 046 435, 673	0	3, 942, 502 643, 810	793, 675	793, 675	31.00
43. 00 04300 NURSERY	328, 325	0	450, 542	1, 536, 819	1, 536, 819	
ANCI LLARY SERVI CE COST CENTERS	1 1					
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	993, 746	0	1, 889, 978	11, 365, 627	11, 365, 627	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	204, 126	0	272, 003 16, 714	961, 441 2, 302, 820	961, 441 2, 302, 820	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 122, 079	0	2, 441, 336	38, 652, 429	38, 652, 429	
60. 00 06000 LABORATORY	761, 148	0	2, 309, 056	25, 669, 418	25, 669, 418	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	475, 718	3, 085, 078	3, 085, 078	
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	277, 763 1, 013	0	439, 127 41, 194	2, 420, 027 247, 021	2, 420, 027 247, 021	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	14,072	0	18, 051	56, 402	56, 402	
69. 00 06900 ELECTROCARDI OLOGY	570, 289	0	886, 178	10, 274, 421	10, 274, 421	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	0	1, 237, 919	6, 541, 962	6, 541, 962	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1, 002, 367 1, 581, 618	3, 159, 052 8, 303, 845	3, 159, 052 8, 303, 845	
OUTPATIENT SERVICE COST CENTERS			170017010	0,000,010		1
90. 00 09000 CLI NI C	19, 562	0	105, 722	224, 903	224, 903	
90. 01 09001 SENI OR CARE	129, 693	0	340, 772	757, 714	757, 714	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 664, 190	0	2, 758, 907	22, 015, 930	22, 015, 930	91.00 92.00
OTHER REIMBURSABLE COST CENTERS		I		I		72.00
95. 00 09500 AMBULANCE SERVICES	2, 108, 214	0	3, 611, 724	9, 231, 301	9, 231, 301	
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	144, 384	0	248, 250	182, 576	182, 576	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	17, 168, 841	-5, 465, 991	34, 404, 336	158, 281, 966	158, 281, 966	118.00
NONREI MBURSABLE COST CENTERS			47 550	<u>م</u>		100.00
190. 00 19000 GLFT FLOWER COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICLANS PRIVATE OFFICES	0 8, 845, 691	0	17, 559 14, 522, 613	0		190. 00 192. 00
194. 00 07950 MARKETI NG	67, 102	0	389, 347	0		194.00
194. 01 07951 PHYSI CLAN BILLING	561, 609	0	798, 053	0		194. 01
194. 02 07952 MOB	0	0	558, 192	0		194.02
194.03 07953 FOUNDATION 200.00 Cross Foot Adjustments	0	0	0	0	0	194. 03 200. 00
201.00 Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B, Part I)	7, 346, 728		5, 465, 991	734, 013	1, 343, 643	
203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part II)	0. 275745 4, 309		0. 107832 432, 770	0. 004637 5, 735	0. 008489 10, 424	203. 00 204. 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000162		0. 008538	0. 000036	0. 000066	205.00
206.00 NAHE adjustment amount to be allocated						206.00
207.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						I

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	HARRI SON COUN	TY HOSPITAL Provider CO	CN: 15-1331 P	In Lie	u of Form CMS- Worksheet B-1	
				rom 01/01/2018	Date/Time Pre 5/30/2019 5:4	pared:
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	AMB PLANT OPS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (TOTAL PATI ENT DAYS)	
	7.00	7.01	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS	1					
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 MOB 1.02 00102 AMB DEPR 2.00 00200 CAP REL COSTS-MVBLE EQUI P 2.01 00201 AMB EQUI P 4.00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5.01 00590 ADMI NI STRATI VE & GENERAL S.02 00570 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 7.00 00700 OPERATI ON OF PLANT 7.01 00701 AMB PLANT SEDVLOE	100, 648 0	0	222.002			1.00 1.01 1.02 2.00 2.01 4.00 5.01 5.02 5.03 7.00 7.01 8.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	916 1, 962		223, 993 16			8.00 9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600	5, 709 2, 852 480 0 0 3, 185	0 0 0	3, 526 0 0 0 0 0 0 0 0	5, 709 2, 852 480 0 0 3, 185	4, 786 0 0 0 0 0 0 0	10. 00 11. 00
17. 00 01700 SOCIAL SERVICE	192		0	192	0	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	00.000		00.010	00.000		
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	23, 203 2, 897		99, 313 0	23, 203 2, 897	4, 462 324	30.00 31.00
43. 00 04300 NURSERY	600		0	600	0	43.00
	17 700	0	15 (02	17 700	0	
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	17,722		15, 602 0	17, 722 0	0	50.00 52.00
53. 00 05300 ANESTHESI OLOGY	0	0	21	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 285		28, 928	9, 285	0	54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	4,880 1,062		0 340	4, 880 1, 062	0	60.00 65.00
66. 00 06600 PHYSI CAL THERAPY	3, 593		3, 481	3, 593	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	1,824 4,356		336 0	1, 824 4, 356	0	69.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	1, 226	0	0	1, 226	0	73.00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	0	1, 435	0	0	90.00
90. 01 09001 SENI OR CARE	0				0	
91.00 09100 EMERGENCY	6, 559	0	54, 268	6, 559	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	0	9, 616	0	0	95.00
101.00 10100 HOME HEALTH AGENCY	0				0	101.00
SPECIAL PURPOSE COST CENTERS	[113.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	92, 503	0	216, 952	89, 625	4, 786	118.00
NONREI MBURSABLE COST CENTERS		-	,		.,	
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	815			815		190.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES 194. 00 07950 MARKETI NG	6, 616 214		7, 041	6, 616 214		192.00 194.00
194. 01 07951 PHYSI CI AN BILLI NG	500		0	500		194.01
194. 02 07952 MOB	0	0	0	0		194. 02
194.03 07953 FOUNDATION 200.00 Cross Foot Adjustments	0	0	0	0	0	194. 03 200. 00
201.00 Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2, 146, 934				782, 692	202. 00
203.00Unit cost multiplier (Wkst. B, Part I)204.00Cost to be allocated (per Wkst. B, Part II)	21. 331114 354, 587		1. 537727 25, 470		163. 537819 151, 456	
205.00 Unit cost multiplier (Wkst. B, Part	3. 523041	0. 000000	0. 113709	0. 581487	31. 645633	
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST A	Financial Systems LLOCATION - STATISTICAL BASIS		NTY HOSPITAL Provider CO		eriod:	u of Form CMS-2 Worksheet B-1	
				FI	rom 01/01/2018 0 12/31/2018	Date/Time Pre 5/30/2019 5:4	
	Cost Center Description	CAFETERI A (HOURS OF SERVI CE)	NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG HR)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (TIME SPENT)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	-
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 2. \ 00 \\ 2. \ 01 \\ 4. \ 00 \\ 5. \ 01 \\ 5. \ 02 \\ 5. \ 03 \\ 7. \ 00 \\ 7. \ 01 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \end{array}$	00101 MOB 00102 AMB DEPR 00200 CAP REL COSTS-MVBLE EQUIP 00201 AMB EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 ADMINI STRATIVE & GENERAL 00570 ADMITTING 00580 CASHI ERING/ACCOUNTS RECEIVABLE 00700 OPERATION OF PLANT 00701 AMB PLANT OPS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINI STRATION 01400 CENTRAL SERVICES & SUPPLY	607, 635 17, 838 14, 975	253, 273	3, 664, 002			1. 01 1. 01 1. 02 2. 00 2. 01 4. 00 5. 01 5. 02 5. 02 5. 03 7. 00 7. 01 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00
14.00	01500 PHARMACY	7,680		3, 664, 002 6, 376	100		14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	33, 318		18, 566	0	158, 281, 966	
17.00	01700 SOCIAL SERVICE	8, 893	0	1, 314	0	0	17.00
~~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	100.005	100.005			40,400,505	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	102, 385 11, 825		80, 484 22, 229	0	10, 499, 505 793, 675	
43.00	04300 NURSERY	11, 330		22, 229	0	1, 536, 819	
	ANCI LLARY SERVI CE COST CENTERS				-1	.,	1
50.00	05000 OPERATING ROOM	32, 784		114, 766	0	11, 365, 627	50.00
52.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	7,044		0	0	961, 441	52.00
53.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	32 45, 133		9, 838 155, 689	0	2, 302, 820 38, 652, 429	
60.00	06000 LABORATORY	31, 894		713, 984	0	25, 669, 418	
65.00	06500 RESPI RATORY THERAPY	C		9, 517	0	3, 085, 078	
66.00	06600 PHYSI CAL THERAPY	9, 653		5, 087	0	2, 420, 027	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY			0	o	247, 021 56, 402	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	20, 932	20, 932	14, 369	0	10, 274, 421	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	-	1, 380, 094	0	6, 541, 962	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	C		1, 002, 367	0	3, 159, 052	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	C	0	0	100	8, 303, 845	73.00
90.00	09000 CLINIC	696	696	1, 278	0	224, 903	90.00
90.01	09001 SENI OR CARE	4, 677		1, 461	0	757, 714	
	09100 EMERGENCY	61, 600	61, 600	66, 991	0	22, 015, 930	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	C	0	59, 478	0	9, 231, 301	95.00
101.00	10100 HOME HEALTH AGENCY	C	0	0	0	182, 576	101.00
112 00	SPECIAL PURPOSE COST CENTERS	1			I		112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	422, 689	253, 273	3, 664, 002	100	158, 281, 966	113.00
	NONREI MBURSABLE COST CENTERS	122,007	200,210	0,001,002		100/2017/00	
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	C	0	0	0		190.00
	19200 PHYSICIANS PRIVATE OFFICES 07950 MARKETING	153, 333 2, 080		0	0		192.00 194.00
	07951 PHYSICIAN BILLING	2,080		0	0		194.00
	07952 MOB	C	0	0	0		194.02
	07953 FOUNDATI ON	C	0	0	0	0	194.03
200.00 201.00							200.00 201.00
202.00	5	502, 017	966, 299	920, 640	919, 535	1, 114, 651	
203.00 204.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 826182 76, 355		0. 251266 8, 921	9, 195. 350000 8, 066	0. 007042 93, 583	203. 00 204. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part II)	0. 125659	0. 086353	0.002435	80. 660000	0. 000591	205. 00
206.00							206. 00
		1	1				1

		cial Systems	HARRI SON COUNT			u of Form CMS-2552-10
COST A	LLOCA	FION - STATISTICAL BASIS		Provider CCN: 15-1331	Period: From 01/01/2018	Worksheet B-1
					To 12/31/2018	Date/Time Prepared: 5/30/2019 5:44 pm
		Cost Center Description	SOCIAL SERVICE			
			(TOTAL PATI ENT DAYS)			
	1		17.00			
1.00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	МОВ				1.01
1.02 2.00		AMB DEPR CAP REL COSTS-MVBLE EQUIP				1. 02 2. 00
2.00		AMB EQUIP				2.00
4.00		EMPLOYEE BENEFI TS DEPARTMENT				4.00
5. 01 5. 02	1	ADMI NI STRATI VE & GENERAL ADMI TTI NG				5. 01 5. 02
5.03	1	CASHI ERI NG/ACCOUNTS RECEI VABLE				5.03
7.00 7.01		OPERATION OF PLANT AMB PLANT OPS				7.00 7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY				9.00
11.00	01100	CAFETERI A				11.00
		NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY				13.00 14.00
15.00	01500	PHARMACY				15.00
		MEDI CAL RECORDS & LI BRARY SOCI AL SERVI CE	4, 786			16.00 17.00
17.00		IENT ROUTINE SERVICE COST CENTERS	4,780			17.00
30.00		ADULTS & PEDIATRICS	4, 462			30.00
		I NTENSI VE CARE UNI T NURSERY	324 0			31.00 43.00
50.00		LARY SERVICE COST CENTERS				F0.00
	•	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0			50.00 52.00
53.00	05300	ANESTHESI OLOGY	0			53.00
		RADI OLOGY-DI AGNOSTI C LABORATORY	0			54.00 60.00
65.00	06500	RESPI RATORY THERAPY	0			65.00
66.00 67.00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0			66.00 67.00
68.00	06800	SPEECH PATHOLOGY	0			68.00
	•	ELECTROCARDI OLOGY MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0			69.00 71.00
		I MPL. DEV. CHARGED TO PATIENTS	0			72.00
73.00		DRUGS CHARGED TO PATIENTS TIENT SERVICE COST CENTERS	0			73.00
	09000	CLINIC	0			90.00
		SENI OR CARE	0			90. 01 91. 00
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	0			91.00
	OTHER	REIMBURSABLE COST CENTERS				05.00
		AMBULANCE SERVICES HOME HEALTH AGENCY	0			95.00 101.00
440.00		AL PURPOSE COST CENTERS				140.00
113.00 118.00	1	INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	4, 786			113. 00 118. 00
	NONRE	MBURSABLE COST CENTERS				
		GIFT FLOWER COFFEE SHOP & CANTEEN PHYSICIANS PRIVATE OFFICES	0			190. 00 192. 00
194.00	07950	MARKETING	0			194.00
194.01 194.02		PHYSICIAN BILLING MOB	0			194. 01 194. 02
194.03	07953	FOUNDATION	0			194. 03
200.00 201.00	•	Cross Foot Adjustments Negative Cost Centers				200. 00 201. 00
201.00		Cost to be allocated (per Wkst. B, Part I)	472, 014			201.00
203.00 204.00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	98. 623903 9, 625			203. 00 204. 00
205.00		Part II) Unit cost multiplier (Wkst. B, Part	2. 011074			205. 00
206.00		NAHE adjustment amount to be allocated				206.00
207.00		(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,				207.00
		Parts III and IV)				

Health Fina	ncial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lieu of Form CMS-2552-10			
COMPUTATI ON	I OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1331	Peri od:	Worksheet C		
					From 01/01/2018 To 12/31/2018	Part I Date/Time Pre	narod	
					10 12/31/2010	5/30/2019 5:4	4 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.						
		<u>26)</u> 1.00	2.00	3.00	4.00	5.00		
	TIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00		
	0 ADULTS & PEDIATRICS	7, 135, 716	1	7, 135, 7	6 0	0	30.00	
	O I NTENSI VE CARE UNI T	966, 844		966, 8		0		
	0 NURSERY	601, 831		601, 8		0		
	LLARY SERVICE COST CENTERS	001,031	I	001, 0		0	45.00	
	O OPERATING ROOM	3, 091, 982		3, 091, 9	32 0	0	50.00	
	O DELIVERY ROOM & LABOR ROOM	353, 419		353, 4		0	52.00	
	O ANESTHESI OLOGY	67, 489		67, 48		0	53.00	
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	3, 900, 583		3, 900, 5		0	54.00	
	O LABORATORY	3, 436, 799		3, 436, 7		0	60.00	
65.00 0650	0 RESPI RATORY THERAPY	625, 948	0	625, 9	18 0	0	65.00	
66.00 0660	O PHYSI CAL THERAPY	664, 238	0	664, 23	38 0	0	66.00	
67.00 0670	O OCCUPATI ONAL THERAPY	50, 618	0	50, 6	0 0	0	67.00	
68.00 0680	O SPEECH PATHOLOGY	21, 135	0	21, 1	35 0	0	68.00	
	0 ELECTROCARDI OLOGY	1, 348, 279		1, 348, 2	79 0	0	69.00	
	O MEDICAL SUPPLIES CHARGED TO PATIENT	1, 988, 742		1, 988, 7	12 0	0	71.00	
	OIMPL. DEV. CHARGED TO PATIENTS	1, 426, 027		1, 426, 02		0	72.00	
	O DRUGS CHARGED TO PATIENTS	2, 878, 191		2, 878, 1	91 0	0	73.00	
	ATIENT SERVICE COST CENTERS	-						
		127, 416		127, 4		0		
	1 SENI OR CARE	414, 983		414, 98		0	90. 01	
	OEMRGENCY	4, 095, 351		4, 095, 3		0	91.00	
	O OBSERVATION BEDS (NON-DISTINCT PART	1, 418, 789		1, 418, 78	39	0	92.00	
	R REIMBURSABLE COST CENTERS	1			-			
	O AMBULANCE SERVICES	4, 217, 093		4, 217, 0		0		
	O HOME HEALTH AGENCY	278, 702		278, 70)2	0	101.00	
	I AL PURPOSE COST CENTERS	1	1	1			112 00	
	0 INTEREST EXPENSE	39, 110, 175		20 110 1		0	113.00 200.00	
200.00 201.00	Subtotal (see instructions) Less Observation Beds	1, 418, 789		39, 110, 1 1, 418, 7			200.00	
201.00	Total (see instructions)	37, 691, 386					201.00	
202.00		37,071,380	1 0	37,091,36		0	1202.00	

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 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/30/2019 5:4	
	-	Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
	(00	7.00	0.00	9.00	Ratio	
INDATIENT DOUTINE SEDVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	6, 415, 606		6, 415, 60			30.00
31. 00 03100 INTENSIVE CARE UNIT						30.00
	793, 675		793, 67			43.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	1, 536, 819		1, 536, 81	9		43.00
50. 00 05000 OPERATING ROOM	2, 993, 397	8, 372, 230	11, 365, 62	0. 272047	0. 000000	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	485, 715	6, 372, 230 475, 726			0.000000	
53. 00 05300 ANESTHESI OLOGY	485, 715 941, 595	1, 361, 225			0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2,075,210	36, 577, 219			0.000000	
60. 00 06000 LABORATORY	3, 572, 644	22, 096, 774			0. 000000	
65. 00 06500 RESPIRATORY THERAPY	2, 252, 843	832, 235			0.000000	
66. 00 06600 PHYSICAL THERAPY	695, 671	1, 724, 356			0. 000000	•
67. 00 06700 OCCUPATI ONAL THERAPY	82, 983	164, 038			0.000000	
68. 00 06800 SPEECH PATHOLOGY	2, 873	53, 529			0.000000	
69. 00 06900 ELECTROCARDI OLOGY	692, 280	9, 582, 141			0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 660, 100	3, 881, 862			0.000000	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	2, 255, 051	904,001			0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 247, 069	6, 056, 776			0. 000000	•
OUTPATIENT SERVICE COST CENTERS	2/2///00/	0,000,770	0,000,0	01010007	0.000000	10100
90. 00 09000 CLINIC	0	224, 903	224, 90	0. 566538	0.00000	90.00
90. 01 09001 SENI OR CARE	0	757, 714			0. 000000	
91. 00 09100 EMERGENCY	1, 340, 623	20, 675, 307			0, 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	16, 905	4,066,994			0.000000	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	9, 231, 301	9, 231, 30	0. 456825	0.00000	95.00
101.00 10100 HOME HEALTH AGENCY	0	182, 576	182, 57	'6		101.00
SPECIAL PURPOSE COST CENTERS				-		
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	31, 061, 059	127, 220, 907	158, 281, 96	6		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	31, 061, 059	127, 220, 907	158, 281, 96	6		202.00

Health Financial Systems	HARRI SON COUNTY	HOSPI TAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1331	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/30/2019 5:4	pared: 4 pm	
		Title XVIII	Hospi tal	Cost		
Cost Center Description	PPS Inpatient Ratio 11.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS					30.00	
31. 00 03100 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 PATIENT	0.000000				71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	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					1	
95.00 09500 AMBULANCE SERVICES	0. 000000				95.00	
101.00 10100 HOME HEALTH AGENCY					101.00	
SPECIAL PURPOSE COST CENTERS						
113.0011300 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 Fina	ncial Systems	HARRI SON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provider C		Peri od:	Worksheet C	
					From 01/01/2018 To 12/31/2018		narod
					10 12/31/2010	5/30/2019 5:4	4 pm
			Titl	e XIX	Hospi tal	Cost	1 pm
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
	TIENT ROUTINE SERVICE COST CENTERS	7 405 744	1			7 405 744	
	0 ADULTS & PEDIATRICS	7, 135, 716		7, 135, 71		7, 135, 716	
	O INTENSIVE CARE UNIT	966, 844		966, 84		966, 844	
	0 NURSERY LLARY SERVICE COST CENTERS	601, 831		601, 83	1 0	601, 831	43.00
	O OPERATING ROOM	3, 091, 982	[3, 091, 98	2 0	3, 091, 982	50.00
	O DELIVERY ROOM & LABOR ROOM	353, 419		353, 41		353, 419	
	0 ANESTHESI OLOGY	67, 489		67, 48		67, 489	•
	0 RADI OLOGY-DI AGNOSTI C	3, 900, 583		3, 900, 58		3, 900, 583	
	0 LABORATORY	3, 436, 799		3, 436, 79		3, 436, 799	
	O RESPI RATORY THERAPY	625, 948		625, 94		625, 948	
	0 PHYSI CAL THERAPY	664, 238		664, 23		664, 238	
	0 OCCUPATIONAL THERAPY	50, 618		50, 61		50, 618	
	O SPEECH PATHOLOGY	21, 135		21, 13		21, 135	
69.00 0690	0 ELECTROCARDI OLOGY	1, 348, 279		1, 348, 27		1, 348, 279	
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENT	1, 988, 742		1, 988, 74		1, 988, 742	
72.00 0720	O IMPL. DEV. CHARGED TO PATIENTS	1, 426, 027		1, 426, 02	7 0	1, 426, 027	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	2, 878, 191		2, 878, 19	0 1	2, 878, 191	
	ATIENT SERVICE COST CENTERS						
		127, 416		127, 41		127, 416	
	1 SENI OR CARE	414, 983		414, 98		414, 983	
	0 EMERGENCY	4, 095, 351		4, 095, 35		4, 095, 351	
	O OBSERVATION BEDS (NON-DISTINCT PART	1, 418, 789		1, 418, 78	9	1, 418, 789	92.00
	R REIMBURSABLE COST CENTERS		1	T			-
	O AMBULANCE SERVICES	4, 217, 093		4, 217, 09		., ,	
	O HOME HEALTH AGENCY	278, 702		278, 70	2	278, 702	101.00
	I AL PURPOSE COST CENTERS			1	-		1110.00
200.00	0 INTEREST EXPENSE Subtotal (see instructions)	20 110 175		20 110 17	5 0	39, 110, 175	113.00
200.00	Less Observation Beds	39, 110, 175 1, 418, 789) 39, 110, 17 1, 418, 78		39, 110, 175 1, 418, 789	
201.00	Total (see instructions)	37, 691, 386					
202.00	Total (See Thisti uctions)	37,071,380	I C	אן אין אין אין אין	0	37,071,380	202.00

Health Financial Systems	HARRI SON COUN	TY HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/30/2019 5:4	
	-		e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	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	l l		•			
30. 00 03000 ADULTS & PEDI ATRI CS	6, 415, 606		6, 415, 60	6		30.00
31.00 03100 INTENSIVE CARE UNIT	793, 675		793, 67	5		31.00
43. 00 04300 NURSERY	1, 536, 819		1, 536, 81	9		43.00
ANCI LLARY SERVI CE COST CENTERS						1
50. 00 05000 OPERATI NG ROOM	2, 993, 397	8, 372, 230	11, 365, 62	7 0. 272047	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	485, 715	475, 726	961, 44	0.367593	0.000000	52.00
53.00 05300 ANESTHESI OLOGY	941, 595	1, 361, 225	2, 302, 82	0 0.029307	0.000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2,075,210	36, 577, 219	38, 652, 42	9 0. 100914	0.000000	54.00
60. 00 06000 LABORATORY	3, 572, 644	22,096,774	25, 669, 41	8 0.133887	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	2, 252, 843	832, 235	3, 085, 07	8 0. 202895	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	695, 671	1, 724, 356	2, 420, 02	7 0. 274475	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	82, 983	164, 038	247, 02	0. 204914	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	2, 873	53, 529	56, 40	2 0. 374721	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	692, 280	9, 582, 141	10, 274, 42	0. 131227	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 660, 100	3, 881, 862	6, 541, 96	2 0. 303998	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 255, 051	904, 001			0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 247, 069	6, 056, 776	8, 303, 84	5 0.346609	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS	· · · · ·					1
90. 00 09000 CLI NI C	0	224, 903	224, 90	3 0. 566538	0.000000	90.00
90. 01 09001 SENI OR CARE	0	757, 714	757, 71	4 0.547678	0.000000	90.01
91.00 09100 EMERGENCY	1, 340, 623	20, 675, 307	22, 015, 93	0 0. 186018	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	16, 905	4,066,994	4, 083, 89	9 0.347410	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS	· · · · ·					1
95.00 09500 AMBULANCE SERVICES	0	9, 231, 301	9, 231, 30	1 0.456825	0.000000	95.00
101.00 10100 HOME HEALTH AGENCY	0	182, 576	182, 57	6		101.00
SPECIAL PURPOSE COST CENTERS						1
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	31, 061, 059	127, 220, 907	158, 281, 96	6		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	31, 061, 059	127, 220, 907	158, 281, 96	6		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1331 Period: To 01/01/2015 Worksheet C Part I Date/Time Prepared: 5/30/2019 5: 44 gm Cost Center Description PPS Inpatient Ratio Title XIX Hospital Cost IMPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 30.00 30.00 0.00 03000 NURSERY 43.00 43.00 43.00 43.00 43.00 052000 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 52.00 52.00 50.00 052000 DELIVERY NOM & LABOR ROOM 0.000000 53.00 52.00 52.00 51.00 052000 DELIVERY NOM & LABOR ROOM 0.000000 53.00 52.00 53.00 51.00 052000 RESPI RATORY THERAPY 0.000000 54.00 54.00 66.00 066000 RESPI RATORY THERAPY 0.000000 66.00 65.00 67.00 0.000000 72.00 73.00 73.00 73.00 73.00 0.000000 0.000000 73.00 73.00 73.00 73.00 0.000000 0.000000 73.00	Health Financial Systems	HARRI SON COUNTY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
Cost Center Description PPS Inpatient Ratio Netion Second 11.00 11.00 11.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 31.00 43.00	COMPUTATION OF RATIO OF COSTS TO CHARGES			From 01/01/2018 To 12/31/2018	Part I Date/Time Pre	pared: 4 pm
Ratio 11.00 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 43.00 04300 NURSERY 43.00 ANDULLARY SERVICE COST CENTERS 50.00 50.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 05300 ANESTHESI OLOCY 0.000000 53.00 05300 ANESTHESI OLOCY 0.000000 54.00 05400 RADIOLOCY-DIAGNOSTI C 0.000000 60.00 060000 LABORARORY 0.000000 60.00 66.00 65.00 67.00 06700 ELECTROCARD IOLOGY 0.000000 68.00 06600 PHYSI CAL THERAPY 0.000000 69.00 66000 ELECTROCARD IOLOGY 0.000000 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 72.00 07300 PRUS CHARGED TO PATIENT 0.000000 73.00 07300 PRUS CHARGED TO PATIENT 0.000000 73.00 07300 PRUS CHARGED TO PATIENT 0.000000 73.00 07300 PRUS CHARGED TO PATIENT 0.000000 73.			Title XIX	Hospi tal	Cost	
30. 00 03000 ADULTS & PEDIATRICS 30. 00 31. 00 03100 INTENSIVE CARE UNIT 31. 00 ANCILLARY SERVICE COST CENTERS 43. 00 ANCILLARY SERVICE COST CENTERS 50. 00 50. 00 05000 (DPERTIN G ROM 0. 000000 52. 00 05200 (DELIVERY ROM & LABOR ROM 0. 000000 52. 00 05200 (DELIVERY ROM & LABOR ROM 0. 000000 54. 00 50. 00 52. 00 53. 00 05300 (ANESTHESI OLOGY 0. 000000 54. 00 50. 00 53. 00 60. 00 66000 (DeCy-DI AROSTI C 0. 000000 60. 00 66000 (PHYSI CAL THERAPY 0. 000000 61. 00 6600 OPECHATIONAL THERAPY 0. 000000 62. 00 6600 OPECHATIONAL THERAPY 0. 000000 63. 00 6600 OPECHATIONAL THERAPY 0. 000000 64. 00 6600 OPECHATIONAL THERAPY 0. 000000 65. 00 6600 OPECHATIONAL THERAPY 0. 000000 71. 00 0100 OPECHATIONAL THERAPY 0. 000000 72. 00 72.00 72.00 73.00 73. 00 01200 IMEL CAL SUPPLIES CHARGED TO PATIENTS	Cost Center Description	Ratio				
31. 00 03100 INTENSI VE CARE UNI T 31. 00 43. 00 04300 NURSERY 43. 00 ANCI LLARY SERVICE COST CENTERS 43. 00 50. 00 05000 DPERATI NG ROOM 0. 000000 52. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 000000 52. 00 53. 00 05300 ANSTHESI OLOGY 0. 000000 52. 00 64. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 000000 64. 00 65. 00 06500 RESPI RATORY THERAPY 0. 000000 65. 00 66. 00 06500 RESPI RATORY THERAPY 0. 000000 66. 00 67. 00 06500 SPEECH PATHOLOGY 0. 000000 67. 00 68. 00 06900 ELCTROCARDI OLOGY 0. 000000 67. 00 71. 00 DO TAGNERDI OLOGY 0. 000000 71. 00 72. 00 07200 DRUGS CHARGED TO PATI ENT 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENT 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENT 0. 0000000 72. 00	INPATIENT ROUTINE SERVICE COST CENTERS					
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ANCILLARY SERVICE COST CENTERS 50.00 05000 DEPENTING ROOM 0.000000 52.00 52.00 DESCOPTERY ROOM & LABOR ROOM 0.000000 52.00 53.00 DS300 ANESTHESI OLOGY 0.000000 53.00 54.00 OS400 RADIOLOGY-DI AGNOSTI C 0.000000 54.00 60.00 O6000 LABORATORY 0.000000 60.00 65.00 O6500 RESPI RATORY THERAPY 0.000000 65.00 66.00 O6700 OCCUPATI ONAL THERAPY 0.000000 67.00 67.00 O6700 SECEN PATHOLOCY 0.000000 68.00 68.00 O6800 SPEECH PATHOLOCY 0.000000 68.00 69.00 GETORARDIOLOGY 0.000000 71.00 71.00 OT200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 O7300 PUGS CHARGED TO PATIENTS 0.000000 73.00 000001 SENI OR CARE 0.000000 90.01 91.00 92.00 05200 OLINI C 0.000000 90.01 </td <td>31. 00 03100 I NTENSI VE CARE UNI T</td> <td></td> <td></td> <td></td> <td></td> <td>31.00</td>	31. 00 03100 I NTENSI VE CARE UNI T					31.00
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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 0CCUPATI ONAL THERAPY 0.000000 66.00 68.00 06900 ELECTROCARDI OLOGY 0.000000 68.00 69.00 O6900 ELECTROCARDI OLOGY 0.000000 71.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 73.00 09000 CLI NI C 0.000000 90.01 90.00 99000 SENI OR CARE 0.000000 90.01 91.00 99100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 92.00 95.00 09500 AMBULANCE SERVI CE	53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73.00 0017PATI ENT SERVICE COST CENTERS 0.000000 90.01 73.00 90.01 O9001 SENI OR CARE 0.000000 90.01 91.00 09100 EMERGENCY 0.000000 90.01 92.00 OSERVATI ON BEDS (NON-DI STINCT PART 0.000000 91.00 92.00 OSERVATI ON BEDS (NON-DI STINCT PART 0.000000 92.00 95.00 09500 AMBULANCE SERVI CES 0.000000 92.00 95.00 09500 MBULANCE SERVI CES 0.000000 92.00 95.00 01100 HOME STELENSE	54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
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OUTPATI ENT_SERVICE_COST_CENTERS 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.00 90.01 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 101.00 95.01 95.02	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS					72.00
90.00 09000 CLINIC 0.00000 90.00 90.01 09001 SENIOR 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 0THER REIMBURSABLE COST CENTERS 95.00 95.00 95.00 0100 HOME HEALTH AGENCY 0.000000 95.00 95.00 101.00 HOME HEALTH AGENCY 101.00 101.00 101.00 101.00 113.00 INTEREST EXPENSE 113.00 200.00 201.00 200.00 201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
90. 01 09001 SENI OR CARE 0.000000 90. 01 91. 00 09100 EMERGENCY 0.000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 92. 00 01HER REI MBURSABLE COST CENTERS 95. 00 95. 00 101.00 10100 HOME HEALTH AGENCY 0.000000 95. 00 101.00 10100 HOME HEALTH AGENCY 101. 00 101. 00 101.00 10100 HOME SERVICES 0.000000 95. 00 101.00 10100 HOME SERVICES 0.000000 101.00 101.00 10100 HOME SERVICES 10.00 101.00 200.01 113.00 INTEREST EXPENSE 113. 00 200. 00 201.00 Less Observati on Beds 201. 00 201. 00 201. 00	OUTPATIENT SERVICE COST CENTERS					
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92.00 OP200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 0.000000 95.00 95.00 95.00 101.00 10100 HOME HEALTH AGENCY 0.000000 101.00 101.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 113.00 113.00 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00	90. 01 09001 SENI OR CARE	0. 000000				90.01
0THER REI MBURSABLE COST CENTERS 95.00 9500 AMBULANCE SERVI CES 0.000000 101.00 200.00 200.00 200.00 201.00 <	91.00 09100 EMERGENCY	0.000000				91.00
95. 00 09500 AMBULANCE SERVICES 0.000000 95. 00 101. 00 10100 HOME HEALTH AGENCY 101. 00 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 201. 00 201. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000				92.00
101.00 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 200.00 Subtotal (see instructions) 201.00 Less Observation Beds		0.000000				
113.00 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						101.00
200.00 Subtotal (see instructions) 200.00 200.00 201.00 201.00		1 1				
201.00 Less Observation Beds 201.00						
202.00 Total (see instructions) 202.00						
	202.00 Total (see instructions)					202.00

Health Financial Systems	HARRISON COUN	TY_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL	L COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Pre 5/30/2019 5:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	487, 740	11, 365, 627	0. 04291	4 744, 551	31, 952	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	4, 514	961, 441	0.00469	95 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	1, 769	2, 302, 820	0.00076	68 135, 375	104	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	336, 118	38, 652, 429	0. 00869	828, 744	7, 207	54.00
60. 00 06000 LABORATORY	168, 544	25, 669, 418	0. 00656	6 1, 362, 197	8, 944	60.00
65. 00 06500 RESPI RATORY THERAPY	33, 502	3, 085, 078	0. 01085	59 796, 602	8, 650	65.00
66. 00 06600 PHYSI CAL THERAPY	102, 858	2, 420, 027	0. 04250	444, 100	18, 876	66.00
67.00 06700 OCCUPATIONAL THERAPY	523	247, 021	0. 00211	7 46, 553	99	67.00
68.00 06800 SPEECH PATHOLOGY	195	56, 402	0.00345	57 1, 468	5	68.00
69. 00 06900 ELECTROCARDI OLOGY	66, 075	10, 274, 421	0.00643	380, 295	2, 446	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	130, 192	6, 541, 962	0. 01990	1, 261, 717	25, 109	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 188	3, 159, 052	0.00417	75 986, 587	4, 119	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	58, 772	8, 303, 845	0.00707	1, 008, 423	7, 138	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	80, 566	224, 903	0. 35822	26 0	0	90.00
90. 01 09001 SENI OR CARE	47, 882	757, 714	0.06319	03 0	0	90.01
91. 00 09100 EMERGENCY	335, 319	22, 015, 930	0. 01523	75, 564	1, 151	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	163, 017	4, 083, 899	0. 03991	7 93	4	92.00
OTHER REIMBURSABLE COST CENTERS				· ·		1
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	2, 030, 774	140, 121, 989		8, 072, 269	115, 804	200. 00

Health Financial Systems	HARRI SON COUN			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 01/01/2018 To 12/31/2018		pared: 4 pm
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	I Allied Health	Allied Health	
	Anestheti st	Post-Stepdown	-	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	_		_			
50.00 05000 OPERATING ROOM	0	C		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	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATIONAL 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 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	l o)	0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 SENI OR CARE	0	0)	0 0	0	90.01
91.00 09100 EMERGENCY	0	0)	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS	•			· ·	-	1
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	C		0 0	0	200.00
				1		

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1				-	
50.00 05000 OPERATI NG ROOM	0	0		0 11, 365, 627		•
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 961, 441		
53. 00 05300 ANESTHESI OLOGY	0	0		0 2, 302, 820		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 38, 652, 429		
60. 00 06000 LABORATORY	0	0		0 25, 669, 418		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 3, 085, 078		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 420, 027		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 247, 021		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 56, 402	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 10, 274, 421	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 6, 541, 962	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 3, 159, 052	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 8, 303, 845	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLINIC	0	0		0 224, 903	0.00000	90.00
90. 01 09001 SENI OR CARE	0	0		0 757, 714	0. 000000	90.01
91.00 09100 EMERGENCY	0	0		0 22, 015, 930	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 4, 083, 899	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 140, 121, 989		200. 00

Health Financial Systems	HARRI SON COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	I npati 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	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	0. 000000	744, 551		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	135, 375		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	828, 744		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	1, 362, 197		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	796, 602		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	444, 100		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000	46, 553		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	1, 468		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	380, 295		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 261, 717		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	986, 587		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 008, 423		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	75, 564		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	93		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS]
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		8, 072, 269		0 0	0	200. 00

Health Financial Systems	HARRISON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-1331	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pre	narodi
				10 12/31/2010	5/30/2019 5:4	4 pm
		Title	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			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			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	0.0700.17					
50. 00 O5000 OPERATING ROOM	0. 272047				0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 367593		88		0	
53. 00 05300 ANESTHESI OLOGY	0. 029307		300, 60		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 100914		11, 482, 31		0	54.00
60. 00 06000 LABORATORY	0. 133887		5, 850, 33		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 202895		328, 17		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 274475		474, 61		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 204914		39, 99		0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 374721		22, 37		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 131227		3, 758, 44		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 303998		933, 57		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 451410		174, 70		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 346609	0	3, 166, 96	1, 471	0	73.00
OUTPATIENT SERVICE COST CENTERS	1	1	1			
90. 00 09000 CLINIC	0. 566538		92, 89		0	
90. 01 09001 SENI OR CARE	0. 547678		531, 47		0	
91.00 09100 EMERGENCY	0. 186018		5, 418, 28		0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 347410	0	1, 620, 72	21 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	T		1	_		
95. 00 09500 AMBULANCE SERVICES	0. 456825			0		95.00
200.00 Subtotal (see instructions)		0	36, 425, 04	4 2, 578		200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		_			_	
202.00 Net Charges (line 200 - line 201)	I	0	36, 425, 04	2, 578	0	202.00

Health F	inancial Systems	HARRISON COUN	TY HOSPI TAL		In Lie	In Lieu of Form CMS-2552-10		
APPORTI (DNMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC		Period: From 01/01/2018 To 12/31/2018	5/30/2019 5:4		
				XVIII	Hospi tal	Cost		
		Cos						
	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					
	NCI LLARY SERVICE COST CENTERS							
	5000 OPERATING ROOM	606, 309					50.00	
	5200 DELIVERY ROOM & LABOR ROOM	325	0				52.00	
	5300 ANESTHESI OLOGY	8, 810	0				53.00	
	5400 RADI OLOGY-DI AGNOSTI C	1, 158, 726	0				54.00	
		783, 284	0				60.00	
	6500 RESPI RATORY THERAPY	66, 585	0				65.00	
	6600 PHYSI CAL THERAPY	130, 271	0				66.00	
	6700 OCCUPATI ONAL THERAPY	8, 196					67.00	
	6800 SPEECH PATHOLOGY	8, 383					68.00	
	6900 ELECTROCARDI OLOGY	493, 210					69.00	
	7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	283, 804					71.00	
	7200 IMPL. DEV. CHARGED TO PATIENTS	78, 861	0				72.00	
	7300 DRUGS CHARGED TO PATIENTS	1, 097, 698	510				73.00	
	UTPATIENT SERVICE COST CENTERS	F2 (20	0					
		52, 629					90.00	
	9001 SENI OR CARE	291,074					90.01	
		1,007,899					91.00	
	9200 OBSERVATION BEDS (NON-DISTINCT PART	563, 055	0				92.00	
	THER REI MBURSABLE COST CENTERS 9500 AMBULANCE SERVI CES	0					95.00	
		-	71/					
200.00	Subtotal (see instructions)	6, 639, 119	716				200. 00 201. 00	
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0					201.00	
202 00		6 620 110	716				202 00	
202.00	Net Charges (line 200 - line 201)	6, 639, 119	/16				202.00	

Health Financial Systems	HARRI SON COUN	TY HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1331	Peri od:	Worksheet D	
		Component		From 01/01/2018		norod.
		Component	CCN: 15-Z331	To 12/31/2018	Date/Time Pre 5/30/2019 5:4	
		Title	e XVIII	Swing Beds - SNF		<u>, built</u>
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 272047	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 367593	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 029307	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 100914	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 133887	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 202895	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 274475	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 204914	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 374721	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 131227	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 303998	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 451410	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 346609	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0. 566538	0		0 0	0	90.00
90. 01 09001 SENI OR CARE	0. 547678	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 186018	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 347410	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	•		•			1
95. 00 09500 AMBULANCE SERVI CES	0. 456825			0		95.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL			n Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC Component C	CN: 15-1331 CCN: 15-Z331	Period: From 01/01, To 12/31,			
			XVIII	Swing Beds	CNE	5/30/2019 5:4 Cost	+4 pili
	Cos			Swilly beus	- 3NF	COST	
Cost Center Description	Cost	Cost					
Cost Center Description	Reimbursed	Reimbursed					
	Servi ces	Servi ces 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	0					50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00 05300 ANESTHESI OLOGY	0	0					53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0					54.00
60. 00 06000 LABORATORY	0	0					60.00
65. 00 06500 RESPI RATORY THERAPY	0	0					65.00
66, 00 06600 PHYSI CAL THERAPY	0	0					66,00
67.00 06700 OCCUPATI ONAL THERAPY	0	0					67.00
68.00 06800 SPEECH PATHOLOGY	0	0					68.00
69.00 06900 ELECTROCARDI OLOGY	0	0					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0					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	0					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	0					200.00
201.00 Less PBP Clinic Lab. Services-Program	0						201.00
Only Charges							
202.00 Net Charges (line 200 - line 201)	0	0					202.00

Health Financial Systems	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		Period: From 01/01/2018 To 12/31/2018		
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 272047		135, 59		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 367593			0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 029307		24, 12		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 100914		435, 05		0	
60. 00 06000 LABORATORY	0. 133887		322, 98	31 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 202895		29, 89	01 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 274475	0	16, 46	07 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 204914	0	63	35 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 374721	0	8, 09	95 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 131227	0	93, 86	03 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 303998	0	111, 92	22 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 451410	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 346609	0	49, 23	39 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 566538	0	49	02 0	0	90.00
90. 01 09001 SENI OR CARE	0. 547678	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 186018	0	386, 27	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 347410	0	116, 35	51 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 456825	0		0		95.00
200.00 Subtotal (see instructions)		0	1, 730, 98	34 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		c	1, 730, 98	34 0	0	202.00

Heal th	Financial Systems	HARRISON COUN	TY HOSPITAL		In Lieu of Form CMS-2552-10			
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C			Worksheet D Part V Date/Time Pro 5/30/2019 5:4		
				e XIX	Hospi tal	Cost		
		Cos						
	Cost Center Description	Cost	Cost					
		Reimbursed	Reimbursed					
		Servi ces	Services Not					
		Subject To	Subject To					
		Ded. & Coins.	Ded. & Coins.					
		(see inst.)	(see inst.) 7.00					
	ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				_	
	05000 OPERATING ROOM	36, 888	0				50.00	
	05200 DELIVERY ROOM & LABOR ROOM	30,000	0				52.00	
	05300 ANESTHESI OLOGY	707	0				53.00	
	05400 RADI OLOGY-DI AGNOSTI C	43, 904					54.00	
	06000 LABORATORY	43, 704					60.00	
	06500 RESPI RATORY THERAPY	6,065	0				65.00	
	06600 PHYSI CAL THERAPY	4, 520					66.00	
	06700 OCCUPATI ONAL THERAPY	130					67.00	
	06800 SPEECH PATHOLOGY	3, 033					68.00	
	06900 ELECTROCARDI OLOGY	12, 317	0				69.00	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	34, 024	0				71.00	
	07200 IMPL. DEV. CHARGED TO PATIENTS	01,021	0				72.00	
	07300 DRUGS CHARGED TO PATIENTS	17,067	0				73.00	
	OUTPATIENT SERVICE COST CENTERS			1				
	09000 CLI NI C	279	0				90.00	
90.01	09001 SENI OR CARE	0	0				90.01	
91.00	09100 EMERGENCY	71, 853	0				91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	40, 422	0				92.00	
	OTHER REIMBURSABLE COST CENTERS			•				
95.00	09500 AMBULANCE SERVI CES	0					95.00	
200.00	Subtotal (see instructions)	314, 452	0				200.00	
201.00	Less PBP Clinic Lab. Services-Program	0					201.00	
	Only Charges							
202.00	Net Charges (line 200 - line 201)	314, 452	0				202.00	

	Financial Systems HARRISON COUNTY ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1331	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2018 To 12/31/2018		
		Title XVIII	Hospi tal	5/30/2019 5:44 Cost	4 pm
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS			F F/F	 1.
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			5, 565 5, 491	2.
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ave)		4, 388	4.
00	Total swing-bed SNF type inpatient days (including private ro	5 /	er 31 of the cost	4, 566	
00	reporting period	am dava) aftar Dacambar	21 of the east	0	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	Join days) after December	31 OF THE COST	0	6.
00	Total swing-bed NF type inpatient days (including private roc	om days) through December	- 31 of the cost	20	7.
00	reporting period Total swing-bed NF type inpatient days (including private roo	om davs) after December 3	31 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)			-	
00	Total inpatient days including private room days applicable t newborn days)	to the Program (excluding	g swing-bed and	1, 972	9.
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII c		room days)	54	10.
I. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII of		com dave) after	0	11.
1.00	December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	
2.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	te room days)	0	12
3. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	13
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
7.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	res through December 31 (of the cost		17
	reporting period	C			''
3. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost		18
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	158. 12	19
). 00	reporting period Medicaid rate for swing-bed NF services applicable to service	as after December 21 of t	the cost	0.00	20
. 00	reporting period		the cost	0.00	20
	Total general inpatient routine service cost (see instruction			7, 135, 716	
2.00	Swing-bed cost applicable to SNF type services through Decemb 5×10^{-1} x line 17)	per 31 of the cost report	ting period (line	0	22
3. 00	Swing-bed cost applicable to SNF type services after December	⁻ 31 of the cost reportin	ng period (line 6	0	23
1.00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	na period (line	3, 162	24
	7 x line 19)		0 1 1		
5.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25
	Total swing-bed cost (see instructions)			72, 622	
7.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		7, 063, 094	27
3. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0. 000000	
	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 mi	, ,	CTIONS)	0.00	
5.00 5.00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00 0	35. 36.
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	7, 063, 094	
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	JUSTMENTS			
3. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			1, 286. 30	38
		e instructions) e 38)		1, 286. 30 2, 536, 584 0	

COMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	HARRISON COUN	Provider C	CN: 15-1331	Peri od:	u of Form CMS- Worksheet D-1	
					From 01/01/2018 To 12/31/2018		
				e XVIII	Hospi tal	5/30/2019 5:4 Cost	4 pm
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
42.00	NURSERY (title V & XIX only)	0					42.0
	Intensive Care Type Inpatient Hospital Units						
13.00	INTENSIVE CARE UNIT	966, 844	324	2, 984.	09 158	471, 486	
14.00 15.00	CORONARY CARE UNI T BURN INTENSIVE CARE UNI T						44.0 45.0
46.00	SURGICAL INTENSIVE CARE UNIT						46.0
47.00	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1 00	
18.00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)			1.00 2,008,577	48.0
19.00	Total Program inpatient costs (sum of lines			ons)		5, 016, 647	
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, su	m of Parts I and	0	50.0
51.00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	0	51.0
	and IV)		, , , , , , , , , , , , , , , , , , ,				
52.00	Total Program excludable cost (sum of lines		lated non rt-		botict and	0	
53.00	Total Program inpatient operating cost exclu- medical education costs (line 49 minus line 4		erated, non-phy	sician anest	netist, and	0	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	()					
54.00	Program di scharges					0	
5.00 6.00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	
7.00	Difference between adjusted inpatient operat	ng cost and ta	raet amount (I	ine 56 minus	line 53)	0	
8.00	Bonus payment (see instructions)		0				
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996, ι	updated and c	ompounded by the	0.00	59.0
50.00	market basket Lesser of lines 53/54 or 55 from prior year	rost report up	dated by the m	arket basket		0.00	60.0
51.00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% o	f the target		
62.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	nstructions)				0	62.0
52.00 53.00	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
54.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost report	ing period (See	69, 460	64.0
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the o	cost reportin	a period (See	0	65.0
	instructions)(title XVIII only)					_	
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVI	ll only). For	69, 460	66.0
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost r	eporting period	0	67.0
071 00	(line 12 x line 19)	0					
68.00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 0
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient =	coutine costs (line 67 + line	· 68)		0	69.0
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PART III - SKILLED NURSING FACILITY, OTHER NU					0	07.0
70.00	Skilled nursing facility/other nursing facili	5)		70. C
71.00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.0
72.00 73.00	Program routine service cost (line 9 x line Medically necessary private room cost application		(line 14 x li	ne 35)			72.0
74.00	Total Program general inpatient routine service						74.0
75.00	Capital-related cost allocated to inpatient	routine service	costs (from V	lorksheet B,	Part II, column		75. C
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.0
7.00	Program capital -related costs (line 9 x line						77.0
8.00	Inpatient routine service cost (line 74 minus	,					78.0
9.00	Aggregate charges to beneficiaries for excess	· ·		,			79.0
0.00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		ost limitation	i (iine /8 mi	nus line 79)		80.0
2.00	Inpatient routine service cost per drem rim)				82.0
3. 00	Reasonable inpatient routine service costs (see instruction					83.0
34.00	Program inpatient ancillary services (see ins						84.0
35.00 36.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.0
.0.00	PART IV - COMPUTATION OF OBSERVATION BED PASS						00.0
37.00	Total observation bed days (see instructions))					87.0
88.00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	•				1, 286. 30 1, 418, 789	
10 00							

Health Financial Systems	HARRI SON COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		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	819, 885	7, 135, 716	0. 11489	9 1, 418, 789	163, 017	90.00
91.00 Nursing School cost	0	7, 135, 716	0.00000	0 1, 418, 789	0	91.00
92.00 Allied health cost	0	7, 135, 716	0.00000	0 1, 418, 789	0	92.00
93.00 All other Medical Education	0	7, 135, 716	0.00000	0 1, 418, 789	0	93.00

	Financial Systems HARRISON COUNTY ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1331	Period: From 01/01/2018	u of Form CMS-2 Worksheet D-1 Date/Time Pre	
		Title VIV		5/30/2019 5:4	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS			5 5 (5	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			5, 565 5, 491	1.
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ned days)		4, 388	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	4, 566	5
00	reporting period Total swing-bed SNF type inpatient days (including private ro	om dave) after December	21 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	Join days) arter beceniber	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	~ 31 of the cost	20	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	om davs) after December (31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable t newborn days)	to the Program (excluding	g swing-bed and	81	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10
. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	5 1	-	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including priva	te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
. 00	after December 31 of the cost reporting period (if calendar) Medically necessary private room days applicable to the Progr			0	14
. 00	Total nursery days (title V or XIX only)	an (excluding swing-bed	uays)	859	
. 00	Nursery days (title V or XIX only)			26	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (of the cost		17
~~~	reporting period				
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	158.12	20
~~~	reporting period	、 、			
. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	7, 135, 716 0	21
	5 x line 17)			-	
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	⁻ 31 of the cost reportin	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25
	x line 20)			C .	
o. 00 7. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		69, 491 7, 066, 225	
. 00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			7,000,223	21
	General inpatient routine service charges (excluding swing-be	ed and observation bed cl	narges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	31
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 7, 066, 225	36
	27 minus line 36)				1 .
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	IUSTMENTS			-
	Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 286. 87	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		104, 236 0	39 40
	Medically necessary private room cost applicable to the Progr			0	1 40

	Financial Systems TATION OF INPATIENT OPERATING COST	HARRI SON COUNT				Peri od:	eu of Form CMS- Worksheet D-1	
						From 01/01/2018 To 12/31/2018		
	Cost Center Description	Total Inpatient Costl 1.00	Total		e XIX Average Per Diem (col. 1 <u>col. 2)</u> 3.00	Hospital Program Days ÷ 4.00	Cost Program Cost (col. 3 x col. 4) 5.00	
42.00	NURSERY (title V & XIX only)	601, 831		859	700.6	2 20	5 18, 216	42.00
43.00 44.00 45.00 46.00 47.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description	966, 844		324	2, 984. C	9 1		6 43.00 44.00 45.00 46.00 47.00
49.00	Program inpatient ancillary service cost (Wks	t D 2 col 2	Line 200)				1.00	3 48.00
48.00 49.00	Total Program inpatient costs (sum of lines 4				าร)		289, 460	
	PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpa	atient routine s	services (f	rom	Wkst. D, sum	of Parts I and	C	50.00
51.00	Pass through costs applicable to Program inpa and IV)	atient ancillary	y services	(fro	om Wkst. D, s	um of Parts II	C	51.00
52.00 53.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclude medical education costs (line 49 minus line 9 TAPCT AUGUNT AUGUNT AUGUNT	ling capital rel	lated, non-	phys	sician anesth	etist, and	(
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program di scharges							54.00
55.00	Target amount per discharge							55.00
56.00	Target amount (line 54 x line 55)			<i>(</i> 1 :		1: 52)	0	
57.00 58.00	Difference between adjusted inpatient operati Bonus payment (see instructions)							
59.00	9.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							59.00
 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 							0.00	1
62. 00 63. 00	62.00 Relief payment (see instructions)							62.00 63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	s through Decer	mber 31 of	the	cost reporti	na period (See	C	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost							
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line d	64 plus lin	e 65	5)(title XVII	l only). For	C	66.00
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	5				51	C	67.00
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)					rting period	C	
69.00	Total title V or XIX swing-bed NF inpatient i PART III - SKILLED NURSING FACILITY, OTHER NU				,		0	69.00
70.00								70.00
71.00	Adjusted general inpatient routine service co		ine 70 ÷ li	ne 2	2)			71.00
72.00 73.00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica	,	(line 14 x	lir	ne 35)			72.00
74.00 75.00	Total Program general inpatient routine servi Capital -related cost allocated to inpatient	ce costs (line	72 + line	73)	,	art II, column		74.00 75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)						76.00
77.00	Program capital -related costs (line 9 x line							77.00
78.00	Inpatient routine service cost (line 74 minus							78.00
79.00	00 0							79.00
80.00 81.00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ust limitat	i on	(iine /8 min	us line 79)		80.00 81.00
82.00	Inpatient routine service cost per drem rim)					82.00
83.00	Reasonable inpatient routine service costs (s	see instructions						83.00
84.00	Program inpatient ancillary services (see ins		n c)					84.00
85.00 86.00	1.5							85.00 86.00
30.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 65)				1	00.00
87.00	Total observation bed days (see instructions)							87.00
88.00	Adjusted general inpatient routine cost per (line 2)				1, 286. 87	
07. UU	Observation bed cost (line 87 x line 88) (see	= instructions)					1, 419, 418	ol 02.00

Health Financial Systems	HARRI SON COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Titl	e XIX	Hospi tal	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	819, 885	7, 135, 716	0. 11489	9 1, 419, 418	163, 090	90.00
91.00 Nursing School cost	0	7, 135, 716	0.00000	0 1, 419, 418	0	91.00
92.00 Allied health cost	0	7, 135, 716	0.00000	0 1, 419, 418	0	92.00
93.00 All other Medical Education	0	7, 135, 716	0.00000	0 1, 419, 418	0	93.00

Health Financial Systems HARRISON C	OUNTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1331	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Pre 5/30/2019 5:4	pared:
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			2, 959, 937		30.00
31. 00 03100 I NTENSI VE CARE UNI T			433, 552		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		1			
50.00 05000 OPERATI NG ROOM		0. 2720		202, 553	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3675		0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 02930		3, 967	
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 1009		83, 632	
60. 00 06000 LABORATORY		0. 1338		182, 380	
65. 00 06500 RESPI RATORY THERAPY		0. 2028		161, 627	
66. 00 06600 PHYSI CAL THERAPY		0. 2744		121, 894	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2049	14 46, 553	9, 539	
68.00 06800 SPEECH PATHOLOGY		0. 37472		550	
69. 00 06900 ELECTROCARDI OLOGY		0. 1312	27 380, 295	49, 905	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3039	98 1, 261, 717	383, 559	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4514	10 986, 587	445, 355	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3466	09 1, 008, 423	349, 528	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 5665	38 0	0	90.00
90. 01 09001 SENI OR CARE		0. 5476	78 0	0	90. 01
91. 00 09100 EMERGENCY		0. 1860	18 75, 564	14, 056	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3474	10 93	32	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 through 9	8)		8, 072, 269	2, 008, 577	200.00
201.00 Less PBP Clinic Laboratory Services-Program only c	harges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			8, 072, 269		202.00

Health Financial Systems	HARRISON COUNTY HOSPITAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period:	Worksheet D-3	
	Component		From 01/01/2018 To 12/31/2018	Date/Time Pre	nared
	component	56N. 15 2551	10 12/31/2010	5/30/2019 5:4	
	Title		Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
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 SERVICE COST CENTERS			1		
50. 00 05000 OPERATI NG ROOM		0. 27204	7 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 36759	3 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 02930	7 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 10091		223	54.00
60. 00 06000 LABORATORY		0. 13388		679	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 20289		461	
66.00 06600 PHYSI CAL THERAPY		0. 27447		11, 366	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 20491		3, 004	
68. 00 06800 SPEECH PATHOLOGY		0. 37472		0	68.00
69.00 06900 ELECTROCARDI OLOGY		0. 13122		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 30399 0. 45141		1, 144	71.00 72.00
73. 00 07200 DRUGS CHARGED TO PATIENTS		0. 34660		3, 653	72.00
OUTPATIENT SERVICE COST CENTERS		0. 34000	7 10, 557	5,005	73.00
90. 00 09000 CLINIC		0. 56653	8 0	0	90.00
90. 01 09001 SENI OR CARE		0. 54767		0	90.01
91. 00 09100 EMERGENCY		0. 18601		153	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 34741		0	
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96			80, 746	20, 683	
201.00 Less PBP Clinic Laboratory Services-Prog	ram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		l	80, 746		202.00

Health Financial Systems HARF	RISON COUNTY HOSPITAL		In Li	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1331	Period: From 01/01/2018 To 12/31/2018		pared:
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			164, 193	3	30.00
31. 00 03100 I NTENSI VE CARE UNI T			30, 184	t	31.00
43. 00 04300 NURSERY			63, 117	7	43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 2720	47 76, 481	20, 806	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3675	93 23, 357	8, 586	52.00
53. 00 05300 ANESTHESI OLOGY		0. 02930	27, 235	798	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1009	14 45, 660	4,608	54.00
60. 00 06000 LABORATORY		0. 1338			60.00
65. 00 06500 RESPI RATORY THERAPY		0. 2028	95 50, 646	10, 276	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 2744	75 17,054	4, 681	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 2049			67.00
68.00 06800 SPEECH PATHOLOGY		0. 3747			68,00
69. 00 06900 ELECTROCARDI OLOGY		0. 1312		1,804	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3039			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4514			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 34660		15, 758	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 5665	38 (0 0	90.00
90. 01 09001 SENI OR CARE		0. 5476	78 (0 0	90.01
91. 00 09100 EMERGENCY		0. 1860	18 27, 262	5, 071	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.3474			
OTHER REIMBURSABLE COST CENTERS				1	
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 thr	ough 98)		587, 987	134, 183	
201.00 Less PBP Clinic Laboratory Services-Program			(201.00
202.00 Net charges (line 200 minus line 201)	5 - 5 - 7		587, 987	7	202.00

Health Financial Systems HARRISON	COUNTY HOSPITAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
	Component	CCN: 15-Z331	From 01/01/2018 To 12/31/2018		
		e XIX	Swing Beds - SNF	5/30/2019 5:4 Cost	4 pili
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
				(col. 1 x col.	
			5	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	-		
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS				-	
50. 00 05000 OPERATING ROOM		0. 27204		0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.36759		0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 02930		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 10091		0	54.00
60. 00 06000 LABORATORY		0. 13388		0	60.00
65. 00 06500 RESPIRATORY THERAPY		0. 20289		0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 27447		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 20491		0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0. 37472		0	68.00 69.00
69.00 06900 ELECTROCARDIOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 13122		0	69.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 30399		-	72.00
72.00 07200 TMPL. DEV. CHARGED TO PATTENTS 73.00 07300 DRUGS CHARGED TO PATTENTS		0. 34660		0	72.00
OUTPATIENT SERVICE COST CENTERS		0. 34000	0	0	/3.00
90. 00 09000 CLINIC		0. 56653	8 0	0	90.00
90. 01 09001 SENI OR CARE		0. 54767		0	90.00
91. 00 09100 EMERGENCY		0. 18601		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 34741		0	92.00
OTHER REIMBURSABLE COST CENTERS		0. 54741	0 0	0	72.00
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through	98)		0	0	200.00
201.00 Less PBP Clinic Laboratory Services-Program only			0	, i i i i i i i i i i i i i i i i i i i	201.00
202.00 Net charges (line 200 minus line 201)			0		202.00
		-			-

	Financial Systems HARRISON COUNTY HOSE ATION OF REIMBURSEMENT SETTLEMENT Pro	ovider CCN: 15-1331	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2018 To 12/31/2018		
		Title XVIII	Hospi tal	5/30/2019 5:44 Cost	4 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions	c)		6, 639, 835 0	1.0 2.0
2.00 3.00	OPPS payments	5)		0	3.0
4.00	Outlier payment (see instructions)			0	4.0
4.01	Outlier reconciliation amount (see instructions)	、 、		0	4.C
5.00 5.00	Enter the hospital specific payment to cost ratio (see instruction Line 2 times line 5	ns)		0. 000 0	5. C
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
3.00	Transitional corridor payment (see instructions)			0	8.0
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, o	col. 13, line 200		0	9.0
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 6, 639, 835	10. C
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			0,007,000	11.0
	Reasonabl e charges				1 4 0 0
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line (69)		0	12.0 13.0
14.00	Total reasonable charges (sum of lines 12 and 13)	57)		0	
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for payme Amounts that would have been realized from patients liable for pay			0	15.0 16.0
16.00	had such payment been made in accordance with 42 CFR §413.13(e)	yment for services t	ni a charyebasis	0	10.0
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.00000	17. C
	Total customary charges (see instructions)			0	18. C
19.00	Excess of customary charges over reasonable cost (complete only in instructions)	Fline 18 exceeds li	ne 11) (see	0	19. C
20.00	Excess of reasonable cost over customary charges (complete only in	fline 11 exceeds li	ne 18) (see	0	20.0
	instructions)		, .		
21.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			6, 706, 233 0	
	Cost of physicians' services in a teaching hospital (see instructi	ions)		0	23.0
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. C
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			75 502	25.0
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24	(for CAH, see instr	ructions)	75, 583 6, 125, 801	25.0
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			504, 849	
00.00	instructions)	50)			200
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, line ESRD direct medical education costs (from Wkst. E-4, line 36)	50)		0	28.0 29.0
30.00				504, 849	
31.00	Primary payer payments			956	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			503, 893	32. C
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)			0	33.0
34.00	Allowable bad debts (see instructions)			893, 021	34.0
35.00	Adjusted reimbursable bad debts (see instructions)			580, 464	35.0
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instructi Subtotal (see instructions)	I ONS)		711, 413 1, 084, 357	
38.00	MSP-LCC reconciliation amount from PS&R			1,004,337	38.0
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.0
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.5
39.97	Demonstration payment adjustment amount before sequestration	dovicos (soo instau	stions)	0	39.9
39.98 39.99	Partial or full credits received from manufacturers for replaced or RECOVERY OF ACCELERATED DEPRECIATION	Jevices (See Instruc		0	39.9
10.00	Subtotal (see instructions)			1, 084, 357	40.0
0.01	Sequestration adjustment (see instructions)			21, 687	40.0
	Demonstration payment adjustment amount after sequestration			0 1 024 547	
1.00 2.00	Interim payments Tentative settlement (for contractors use only)			1, 924, 547 0	41. C
43.00	Balance due provi der/program (see instructions)			-861, 877	43.0
44.00	Protested amounts (nonallowable cost report items) in accordance w	with CMS Pub. 15-2,	chapter 1,	0	44.0
	§115.2 TO BE COMPLETED BY CONTRACTOR				
				0	90. C
90. 00	Original outlier amount (see instructions)				
90.00 91.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	91.0
				0	91.0 92.0 93.0

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1331	Period: From 01/01/2018 To 12/31/2018	om 01/01/2018 Part I	
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Pai	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		4, 222, 3	02	1, 924, 547	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER	08/13/2018	175, 4	00	0	3
)2		00, 10, 2010		0	0	3
03				0	0	3
04				0	0	3
05				0	0	3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		175, 4	00	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 397, 7	02	1, 924, 547	4
00	(transfer to Wkst. E or Wkst. E-3, line and column as		4, 377, 7	02	1, 724, 347	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
0.1	Program to Provider			0		.
01 02	TENTATI VE TO PROVIDER			0	0	5
)2)3				0	0	5
55	Provider to Program			0	0	
50	TENTATI VE TO PROGRAM			0	0	1 5
51				0	0	
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)		40.7	10		,
01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		43, 6	0	0	6
02 00	Total Medicare program liability (see instructions)		4, 441, 3	-	861, 877 1, 062, 670	
50			4, 441, 3	Contractor	NPR Date	+ '
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	
00	Name of Contractor					8

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C		Period: From 01/01/2018		
		Component	CCN: 15-Z331	To 12/31/2018	Date/Time Pre 5/30/2019 5:4	eparec 14 nm
		Title	XVIII	Swing Beds - SN		
		I npati en	t Part A	Pai	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		90, 91	7	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					J J.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0	0	
)2				0	0	
03				0	0	
04				0	0	
)5	Dravidar to Dragram			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)		90, 91	7	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					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider				1	
)1	TENTATI VE TO PROVI DER			0	0	
)2)3				0		
55	Provider to Program			0	0	1 3
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
)1	the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6
)2	SETTLEMENT TO PROVIDER		1, 69	-	0	
)2)0	Total Medicare program liability (see instructions)		89, 22			
				Contractor	NPR Date	1
				Number	(Mo/Day/Yr)	
)	1.00	2.00	1

Heal th	Financial Systems HARRISON CO	DUNTY HOSPITAL	In Lie	u of Form CMS	-2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1331 Period: From 01/01/2018 P To 12/31/2018 5					
		Title XVIII	Hospi tal	Cost		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORT				_	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULA				1.00	
1.00						
2.00						
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12					
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 20				5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col.				6.00	
7.00	CAH only - The reasonable cost incurred for the purchase line 168	of certified HIT technology	Wkst. S-2, Pt. I		7.00	
8.00	Calculation of the HIT incentive payment (see instruction	ns)			8.00	
9.00	Sequestration adjustment amount (see instructions)				9.00	
10.00	Calculation of the HIT incentive payment after sequestra	tion (see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	30.00 Initial/interim HIT payment adjustment (see instructions)					
31.00	Other Adjustment (specify)				31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 a	and line 31) (see instructior	is)		32.00	

LCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1331	Period:	Worksheet E-2	
		Component CCN: 15-Z331	From 01/01/2018 To 12/31/2018	Date/Time Pre	
		Title XVIII	Swing Beds – SNF	5/30/2019 5:44 Cost	4 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)		70, 155	0	1.
00	Inpatient routine services - swing bed-NF (see instructions)				2.
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		20, 890	0	3.
00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins Per diem cost for interns and residents not in approved teachi			0.00	4.
00	instructions)	ng program (see		0.00	4.
00	Program days		54	0	5.
00	Interns and residents not in approved teaching program (see in	nstructions)		0	
00	Utilization review - physician compensation - SNF optional met	thod only	0		7.
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		91, 045	0	8
00	Primary payer payments (see instructions)		0	0	
. 00	Subtotal (line 8 minus line 9)		91, 045	0	
. 00	Deductibles billed to program patients (exclude amounts applic professional services)	cable to physician	0	0	11
. 00	Subtotal (line 10 minus line 11)		91, 045	0	12
. 00	Coinsurance billed to program patients (from provider records)) (exclude coinsurance	91,045	0	
	for physician professional services)		Ŭ	Ű	''
. 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 1	14)	91, 045	0	15
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
. 50	Pioneer ACO demonstration payment adjustment (see instructions				16
. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16
. 99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	0	16
	Allowable bad debts (see instructions)		0	0	
01	Adjusted reimbursable bad debts (see instructions)		0	0	
. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	
. 00	Total (see instructions)		91, 045	0	19
	Sequestration adjustment (see instructions)		1, 821	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
	Interim payments		90, 917	0	
	Tentative settlement (for contractor use only)	and 21)	1 (02	0	
. 00 . 00	Balance due provider/program (line 19 minus lines 19.01, 20, a Protested amounts (nonallowable cost report items) in accordar	-	-1, 693	0	
. 00	chapter 1, §115.2	ice wi th cm3 rub. 13-2,	0	0	25
	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adjustment			
	Is this the first year of the current 5-year demonstration per				200
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				1201
1.00	Medicare swing-bed SNF inpatient routine service costs (from V	NKST. D-I, PT. II, IINE			201
2 00	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst D-3 col 3 line	_		202
2.00	200 (title XVIII swing-bed SNF))				202
3. 00	Total (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)				204
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the current	nt 5-year demonst	ration	
	period) Medicare swing-bed SNF target amount				1205
	Medicare swing-bed SNF target amount Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			205 206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				200
	Program reimbursement under the §410A Demonstration (see instr				207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2		1		208
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209
	Reserved for future use				210
	Comparision of PPS versus Cost Reimbursement				1

LCULA	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1331	Peri od:	Worksheet E-2
		Component CCN: 15-Z331	From 01/01/2018 To 12/31/2018	Date/Time Prepar 5/30/2019 5:44 p
		Title XIX	Swing Beds - SNF	
			Part A	Part B
			1.00	2.00
	COMPUTATION OF NET COST OF COVERED SERVICES		I	
	Inpatient routine services - swing bed-SNF (see instructions)		0	
	Inpatient routine services - swing bed-NF (see instructions)		0	
	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 Per diem cost for interns and residents not in approved teachi		0.00	
	instructions)		0.00	
	Program days		0	
00	Interns and residents not in approved teaching program (see ir	nstructions)	0	
00	Utilization review - physician compensation - SNF optional met	hod only	0	
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	
	Primary payer payments (see instructions)		0	
	Subtotal (line 8 minus line 9)		0	1
	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	1
	professional services)		0	1
	Subtotal (line 10 minus line 11) Coinsurance billed to program patients (from provider records)	(oveludo, coi neuranco	0	1
	for physician professional services)	(exclude corrisulance	0	
	80% of Part B costs (line 12 x 80%)		0	1
	Subtotal (enter the lesser of line 12 minus line 13, or line 1	4)	0	1
	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)			
	Demonstration payment adjustment amount before sequestration		0	1
	Allowable bad debts (see instructions)		0	1
	Adjusted reimbursable bad debts (see instructions)		0	1
	Allowable bad debts for dual eligible beneficiaries (see instr Total (see instructions)	uctions)	0	1
	Sequestration adjustment (see instructions)		0	1
	Demonstration payment adjustment amount after sequestration)		0	1
	Interim payments		0	2
	Tentative settlement (for contractor use only)		0	2
. 00	Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	0	2
. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	0	2
	chapter 1, §115.2			
	Rural Community Hospital Demonstration Project (§410A Demonstr			
	Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	riod under the 21st		20
	Cost Reimbursement			
	Medicare swing-bed SNF inpatient routine service costs (from W	Kst. 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 period)	TIRST year of the curre	ent 5-year demonst	ration
- F	Medicare swing-bed SNF target amount			20
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 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	·	1	20
	and 3)			
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)		20
	Reserved for future use			21
	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line 2			
				21

	Financial Systems HARRISON COUNT			u of Form CMS-2	
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1331	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/30/2019 5:4	pared:
		Title XVIII	Hospi tal	Cost	
				1.00	
1 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	RE PART A SERVICES - CUST	REIMBURSEMENT	E 014 447	1 1 00
1.00 2.00	Inpatient services Nursing and Allied Health Managed Care payment (see instruct	ti onc)		5, 016, 647 0	1.00
2.00	Organ acqui si ti on	LI OIIS)		0	3.00
4.00	Subtotal (sum of lines 1 through 3)			5, 016, 647	4.00
5.00	Primary payer payments			6, 545	
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			5, 060, 268	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			0,000,200	
	Reasonable charges				1
7.00	Routi ne servi ce charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11.00	Aggregate amount actually collected from patients liable for			0	
12.00	Amounts that would have been realized from patients liable f		on a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13((e)			
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete c instructions)	only if line 14 exceeds li	ne 6) (see	0	15.00
16.00	Excess of reasonable cost over customary charges (complete o	only if line 6 exceeds lin	0 14) (500	0	16.00
10.00	instructions)	Shi y 11 11he o exceeds 111	(366	0	10.00
17.00		structions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
18.00	Direct graduate medical education payments (from Worksheet E	E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			5, 060, 268	19.00
20.00	Deductibles (exclude professional component)			545, 299	20.00
21.00	Excess reasonable cost (from line 16)			0	
22.00	Subtotal (line 19 minus line 20 and 21)			4, 514, 969	
23.00	Coinsurance			335	
24.00	Subtotal (line 22 minus line 23)			4, 514, 634	
25.00	Allowable bad debts (exclude bad debts for professional serv	/ices) (see instructions)		26, 644	
26.00	Adjusted reimbursable bad debts (see instructions)			17, 319	
27.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		15, 723	
28.00 29.00	Subtotal (sum of lines 24 and 25, or line 26)			4, 531, 953	28.00 29.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	>		0	
29.50 29.99	Pioneer ACO demonstration payment adjustment (see instruction			0	
29.99	Demonstration payment adjustment amount before sequestration Subtotal (see instructions)	1		4, 531, 953	
30.00	Sequestration adjustment (see instructions)			4, 531, 953	
30.01	Demonstration payment adjustment amount after sequestration			90, 839	30.0
31.00	Interim payments			4, 397, 702	
32.00	Tentative settlement (for contractor use only)			4, 397, 702	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.	02. 31. and 32)		43, 612	
34.00	Protested amounts (nonallowable cost report items) in accord		chapter 1.	43, 012	34.00
	§115. 2				

	Financial Systems HARRISON COUN SHEET (If you are nonproprietary and do not maintain	Provider C		In Lie eriod:	Worksheet G	
nd-ty Iy)	pe accounting records, complete the General Fund column			rom 01/01/2018 o 12/31/2018	Date/Time Pre 5/30/2019 5:4	
		General Fund	Purpose Fund	Endowment Fund	Plant Fund	
0	CURRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	1, 382, 969	0	0	0	1 1
	Temporary investments	1, 126, 303		-	0	
	Notes receivable	0	Ő	-	0	
	Accounts receivable	30, 903, 275		-	0	
00	Other recei vabl e	610, 430		0	0	5
00	Allowances for uncollectible notes and accounts receivable	-22, 522, 204	0	0	0	6
00	Inventory	1, 264, 855	0	0	0	7
	Prepaid expenses	629, 899	0	0	0	
	Other current assets	0	0	-	0	
	Due from other funds	0	0	-	0	
	Total current assets (sum of lines 1-10)	13, 395, 527	0	0	0	11
	FI XED ASSETS	2 001 120			0	1 1 2
	Land	3,001,138			0	
	Land improvements Accumulated depreciation	3, 379, 433 -2, 382, 005		-	0	
	Buildings	41, 249, 261		-	0	
	Accumul ated depreciation	-22, 004, 768		-	0	
	Leasehold improvements	3, 605, 135		-	0	
	Accumul ated depreciation	-2, 154, 381		-	0	
	Fixed equipment	2, 134, 301	0	-	0	
	Accumul ated depreciation	0	Ő		0	
	Automobiles and trucks	0	0	0	0	
	Accumulated depreciation	0	0	0	0	
	Major movable equipment	27, 380, 236	0	0	0	23
00	Accumulated depreciation	-23, 036, 747	0	0	0	24
00	Minor equipment depreciable	0	0	0	0	25
00	Accumul ated depreciation	0	0	0	0	26
00	HIT designated Assets	0	0	0	0	27
	Accumulated depreciation	0	0	-	0	
	Minor equipment-nondepreciable	0	0		0	
	Total fixed assets (sum of lines 12-29)	29, 037, 302	0	0	0	30
	OTHER ASSETS	0 000 447				
	Investments	8, 399, 147	0		0	
	Deposits on leases Due from owners/officers	0		-	0	
	Other assets	574, 365	-	0	0	
	Total other assets (sum of lines 31-34)	8, 973, 512		0	0	
	Total assets (sum of lines 11, 30, and 35)	51, 406, 341		-	0	
	CURRENT LI ABI LI TI ES	0171007011	<u> </u>			1
	Accounts payable	2, 054, 213	0	0	0	1 37
	Salaries, wages, and fees payable	2, 421, 505	0	0	0	38
00	Payroll taxes payable	39, 664	0	0	0	39
00	Notes and Loans payable (short term)	0	0	0	0	40
00	Deferred income	0	0	0	0	41
	Accelerated payments	0				42
	Due to other funds	0	0		0	
	Other current liabilities	427, 441			0	
	Total current liabilities (sum of lines 37 thru 44)	4, 942, 823	0	0	0	45
-	ONG TERM LIABILITIES					1
	Mortgage payable	11 002 102	0	0	0	
	Notes payable	11, 983, 182		0	0	1
	Unsecured loans Other long term liabilities			0	0	
	Total long term liabilities (sum of lines 46 thru 49)	11, 983, 182			0	
	Total liabilities (sum of lines 45 and 50)	16, 926, 005		-	0	
	CAPITAL ACCOUNTS	10, 720, 000		0	0	1
	General fund balance	34, 480, 336				1 52
	Specific purpose fund		0			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	57
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
. 00	Total fund balances (sum of lines 52 thru 58)	34, 480, 336		0	0	
. 00	Total liabilities and fund balances (sum of lines 51 and	51, 406, 341			0	60

Heal th	Financial Systems	HARRI SON COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1331	Period: From 01/01/2018 To 12/31/2018	Worksheet G-1	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balance at end of period per balance		2,00 38,081,643 -3,601,307 34,480,336 0 34,480,336 0 34,480,336				$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	000000000000000000000000000000000000000		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0	0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

				From 01/01/201 To 12/31/201		
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					1
	General Inpatient Routine Services				1	
1.00	Hospi tal		14, 286, 5	28	14, 286, 528	
2.00	SUBPROVIDER - IPF					2.0
3.00	SUBPROVIDER - IRF					3.0
4.00	SUBPROVI DER					4.0
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00 8.00	SKILLED NURSING FACILITY NURSING FACILITY					7.0
9.00 9.00	OTHER LONG TERM CARE					9.0
9.00 10.00	Total general inpatient care services (sum of lines 1-9)		14, 286, 5	20	14, 286, 528	
10.00	Intensive Care Type Inpatient Hospital Services		14, 200, 3	20	14, 200, 320	1 10.0
11.00	INTENSIVE CARE UNIT		1, 070, 4	69	1, 070, 469	11.0
12.00	CORONARY CARE UNIT		1,070,4	07	1,070,407	12.0
13.00	BURN I NTENSI VE CARE UNI T					13.0
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.0
15.00	OTHER SPECIAL CARE (SPECIFY)					15.0
16.00	Total intensive care type inpatient hospital services (sum of	lines	1, 070, 4	69	1, 070, 469	
	11-15)				,	
17.00	Total inpatient routine care services (sum of lines 10 and 16)		15, 356, 9	97	15, 356, 997	17.0
18.00	Ancillary services		19, 453, 3	11 94, 692, 93	9 114, 146, 250	18.0
19.00	Outpatient services		382, 4	87 20, 534, 35	9 20, 916, 846	19.0
20.00	RURAL HEALTH CLINIC				0 0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			-	0 0	
22.00	HOME HEALTH AGENCY			182, 57		
23.00	AMBULANCE SERVICES			0 9, 231, 30	1 9, 231, 301	
24.00						24.0
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.0
26.00	HOSPICE		4 500 7	47 004 07	10 004 407	26.0
27.00	OTHER	to Wkot	1, 599, 7			
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 G-3. line 1)	LO WKSL.	36, 792, 5	32 141, 845, 54	5 178, 638, 077	28.0
	PART II - OPERATING EXPENSES					1
29.00	Operating expenses (per Wkst. A, column 3, line 200)			58, 853, 88	4	29.0
30.00	ADD (SPECIFY)			0		30.0
31.00				0		31.0
32.00				0		32.0
33.00				0		33.0
34.00				0		34.0
35.00				0		35.0
36.00	Total additions (sum of lines 30-35)				o	36.0
37.00	DEDUCT (SPECI FY)			0		37.0
38.00				0		38.0
39.00				0		39.0
40.00				0		40.0
41.00				0		41.0
42.00	Total deductions (sum of lines 37-41)				0	42.0
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42 to Wkst. G-3, line 4))(transfer		58, 853, 88	4	43.0

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 CCN: 15-1331	Peri od:	Worksheet G-3		
				From 01/01/2018 To 12/31/2018	Date/Time Pre	arod	
					5/30/2019 5: 44		
					1.00		
1.00	Total patient revenues (from Wkst. G-2, Part				178, 638, 077	1.00	
2.00	Less contractual allowances and discounts on	patients' account	S		126, 127, 793	2.00	
3.00	Net patient revenues (line 1 minus line 2)				52, 510, 284	3.00	
4.00	Less total operating expenses (from Wkst. G-		3)		58, 853, 884	4.00	
5.00	Net income from service to patients (line 3	minus line 4)			-6, 343, 600	5.00	
	OTHER I NCOME						
6.00	Contributions, donations, bequests, etc				0	6.00	
7.00	Income from investments				-60, 665	7.00	
8.00	Revenues from telephone and other miscellane	ous communication	services		0	8.00	
9.00	Revenue from television and radio service				0	9.00	
10.00	Purchase di scounts				1, 355	10.00	
11.00	Rebates and refunds of expenses				0	11.00	
12.00	Parking lot receipts				0	12.00	
13.00	Revenue from Laundry and Linen service	ata			124.054	13.00	
14.00 15.00	Revenue from meals sold to employees and gue	sts			134, 956	14.00 15.00	
16.00	Revenue from rental of living quarters	nalioo to other th	on noti onto		0	15.00	
	Revenue from sale of medical and surgical su Revenue from sale of drugs to other than pat		ian patrents		0	16.00	
17.00 18.00	Revenue from sale of medical records and abs				25, 286	17.00	
19.00	Tuition (fees, sale of textbooks, uniforms,				25, 280	19.00	
20.00	Revenue from gifts, flowers, coffee shops, a				0	20.00	
20.00	Rental of vending machines	nu canteen			0	20.00	
21.00	Rental of hospital space				1, 076, 301	22.00	
23.00	Governmental appropriations				1, 202, 683		
23.00	IDENTIFIED ON TRIAL BALANCE				362, 377	24.00	
24.00	Total other income (sum of lines 6-24)				2, 742, 293		
26.00	Total (line 5 plus line 25)				-3, 601, 307	26.00	
	OTHER EXPENSES (SPECIFY)				0,001,007	27.00	
	Total other expenses (sum of line 27 and sub	scripts)			0	28.00	
	Net income (or loss) for the period (line 26	1 /			-3, 601, 307		
				I	-,,,		

	Financial Systems SIS OF HOSPITAL-BASED HOME HEALT	H AGENCY COSTS	HARRI SON COUN	Provider C		Period:	u of Form CMS-2 Worksheet H	2002-11
				HHA CCN:		From 01/01/2018 To 12/31/2018	Date/Time Pre 5/30/2019 5:4	pared: 4 pm
						Home Health Agency I	PPS	•
		Sal ari es	Employee Benefits	Transportation (see	chased	r Other Costs	Total (sum of cols. 1 thru	
		1.00	2.00	<u>instructions)</u> 3.00	Services 4.00	5.00	5) 6.00	
	GENERAL SERVICE COST CENTERS	 I						
. 00	Capital Related - Bldg. & Fixtures			0		0	0	1.0
. 00	Capital Related - Movable			0		0	0	2.0
	Equipment							
. 00 . 00	Plant Operation & Maintenance Transportation		0	0			0	
. 00	Administrative and General	28, 776	Ŭ	4, 074		43, 158		
~~	HHA REIMBURSABLE SERVICES	40.070			1		40.070	
. 00 . 00	Skilled Nursing Care Physical Therapy	42, 378 51, 783		0			42, 378 51, 783	
. 00	Occupational Therapy	0		0		0 0	0	
. 00	Speech Pathology	0	0	0		0 0	0	9.0
0.00	Medical Social Services Home Health Aide	0	0	0			0	
1.00 2.00	Supplies (see instructions)	21,447	Ű	0		0 7,510	21, 447 7, 510	
3.00	Drugs	0	0	0		0 0	0	
4.00		0	0	0		0 0	0	14.0
5.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0 0	0	15.0
6.00	Respiratory Therapy	0	-	0		0 0	0	
7.00	Private Duty Nursing	0	0	0		0 0	0	
8.00 9.00	Clinic Health Promotion Activities	0	0	0			0	
0.00	Day Care Program	0	0	0		0 0	0	
21.00	Home Delivered Meals Program	0	0	0		o o	0	
22.00 23.00	Homemaker Service All Others (specify)	0	0	0			0	22. 0 23. 0
23.50	Tel emedi ci ne	0	0	0		0 0	0	
4.00	Total (sum of lines 1-23)	144, 384		4, 074		50, 668	222, 574	24.0
		Reclassificati on	Reclassified Trial Balance	Adjustments	Net Expenses for Allocatio	n		
			(col . 6 +		(col. 8 + col			
			1 7)		9)			
		7.00	col.7)	0.00		-		1
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	_		
. 00	Capital Related - Bldg. &	7.00	8.00	9.00	10.00			1.0
	Capital Related - Bldg. & Fixtures		8.00		10.00			
	Capital Related - Bldg. &		8.00		10.00			
2. 00 2. 00 3. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance	0 0 0	8.00 0 0		10.00			2. 0 3. 0
2.00 3.00 4.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation	0 0 0 0	8.00 0 0 0 0	0 0 0 0	10.00			2.0 3.0 4.0
2.00 3.00 4.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General	0 0 0	8.00 0 0 0 0		10.00			2.0 3.0 4.0
2. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation	0 0 0 1, 163 -595	8.00 0 0 0 100,619 41,783	0 0 0 0	10. 00 77, 17 41, 78	3		2.00 3.00 4.00 5.00
2. 00 3. 00 4. 00 5. 00 5. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy	0 0 0 1, 163 -595 -790	8.00 0 0 100,619 41,783 50,993	0 0 0 -23, 448	10.00 77,17 41,78 50,99	3 3		2.0 3.0 4.0 5.0 6.0 7.0
. 00 . 00 . 00 . 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy	0 0 0 1, 163 -595 -790 295	8.00 0 0 0 100,619 41,783 50,993 295	0 0 0 -23, 448 0	10.00 77,17 41,78 50,99 29	3 5 5		2.0 3.0 4.0 5.0 6.0 7.0 8.0
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy	0 0 0 1, 163 -595 -790	8.00 0 0 0 100,619 41,783 50,993 295 0	0 0 0 -23, 448 0	10.00 77,17 41,78 50,99 29	3 3		2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0
2.00 3.00 5.00 5.00 7.00 5.00 7.00 0.00 1.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	0 0 0 1, 163 -595 -790 295 0 0 0 -73	8.00 0 0 100,619 41,783 50,993 295 0 0 0 21,374	0 0 0 -23, 448 0	10.00 77,17 41,78 50,99 29 21,37	3 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	0 0 0 1, 163 -595 -790 295 0 0 0 -73 0	8.00 0 0 0 100,619 41,783 50,993 295 0 0 21,374 7,510	0 0 0 -23, 448 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 77,17 41,78 50,99 29	3 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00 2. 00 3. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	0 0 0 1, 163 -595 -790 295 0 0 0 -73	8.00 0 0 100,619 41,783 50,993 295 0 21,374 7,510 0	0 0 0 -23, 448 0	10.00 77,17 41,78 50,99 29 21,37 7,51	3 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0
2. 00 3. 00 5. 00 5. 00 7. 00 3. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES	0 0 0 1, 163 -595 -790 295 0 0 -73 0 0 0 -73	8.00 0 0 0 100,619 41,783 50,993 295 0 0 21,374 7,510 0 0	0 0 0 -23, 448 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 77,17 41,78 50,99 29 21,37 7,51	3 3 5 5 0 4 0 0 1		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
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONRELMBURSABLE SERVICES Home Dialysis Aide Services	0 0 0 1, 163 -595 -790 295 0 0 0 -73 0 0 0 0 0 0 0 0	8.00 0 0 0 0 0 100,619 41,783 50,993 295 0 0 21,374 7,510 0 0	0 0 0 0 -23, 448 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 77,17 41,78 50,99 29 21,37 7,51	3 3 5 0 0 1 1 3 3 5 0 0 0 0 0 4 4 0 0 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
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES	0 0 0 1, 163 -595 -790 295 0 0 -73 0 0 0 -73	8.00 0 0 0 0 0 100,619 41,783 50,993 295 0 0 21,374 7,510 0 0	0 0 0 -23, 448 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 77,17 41,78 50,99 29 21,37 7,51	3 3 5 5 0 4 0 0 1		2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0 16.0
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0 0 0 1, 163 -595 -790 295 0 0 0 -73 0 0 0 0 0 0 0 0	8.00 0 0 0 0 0 100,619 41,783 50,993 295 0 0 21,374 7,510 0 0	0 0 0 -23, 448 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 77,17 41,78 50,99 29 21,37 7,51	3 3 5 5 0 4 0 0 1		2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0 14.0 15.0 18.0
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	0 0 0 1, 163 -595 -790 295 0 0 0 -73 0 0 0 0 0 0 0 0	8.00 0 0 0 0 0 100,619 41,783 50,993 295 0 0 21,374 7,510 0 0	0 0 0 -23, 448 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 77,17 41,78 50,99 29 21,37 7,51	3 3 5 5 0 4 0 0 1		2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0 14.0 15.0 14.0 15.0 17.0 17.0 0 17.0 0 19.0
2. 00 3. 00 5. 00 5. 00 7. 00 8. 00 7. 00 9. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 9. 00 0. 00 9. 00 0. 00 9. 00 0. 00 9. 00 0.	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0 0 0 1, 163 -595 -790 295 0 0 0 -73 0 0 0 0 0 0 0 0	8.00 0 0 0 0 0 100,619 41,783 50,993 295 0 0 21,374 7,510 0 0	0 0 0 -23, 448 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 77,17 41,78 50,99 29 21,37 7,51	3 3 5 5 0 4 0 0 1		2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0 15.0 16.0 17.0 18.0 19.0 20.0 18.0 19.0 20.0 18.0 19
2.00 3.00 5.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	0 0 0 1, 163 -595 -790 295 0 0 0 -73 0 0 0 0 0 0 0 0	8.00 0 0 0 0 0 100,619 41,783 50,993 295 0 0 21,374 7,510 0 0	0 0 0 -23, 448 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 77,17 41,78 50,99 29 21,37 7,51	3 3 5 5 0 4 0 0 1		2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2. 00 3. 00 5. 00 5. 00 5. 00 7.	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA RELMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 1, 163 -595 -790 295 0 0 0 -73 0 0 0 0 0 0 0 0	8.00 0 0 0 0 0 100,619 41,783 50,993 295 0 0 21,374 7,510 0 0	0 0 0 -23, 448 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 77,17 41,78 50,99 29 21,37 7,51	3 3 5 5 0 4 0 0 1		2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 18.0 17.0 19.0 20.0 21.0

Heal th	Financial Systems		HARRI SON COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
	LLOCATION - HHA GENERAL SERVICE	E COST		Provider C	CN: 15-1331	Period: From 01/01/2018	Worksheet H-1	
				HHA CCN:	15-7242	To 12/31/2018	Date/Time Pre	pared:
						Home Health	5/30/2019 5:4 PPS	4 pm
						Agency I		
			Capital Rela	ated Costs				
		Net Expenses	BIdgs &	Movable	Plant	Transportation		1
		for Cost Allocation	Fixtures	Equi pment	Operation 8 Maintenance		(cols. 0-4)	
		(from Wkst. H,						
		col . 10) 0	1.00	2.00	3.00	4.00	4A. 00	
	GENERAL SERVICE COST CENTERS	-						
1.00	Capital Related - Bldg. & Fixtures	0	0				C	1.00
2.00	Capital Related - Movable	0		C			C	2.00
3.00	Equipment Plant Operation & Maintenance	0	0	0		0	C	3.00
4.00	Transportation	0	Ō	C		0 0		4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	77, 171	0	C		0 0	77, 171	5.00
6.00	Skilled Nursing Care	41, 783	0	0	1	0 0	41, 783	6.00
7.00	Physical Therapy	50, 993	0	0		0 0		
8.00 9.00	Occupational Therapy Speech Pathology	295 0	0	0		0 0 0 0	295 C	1
10.00	Medical Social Services	0	0	C		0 0	C	10.00
11.00 12.00	Home Health Aide Supplies (see instructions)	21, 374 7, 510	0	0		0 0	21, 374 7, 510	
13.00	Drugs	0	0	C		0	C	1
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0	1	0 0	C	14.00
15.00	Home Dialysis Aide Services	0	0	0	1	0 0	C	15.00
16.00	Respiratory Therapy	0	0	0		0 0		
17.00 18.00	Private Duty Nursing Clinic	0	0	0		0 0 0 0		
19.00	Health Promotion Activities	0	0	C		0 0	C	
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0		0 0		
22.00	Homemaker Service	0	Ō	C		0 0	C	22.00
23.00 23.50	All Others (specify) Telemedicine	0	0	0		0 0 0 0		
	Total (sum of lines 1-23)	199, 126	0	0	1	0 0	199, 126	1
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					-
1 00	GENERAL SERVICE COST CENTERS	1						1.00
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	77 171						4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	77, 171						5.00
6.00	Skilled Nursing Care	26, 440	68, 223					6.00
7.00 8.00	Physical Therapy Occupational Therapy	32, 267 187	83, 260 482					7.00 8.00
9.00	Speech Pathol ogy	0	0					9.00
10. 00 11. 00	Medical Social Services Home Health Aide	0 13, 525	0 34, 899					10.00
12.00	Supplies (see instructions)	4, 752	12, 262					12.00
13.00 14.00	Drugs DME	0	0					13.00 14.00
14.00	HHA NONREI MBURSABLE SERVI CES		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 20. 00	Health Promotion Activities Day Care Program	0	0					19.00 20.00
21.00	Home Delivered Meals Program	0	0					21.00
22. 00 23. 00	Homemaker Service All Others (specify)	0	0					22.00 23.00
23.00 23.50	Tel emedi ci ne	0	0					23.00
24.00	Total (sum of lines 1-23)		199, 126					24.00

	Financial Systems		HARRI SON COUN			In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HHA STATISTICAL BAS	il S		Provider C HHA CCN:	CN: 15-1331 15-7242	Period: From 01/01/2018 To 12/31/2018		pared:
						Home Health Agency I	PPS	•
		Capital Rel	ated Costs					
		BI dgs & Fi xtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Pl ant Operati on & Mai ntenance (SQUARE FEET)	Transportati (MI LEAGE)	onReconci I i ati on	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related – Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	C		0		3.00
4.00	Transportation (see	0	0	C		0		4.00
	instructions)	_	_	_				
5.00	Administrative and General	0	0	0		0 -77, 171	121, 955	5.00
(00	HHA REIMBURSABLE SERVICES						44. 700	1 / 00
6.00	Skilled Nursing Care	0	0	0		0 0	41, 783	
7.00 8.00	Physical Therapy Occupational Therapy	0	0	0		0 0	50, 993 295	
9.00	Speech Pathol ogy		0	0		0 0	293	
10.00	Medical Social Services	0	0	0		0 0	0	
11.00	Home Heal th Ai de	0	0	0		0 0	-	11.00
12.00	Supplies (see instructions)	0	0	0		0 0		12.00
13.00	Drugs	0	0	C		0	0	1
14.00	DME	0	0	C		0 0	0	14.00
	HHA NONREI MBURSABLE SERVI CES	•				·		
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	
16.00	Respiratory Therapy	0	0	C		0 0	0	
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0 0	0	
20.00 21.00	Day Care Program Home Delivered Meals Program		0				0	
21.00	Homemaker Service						0	
22.00	All Others (specify)						0	
23.50		0	0	0		0 0	0	
24.00	Total (sum of lines 1-23)	0	0	C		0 -77, 171	121, 955	
25.00		0	0	0		0		25.00
	Worksheet H-1, Part I)						-	
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0. 0000	00	0. 632783	26.00

LLOCATI 0	IN OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider CC		Period: From 01/01/2018 To 12/31/2018 Home Health		pared
						Agency I		
	Cost Center Description	HHA Trial	CAPITAL RELATED COSTS BLDG & FIXT	МОВ	AMB DEPR	MVBLE EQUIP	AMB EQUIP	
		Balance (1)						
00 44	ministrative and Conaral	0	1.00	1.01 9,311	1.02	2.00	2.01	1.0
. 00 Sk	ministrative and General illed Nursing Care	68, 223	0	9, 311			C	2.0
	ysical Therapy cupational Therapy	83, 260 482		0				
	eech Pathol ogy	482		0				
	di cal Soci al Servi ces	0	-	0		0 0	C	
	me Health Aide	34, 899		0	(0 0	C	
	pplies (see instructions)	12, 262		0		0 0	C	
00 Dri 0.00 DM	ugs	0	0	0				
	∟ me Dialysis Aide Services	0	0	0		0 0		
	spiratory Therapy	0	0	0		0 0	C	
	ivate Duty Nursing	0	0	0		0 0	C	
	inic	0	0	0		0 0	C	
	alth Promotion Activities y Care Program	0	0	0				
	me Delivered Meals Program	0	0	0		0 0	C	
	memaker Service	0	0	0	(0 0	C	
	l Others (specify)	0	0	0		0 0	C	
	lemedicine	0	0	0		0 0	C	
	tal (sum of lines 1–19) (2) it Cost Multiplier: column	199, 126	0	9, 311		5 0	C	20.0
	, line 1 divided by the sum							21. \
	column 26, line 20 minus							
	lumn 26, line 1, rounded to							
0	decimal places. Cost Center Description	EMPLOYEE	Subtotal	ADMI NI STRATI VE	ADMI TTI NG	CASHI ERI NG/ACC	OPERATION OF	
		BENEFITS		& GENERAL		OUNTS	PLANT	
		DEPARTMENT 4.00	4A	5.01	5.02	RECEI VABLE 5. 03	7.00	
00 Ad	ministrative and General	4.00			3.02		7.00) 1.(
	illed Nursing Care	11, 521				0 0	C	
	ysical Therapy	14, 061	97, 321	10, 494		0 0	C	
	cupational Therapy	81	563			0 0	C	
	eech Pathology dical Social Services	0	0	0				
	me Health Aide	5, 894	40, 793	4, 399		0 0		
	pplies (see instructions)	0	12, 262		(0 0	C	
	ugs	0		-	(0 0	C	
. 00 DM		0	u u	-		0 0	C	
	me Dialysis Aide Services spiratory Therapy	0	0	-				
	ivate Duty Nursing	0	-	0				
	inic	0	0	0	(0 0	C	
	alth Promotion Activities	0	0	0	(0 0	C	
	y Care Program	0	0	0	(0 0	C	
	me Delivered Meals Program memaker Service	0	0	0				
	I Others (specify)	0	0	0				
1	l emedi ci ne	0	0	0		0 0	C	
. 00 To	tal (sum of lines 1–19) (2)	39, 813			84	7 1, 550	C	20.
	it Cost Multiplier: column		0. 000000					21.
	, line 1 divided by the sum column 26, line 20 minus							
	lumn 26, line 1, rounded to							
CO	rumn 26, rrne r, rounded to j							

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

	Financial Systems ATION OF GENERAL SERVICE COSTS		HARRISON COUN	TY HOSPITAL Provider CO	°N- 15 1221	In L Period:	ieu of Form CMS- Worksheet H-2	
ALLUCA	ATTON OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS	HHA CCN:	15-7242	From 01/01/20 To 12/31/20	18 Part I	pared:
						Home Health Agency I		
	Cost Center Description	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERIA	NURSI NG ADMI NI STRATI ON	
		7.01	8.00	9.00	10.00	11.00	13.00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 15.00\\ 15.00\\ 19.00\\ 19.00\\ 19.00\\ 19.50\\ 20.00\\ 21.00\\ \end{array}$	Homemaker Service All Others (specify)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 2, 00\\ 3, 00\\ 4, 00\\ 5, 00\\ 6, 00\\ 7, 00\\ 8, 00\\ 9, 00\\ 10, 00\\ 11, 00\\ 12, 00\\ 13, 00\\ 14, 00\\ 15, 00\\ 16, 00\\ 17, 00\\ 18, 00\\ 19, 00\\ 19, 50\\ \end{array}$
	6 decimal places. Cost Center 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	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 21.\ 00\\ 21.\ 00\\ 21.\ 00\\ \end{array}$	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			1, 286 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 23, 1 0 88, 3 0 107, 8 0 6 0 0 0 45, 1 0 13, 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	43 0 15 0 24 0 0 0 92 0 84 0 0 0	$\begin{array}{c} 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 50\\ \end{array}$

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

Heal th	Financial Systems		HARRISON COUN	TY HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider CC	CN: 15-1331 15-7242	Peri od: From 01/01/2018 To 12/31/2018	5/30/2019 5:4	epared:
						Home Health Agency I	PPS	
	Cost Center Description	Subtotal	Allocated HHA	Total HHA		Agency I		
			A&G (see Part	Costs				
			11)					
		26.00	27.00	28.00				
1.00	Administrative and General	23, 144						1.00
2.00	Skilled Nursing Care	88, 343		96, 344				2.00
3.00	Physical Therapy	107, 815		117, 578				3.00
4.00	Occupational Therapy	624	57	681				4.00
5.00	Speech Pathology	0	0	0				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	45, 192		49, 285				7.00
8.00	Supplies (see instructions)	13, 584		14, 814				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00 12.00
12.00 13.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing Clinic	0	0	0				13.00
14.00	Health Promotion Activities	0	0	0				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	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Tel emedi ci ne	0	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	278, 702	23, 144	278, 702				20.00
21.00	Unit Cost Multiplier: column	210,102	0. 090563	270,702				21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							

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

	Financial Systems TION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	HARRISON COUN TERS STATISTICA		CN: 15-1331	Peri od:	u of Form CMS-2 Worksheet H-2	
BASI S				HHA CCN:	15-7242	From 01/01/2018 To 12/31/2018	Part II	pared:
						Home Health	PPS	
			CAPI	TAL RELATED CO)STS	Agency I		
	Cost Center Description	BLDG & FIXT	MOB	AMB DEPR	MVBLE EQUIF	AMB EQUIP	EMPLOYEE	
		(SQUARE FEET)	(SQUARE FEET)	(SQ UARE FEET)	(SQUARE FEET) (SQ UARE FEET)	BENEFI TS DEPARTMENT (GROSS SALARI ES)	
1 00		1.00	1.01	1.02	2.00	2.01	4.00	1
1.00 2.00	Administrative and General Skilled Nursing Care	0	476 0	0		0 0	29, 940 41, 782	
2.00 3.00	Physical Therapy		0	0		0 0	50, 993	•
4.00	Occupational Therapy	0	0	0		0 0	295	
5.00	Speech Pathology	0	0	0		0 0	0	5.00
6.00	Medical Social Services	0	0	0		0 0	0	6.00
7.00	Home Health Aide	0	0	0		0 0	21, 374	7.00
8.00	Supplies (see instructions)	0	0	0		0 0	0	8.00
9.00	Drugs	0	0	0		0 0	0	9.00
10. 00 11. 00	DME Home Dialysis Aide Services		0	0		0 0	0	10.00
12.00	Respiratory Therapy		0	0		0 0	0	12.00
13.00	Private Duty Nursing	0	0	0		0 0	0	13.00
14.00	Clinic	0	0	0		0 0	0	14.00
15.00	Health Promotion Activities	0	0	0		0 0	0	15.0
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	17.00
18. 00 19. 00	Homemaker Service All Others (specify)		0	0		0 0	0	18.00 19.00
19.50	Tel emedi ci ne	0	0	0		0 0	0	19.50
20.00	Total (sum of lines 1-19)	0	476	0		0 0	144, 384	
21.00	Total cost to be allocated	0	9, 311	0		0 0	39, 813	21.00
22.00	Unit cost multiplier	0.00000		0.00000			0. 275744	22.00
	Cost Center Description	Reconciliation	& GENERAL	ADMI TTI NG (GROSS	CASHI ERI NG/A OUNTS	CC OPERATION OF PLANT	AMB PLANT OPS (SQUARE FEET)	
			(ACCUM. COST)	CHARGES)	RECEIVABLE		(SQUARE ILLI)	
			(//0001//	01# ((020)	(GROSS	(000) 112 1221)		
					CHARGES)			
1.00	Administrative and General	5A. 01 0	5.01 17,567	<u>5. 02</u> 182, 576	5. 03 182, 5	7.00 76 0	7.01	1.00
2.00	Skilled Nursing Care	0	79, 744	182, 570	102, 5	0 0	0	2.00
3.00	Physical Therapy	0	97, 321	0		0 0	0	3.00
4.00	Occupational Therapy	0	563	0		0 0	0	4.00
5.00	Speech Pathology	0	0	0		0 0	0	5.00
6.00	Medical Social Services	0	0	0		0 0	0	6.00
7.00	Home Health Aide	0	40, 793	0		0 0	0	7.00
8.00 9.00	Supplies (see instructions)	0	12, 262	0		0 0	0	8.00 9.00
10.00	Drugs DME		0	0		0 0	0	10.0
11.00	Home Dialysis Aide Services	0	0	0		0 0	0	11.0
12.00	Respiratory Therapy	0	0	0		0 0	0	
13.00	Private Duty Nursing	0	0	0		0 0	0	13.00
14.00	Clinic	0	0	0		0 0	0	14.00
15.00	Health Promotion Activities	0	0	0		0 0	0	15.00
16.00	Day Care Program		0	0		0 0	0	16.00
17.00 18.00	Home Delivered Meals Program Homemaker Service		0	0			0	17.0 18.0
18.00	All Others (specify)		0	0			0	
	Tel emedi ci ne		0	0			0	
19.50 20.00	Total (sum of lines 1-19)		248, 250	182, 576		76 0	0	20.0
19. 50 20. 00 21. 00			248, 250 26, 769 0. 107831	847	1, 5	50 0	0	20. 0 21. 0

Heal th	n Financial Systems		HARRI SON COUN	TY HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOC BASI S	ATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS STATISTICA			Period: From 01/01/2018		
				HHA CCN:	15-7242	To 12/31/2018	Date/Time Pre 5/30/2019 5:4	pared: 4 pm
						Home Health Agency I	PPS	
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (TOTAL PATI ENT DAYS)	CAFETERI A (HOURS OF SERVI CE)	NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG HR)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 19.\ 00\\ 19.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$	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	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0. 0000	0 0 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
	cost center bescription	(TIME SPENT)	MEDICAL RECORDS & LI BRARY (GROSS CHARGES) 16.00	(TOTAL PATI ENT DAYS) 17.00				
19. 50 20. 00 21. 00	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		182, 576 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$

Heal th	n Financial Systems		HARRI SON COUN	TY HOSPITAL		Inlie	eu of Form CMS-2	2552-10
	TIONMENT OF PATIENT SERVICE COST	S			CN: 15-1331	Peri od:	Worksheet H-3	
				HHA CCN:	15-7242	From 01/01/2018 To 12/31/2018		
				Title	e XVIII	Home Health	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Agency I Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (col s.		Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
		0	1.00	Part II) 2.00	3.00	4.00	4) 5.00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00 2.00	Skilled Nursing Care Physical Therapy	2.00 3.00			96, 34 117, 57			1.00 2.00
2.00	Occupational Therapy	4.00						
4.00	Speech Pathol ogy	5.00		(0 0		
5.00	Medical Social Services	6. 00				0 0		
6.00	Home Heal th Ai de	7.00			49, 28			
7.00	Total (sum of lines 1-6)		263, 888	(263,88 Program Visit			7.00
			1			art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					Deductibles			
		0	1.00	2.00	Coi nsurance	4.00	5.00	
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	5.00	
8.00	Skilled Nursing Care		31140	() 32	24		8.00
8.01	Skilled Nursing Care		99915	C				8.01
9.00	Physical Therapy		31140	(1			9.00
9. 01 10. 00	Physical Therapy Occupational Therapy		99915 31140			81 2		9.01 10.00
10.00			99915			0		10.00
11.00			31140	(0		11.00
11.01	1 55		99915	C		0		11.01
12.00			31140	(0		12.00
12. 01 13. 00	Medical Social Services Home Health Aide		99915 31140		22	0		12.01 13.00
13.00	Home Health Aide		99915			18		13.00
	Total (sum of lines 8-13)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(92			14.00
		From Wkst. H-2	Facility Costs		Total HHA			
		Part I, col.	(from Wkst.	Ancillary	Costs (col s.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from Part II)	+ 2)	Records)		
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computa	ations						
15.00		8.00						
16.00	Cost of Drugs	9.00	0 Program Visits		Cost of	0 0	0. 000000	16.00
					Services			
				tВ		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	, ,	
			Deductibles &			Deductibles &		
		6.00	Coi nsurance 7.00	Coi nsurance 8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	426			0 88, 838		1.00
2.00	Physical Therapy	0				0 109, 976		2.00
3.00	Occupational Therapy	0				0 681		3.00
4.00 5.00	Speech Pathology Medical Social Services	0				0 0		4.00 5.00
5.00 6.00	Home Health Aide					0 48, 758		6.00
7.00	Total (sum of lines 1-6)	0				0 248, 253		7.00

	MENT OF PATIENT SERVICE COST	S		Provider CO	CN· 15-1331	Peri od:	u of Form CMS- Worksheet H-3	
		0		HHA CCN:	15-7242	From 01/01/2018 To 12/31/2018	Part I Date/Time Pre	pared
				Ti tl e	XVIII	Home Health	5/30/2019 5:4 PPS	4 pm
	Cost Center Description					Agency I		
		6.00	7.00	8.00	9.00	10.00	11.00	
	nitation Cost Computation		I					
	illed Nursing Care illed Nursing Care							8.0
	ysical Therapy							9.0
	ysical Therapy ysical Therapy							9.0
	cupational Therapy							10. (
	cupational Therapy							10.
	eech Pathol ogy							11.
	eech Pathology							11.
	di cal Soci al Servi ces							12.
	di cal Social Services							12.
	me Health Aide							13.
	me Health Aide							13.
	tal (sum of lines 8-13)							14.
1100 1101		Prog	ram Covered Cha	rges	Cost of			
					Servi ces			
			Part			Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
			Deductibles &				Deductibles &	
		6.00	Coinsurance 7.00	Coi nsurance 8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
Sup	oplies and Drugs Cost Computa		7.00	0.00	9.00	10.00	11.00	
	st of Medical Supplies	0	0	3, 701		0 0	7,300	15.
	st of Drugs	-	0	0		0	0	
I	Cost Center Description	Total Program			•			
		Cost (sum of						
		cols. 9-10)						1
								4
		12.00						
	RT I - COMPUTATION OF LESSER	12.00	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	 !	
BEN	EFICIARY COST LIMITATION	12.00	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	!	
BEN Cos	NEFICIARY COST LIMITATION	12.00 OF AGGREGATE F		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	!	
BEN Cos . 00 Ski	NEFICIARY COST LIMITATION st Per Visit Computation illed Nursing Care	12. 00 OF AGGREGATE F 88, 838		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	1	
. 00 BEN . 00 Ski . 00 Phy	NEFICIARY COST LIMITATION St Per Visit Computation illed Nursing Care ysical Therapy	12. 00 OF AGGREGATE F 88, 838 109, 976		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2.
BEN Cos . 00 Ski . 00 Phy . 00 Occ	NEFICIARY COST LIMITATION St Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy	12. 00 OF AGGREGATE F 88, 838 109, 976 681		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 3.
BEN Cos . 00 Ski . 00 Phy . 00 Occ . 00 Spe	NEFICIARY COST LIMITATION St Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology	12.00 OF AGGREGATE F 88,838 109,976 681 0		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 3. 4.
BEN Cos . 00 Ski . 00 Phy . 00 Occ . 00 Spe . 00 Med	VEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services	12.00 OF AGGREGATE F 88,838 109,976 681 0 0		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 3. 4. 5.
BEN Cos 00 Ski 00 Phy 00 Occ 00 Spe 00 Mec 00 Hor	VEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	1. (2. (3. (4. (5. (6. (
BEN Cos 00 Ski 00 Phy 00 Occ 00 Spe 00 Mec 00 Hor	VEFICIARY COST LIMITATION st Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6)	12.00 OF AGGREGATE F 88,838 109,976 681 0 0		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5. 6.
BEN Cos . 00 Ski . 00 Phy . 00 Occ . 00 Spe . 00 Mec . 00 Hon	VEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758 248, 253		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5. 6.
BEN Cos 00 Ski 00 Phy 00 Occ 00 Spe 00 Mec 00 Hon 00 Tot	NEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5.
BEN Cos 00 Ski 00 Phy 00 Occ 00 Spe 00 Med 00 Hon 00 Tot	NEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description mitation Cost Computation	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758 248, 253		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5. 6. 7.
BEN Cos .00 Ski .00 Physical .00 Occord .00 Specific .00 Mecord .00 Hom .00 Tot	NEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758 248, 253		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5. 6. 7. 8.
BEN Cos 00 Ski 00 Phy 00 Occ 00 Spe 00 Mec 00 Hon 00 Tot	VEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description nitation Cost Computation illed Nursing Care	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758 248, 253		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5. 6. 7. 8. 8.
BEN Cos .00 Ski .00 Phy .00 Spe .00 Mec .00 Hon .00 To1 .00 Ski .00 Ski .00 So .00 Ski .00 Ski .00 Ski .00 Ski .00 Ski	VEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description mitation Cost Computation illed Nursing Care illed Nursing Care	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758 248, 253		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5. 6. 7. 8. 8. 8. 9.
BEN Cos 00 Ski 00 Phy 00 Occ 00 Spe 00 Mec 00 Hon 00 Tot 00 Ski 00 Ski 00 Ski 01 Ski 00 Phy 01 Phy	VEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description nitation Cost Computation illed Nursing Care ysical Therapy	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758 248, 253		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5. 6. 7. 8. 8. 9. 9.
BEN Cos .00 Ski .00 Phy .00 Occ .00 Spe .00 Hon .00 Hon .00 Hon .00 Ki .00 Ski .00 Ski .00 Ski .01 Ski .01 Phy .01 Phy .01 Phy	VEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description mitation Cost Computation illed Nursing Care ysical Therapy ysical Therapy	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758 248, 253		GREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5. 6. 7. 8. 8. 8. 9. 9. 10.
BEN Cos .00 Ski .00 Phy .00 Occ .00 Spe .00 Hon .00 Hon .00 Tot .00 Ski .00 Ski .01 Ski .01 Phy .01 Phy .01 Phy .01 Phy .01 Occ .01 Occ .01 Occ	VEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description nitation Cost Computation illed Nursing Care ysical Therapy ysical Therapy cupational Therapy	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758 248, 253		GREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5. 6. 7. 8. 8. 9. 9. 10. 10.
BEN Cos .00 Ski .00 Physical .00 Scalar .00 Special .00 Special .00 Tot .00 Ski .00 Tot .00 Ski .01 Ski .01 Physical .01 Obsect .02 Obsect .03 Obsect	VEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description nitation Cost Computation illed Nursing Care ysical Therapy ysical Therapy cupational Therapy cupational Therapy	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758 248, 253		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5. 6. 7. 7. 8. 8. 9. 9. 10. 10. 11.
BEN Cos .00 Ski .00 Phy .00 Spe .00 Spe .00 Med .00 Tot .00 Ski .00 Tot .00 Ski .01 Ski .01 Phy .00 Oc .01 Phy .00 Oc .01 Phy .00 Spe 1.00 Spe 1.01 Spe	VEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description nitation Cost Computation illed Nursing Care illed Nursing Care ysical Therapy ysical Therapy cupational Therapy eech Pathology	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758 248, 253		GREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5. 6. 7. 8. 8. 9. 9. 10. 10. 11. 11.
BEN Cos .00 Ski .00 Phy .00 Spe .00 Mec .00 Hon .00 Tot .00 Ski .00 Ki .00 Ski .00 Ski .00 Ski .00 Phy .00 Ski .01 Ski .00 Oc .01 Phy .00 Oc .01 Spe .00 Spe .00 Spe	VEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description nitation Cost Computation illed Nursing Care ysical Therapy ysical Therapy cupational Therapy cupational Therapy eech Pathology eech Pathology	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758 248, 253		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5. 6. 7. 8. 8. 9. 9. 10. 10. 11. 11. 12.
BEN Cos .00 Ski .00 Phy .00 Ski .00 Phy .00 Spi .00 Spi .00 Mec .00 Mec .00 Tot 3.00 Ski 3.00 Ski 3.00 Ski 0.01 Phy 0.00 Occ 0.01 Phy 0.00 Spi 1.01 Spi 2.00 Mec 2.01 Mec	VEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description nitation Cost Computation illed Nursing Care ysical Therapy ysical Therapy cupational Therapy cupational Therapy eech Pathology eech Pathology dical Social Services	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758 248, 253		GREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5. 6.
BEN Cos	VEFICIARY COST LIMITATION at Per Visit Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description nitation Cost Computation illed Nursing Care ysical Therapy ysical Therapy cupational Therapy cupational Therapy eech Pathology eech Pathology dical Social Services dical Social Services	12. 00 OF AGGREGATE F 88, 838 109, 976 681 0 0 48, 758 248, 253		GREGATE OF TH	E PROGRAM LI	MITATION COST, OR		2. 3. 4. 5. 6. 7. 8. 8. 8. 9. 9. 10. 10. 11. 11. 11. 12. 12.

Heal th	Financial Systems		HARRISON COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provider C	CN: 15-1331	Period: From 01/01/2018	Worksheet H-3 Part II	
				HHA CCN:	15-7242	To 12/31/2018		pared: 4 pm
				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.	Rati o	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	ES FURNI SHED B	BY SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physical Therapy	66.00	0. 274475	()	0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 204914	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 374721	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 303998	0		0 col. 2, line 1	5.00	4.00
5.00	Cost of Drugs	73.00	0. 346609	0		0 col. 2, line 1	6. 00	5.00

Heal th	Financial Systems HARRISON COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	N: 15-1331	Peri od:	Worksheet H-4	
		HHA CCN:	15-7242	From 01/01/2018 To 12/31/2018	Part I-II Date/Time Prep 5/30/2019 5:44	
		Title	XVIII	Home Health	PPS	
				Agency I	t B	
			Part A	Not Subject to		
				Coi nsurance	Coi nsurance	
	L		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	OMARY CHARGES	5			
1.00	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0 0	0	1.00
2.00	Total charges			0 0		2.00
	Customary Charges				_	
3.00	Amount actually collected from patients liable for payment fo on a charge basis (from your records)	r services		0 0	0	3.00
4.00	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in			0 0	0	4.00
	with 42 CFR §413.13(b)					
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000			5.00
6.00 7.00	Total customary charges (see instructions) Excess of total customary charges over total reasonable cost	(complete		0 0	0	6.00 7.00
	only if line 6 exceeds line 1)			-		
8.00	Excess of reasonable cost over customary charges (complete on 1 exceeds line 6)	lyifine		0 0	0	8.00
9.00	Primary payer amounts			0 0	0	9.00
				Part A Services	Part B Services	
				1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)			0	0	
11. 00 12. 00	Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers			0	105, 790 9, 226	
13.00	Total PPS Reimbursement - LUPA Episodes			0	2, 969	12.00
14.00	Total PPS Reimbursement - PEP Episodes			0	9, 716	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	4, 081	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	16.00
17.00 18.00	Total Other Payments DME Payments			0	0	17. 00 18. 00
19.00	Oxygen Payments			0	0	19.00
20.00	Prosthetic and Orthotic Payments			0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coins	urance)			0	21.00
22.00 23.00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)			0	131, 782 0	22. 00 23. 00
23.00	Subtotal (line 22 minus line 23)			0	131, 782	23.00
25.00	Coinsurance billed to program patients (from your records)				0	25.00
26.00	Net cost (line 24 minus line 25)			0	131, 782	26.00
27.00	Reimbursable bad debts (from your records)					27.00
28.00 29.00	Reimbursable bad debts for dual eligible beneficiaries (see i Total costs – current cost reporting period (line 26 plus lin			0	131, 782	28. 00 29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	6 27)		0	0	30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	0	30. 50
30.99	Demonstration payment adjustment amount before sequestration			0	0	30.99
31.00	Subtotal (see instructions)			0	131, 782	31.00
31. 01 31. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	2, 636 0	31. 01 31. 02
32.00	Interim payments (see instructions)			0	129, 146	32.00
33.00	Tentative settlement (for contractor use only)			0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32,			0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accorda chapter 1, §115.2	nce with CMS	PUD. 15-2,	0	0	35.00
	· · · · ·			1		

ealth Financial Systems HARRISON COUN NALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED O PROGRAM BENEFICIARIES		Provider CCN: 15-1331			eriod:	Worksheet H-5	
		HHA CCN: 15-7242		From 01/01/2018 To 12/31/2018			
					Home Health Agency I	PPS	_ <u>hiii</u>
		Inpatient Part A				t B	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
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		129, 146 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)						3.
	Program to Provider						
01				0		0	3.
02				0		0	3. 3.
03 04				0		0	3. 3.
)5)5				0		0	3
	Provider to Program			- 1	I		
0				0		0	3
51				0		0	3
52				0		0	3
53 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) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		129, 146	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
	Program to Provider				I		
)1				0		0	5
)2				0		0	5
)3	Provider to Program			U		0	5
0				0		0	5
51				0		0	5
52				0		0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0	5
0	Determined net settlement amount (balance due) based on the cost report. (1)						6
01	SETTLEMENT TO PROVIDER			0		0	6
02	SETTLEMENT TO PROGRAM			0		0	6
00	Total Medicare program liability (see instructions)			0		129, 146	7
		Contractor Number			Contractor	NPR Date (Mo/Day/Yr)	
	-	()		1.00	2.00	_