ilcai tii i i ilailci	ai bystems	WASON 11031 I	IAL	TIT LI C	3 01 101111 0W3 2332 10
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Fai	lure to report can i	result in all interin	n FORM APPROVED
payments made	since the beginning of the cost	reporting period being	deemed overpayments	s (42 USC 1395g).	OMB NO. 0938-0050
				-	EXPIRES 05-31-2019
HOSPI TAL AND I	HOSPITAL HEALTH CARE COMPLEX COS	T REPORT CERTIFICATION	Provider CCN: 15-00	97 Peri od:	Worksheet S
AND SETTLEMEN	Γ SUMMARY			From 01/01/2018	
				To 12/31/2018	
					5/23/2019 3:17 pm
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed co	ost report		Date: 5/23/20	19 Time: 3:17 pm
use only	2. [] Manually submitted cost	report			
	3. [0] If this is an amended r	eport enter the number	of times the provide	er resubmitted this o	cost report
	4. [F] Medicare Utilization. E				
Contractor	5. [1]Cost Report Status 6.	Date Received:		10. NPR Date:	
use only	(1) As Submitted 7.	Contractor No.		11. Contractor's Vendo	or Code: 4
u 00 0 j	(2) Settled without Audit 8.	[N] Initial Report fo	r this Provider CCN	12. [0]If line 5, co	olumn 1 is 4: Enter
	(3) Settled with Audit 9.	[N] Final Report for	this Provider CCN		nes reopened = 0-9.
	(4) Reopened				•
	(5) Amended				

PART II - CERTIFICATION

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

CERTIFICATION BY 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 MAJOR HOSPITAL (15-0097) 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 gned)
Officer or Administrator of Provider(s)
Ti tl e
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	-49, 288	23, 074	0	-354, 426	1.00
2.00	Subprovi der - I PF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3.00
4.00	SUBPROVI DER I						4. 00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	MHP PEDIATRICS I	0		632		0	10.00
10.01	MHP OBGYN II	0		25, 109		0	10. 01
10.02	MHP FIM III	0		1, 065, 122		0	10.02
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	-49, 288	1, 113, 937	0	-354, 426	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.

23.00

3

Ν

rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25

yes or "N" for no.

If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

Ν

58.00

59.00

of (column 1 divided by (column 1 + column 2)). (see instructions)

	4)). (see instructions)								
						1.00	2.00	3. 00	
	Inpatient Psychiatric Facility	PPS							
70.00	Is this facility an Inpatient Page 1	sychiatric Facility (IPF), or does it cont	ain an IPF sub	provi der?	N			70.00
	Enter "Y" for yes or "N" for no	0.							
71.00	If line 70 is yes: Column 1: Die	d the facility have a	n approved GME teachi	ng program in	the most			0	71.00
	recent cost report filed on or I								
	42 CFR 412. 424(d)(1)(iii)(c)) Co								
	program in accordance with 42 Cl	FR 412.424 (d)(1)(iii)(D)? Enter "Y" for y	es or "N" for	no.				
	Column 3: If column 2 is Y, indi	icate which program y	ear began during this	cost reportin	g period.				
	(see instructions)								
	Inpatient Rehabilitation Facili	ty PPS							
	Is this facility an Inpatient R		y (IRF), or does it c	ontain an IRF		N			75.00
	subprovider? Enter "Y" for yes	and "N" for no.							

OSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DATA	Provider CCN	: 15-0097	Peri od	: 1/01/2018	Worksheet S- Part I	2
					2/31/2018	Date/Time Pr 5/23/2019 3:	
					1. 00	2. 00	4
40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in column 1. If	yes, and home of	office cos		Υ Υ	2.00	140. C
1.00	2.0				3. 00		
If this facility is part of a cha office and enter the home office			gh 143 th	e name ar	nd address	of the home	
11.00Name:	Contractor Name and Contra	actor Humber.	Contrac	ctor's Nu	ımber:		141. (
12.00 Street:	PO Box:						142.
13. 00 Ci ty:	State:		Zi p Coo	de:			143. (
						1. 00	-
14.00 Are provider based physicians' co	sts included in Worksheet	A?				Y	144.
					1. 00	2. 00	
15.00 If costs for renal services are of inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 16.00 Has the cost allocation methodology.	" for yes or "N" for no in clude Medicare utilization for no in column 2.	column 1. If conforthis cost m	olumn 1 is reporting	5	N		145. (
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	n column 1. (See CMS Pub.			lf			
						1. 00	
7.00Was there a change in the statist	ical basis? Enter "Y" for	yes or "N" for r	10.			N	147.
8.00 Was there a change in the order of	f allocation? Enter "Y" fo	or yes or "N" for	no.			N	148.
9.00Was there a change to the simplif	ied cost finding method? E					N	149.
		Part A 1.00	Part B 2.00	- 1	itle V 3.00	Title XIX 4.00	-
Does this facility contain a provor charges? Enter "Y" for yes or		exemption from	the appl		of the low	er of costs	
55.00 Hospi tal	·	N	N		N	N	155.
6.00 Subprovi der - IPF		N I	N		N	N	156.
7.00 Subprovi der – IRF 8.00 SUBPROVI DER		N	N		N	N	157. 158.
9. 00 SNF		N	N		N	N	159.
O. OO HOME HEALTH AGENCY		N	N		N	N	160.
1. 00 CMHC			N		N	N	161.
Mul +i compus						1. 00	
Multicampus 55.00 s this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has on	e or more campus	ses in dif	ferent C	BSAs?	N	165.
	Name 0	County 1.00	State 2 2.00	Zip Code 3.00	4. 00	FTE/Campus 5.00	-
o6.00 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)	U	1.00	2.00	3.00	4.00		00 166.
(222 1121 401 616)					·		
						1. 00	
Health Information Technology (HI 7.00 s this provider a meaningful use						Υ	167.
7.00 s this provider a meaningful use 3.00 f this provider is a CAH (line 1					r the		0168.
reasonable cost incurred for the	HIT assets (see instructio	ns)					
8.01 If this provider is a CAH and is					dshi p		168.
exception under §413.70(a)(6)(ii) 9.00 f this provider is a meaningful	user (line 167 is "Y") and				enter the	9. 9	99169.
							1
transition factor. (see instructi	ons)			Po	ai nni na	Endi na	
transition factor. (see instructi	ons)				gi nni ng 1. 00	Endi ng 2. 00	

Health Financial Systems		In Lieu	of Form CMS-	2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION I	DATA	Provi der		Peri		Worksheet S-2	
					01/01/2018	Date/Time Pre	narod:
				10	12/31/2010	5/23/2019 3: 1	
					1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any day	s for indiv	i duals enr	rolled in		N	0	171.00
section 1876 Medicare cost plans reported on Wkst.	section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter						
"Y" for yes and "N" for no in column 1. If column 1	is yes, en	iter the nu	umber of section	on			
1876 Medicare days in column 2. (see instructions)	•						

Health Financial Systems MAJOR HO				u of Form CM				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (CCN: 15-0097	Peri od: From 01/01/2018 To 12/31/2018		repared:			
		i pti on	Y/N	Y/N				
20 00 lf line 14 on 17 is yes, were adjustments made to DCOD		0	1. 00 N	3.00	20.00			
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN	N	20.00			
nopor t data for other boods be the other day detimented	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		21.00			
				1. 00				
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS	HOSPI TALS)		1.00				
Capital Related Cost		,						
22.00 Have assets been relifed for Medicare purposes? If yes, see 23.00 Have changes occurred in the Medicare depreciation expense			ring the cost	N N	22. 00 23. 00			
24.00 Were new leases and/or amendments to existing leases entere	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reporting periods.							
If yes, see instructions 25.00 Have there been new capitalized leases entered into during instructions.	the cost repo	orting period	? If yes, see	N	25. 00			
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	he cost report	ing period?	If yes, see	N	26. 00			
27.00 Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? I	f yes, submit	N	27. 00			
<pre>Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit er</pre>	ntered into du	ıring the cos	t reporting	N	28. 00			
	period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)							
30.00 Has existing debt been replaced prior to its scheduled maturing instructions.		debt? If ye	s, see	N	30.00			
31.00 Has debt been recalled before scheduled maturity without is instructions.	ssuance of nev	debt? If ye	s, see	N	31.00			
Purchased Services 32.00 Have changes or new agreements occurred in patient care set		ned through c	ontractual	N	32. 00			
arrangements with suppliers of services? If yes, see instructions. arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135. 2 applied to the services.		ng to compet	tive bidding? If	N	33. 00			
Provi der-Based Physi ci ans								
34.00 Are services furnished at the provider facility under an a	rrangement wit	th provider-b	ased physicians?	Y	34.00			
If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ents with the	provi der-based	N	35. 00			
physicians during the cost reporting period: if yes, see if	iisti ucti olis.		Y/N	Date				
			1.00	2. 00				
Home Office Costs								
36.00 Were home office costs claimed on the cost report?			N		36.00			
37.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office	? N		37.00			
If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end			f N		38. 00			
39.00 If line 36 is yes, did the provider render services to other see instructions.			s, N		39. 00			
40.00 If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00			
	1	. 00	00					
Cost Report Preparer Contact Information	lou E		CM TH		4.5.5-			
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMI TH		41.00			
	BLUE & CO				42.00			
	317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43.00			

Health Financial Systems MAJOR	HOSPI TAL	In Lie	u of Form CMS-2	552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0097	Peri od: From 01/01/2018		
		To 12/31/2018	Date/Time Prep 5/23/2019 3:17	
	3. 00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	SENIOR MANAGER			41.00
held by the cost report preparer in columns 1, 2, and 3,				
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cost				43.00
report preparer in columns 1 and 2, respectively.				

Health Financial Systems MA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0097

						To 12/31/2018	Date/Time Pre 5/23/2019 3:1	
							1/P Days /	/ piii
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No	. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		0.00	Available	4.00	F 00	
1 00	Harrital Adulta & Dada (asluma 5 (7 and	1. 00		2.00	3.00	4.00	5. 00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30. 00		40	14, 60	0.00	0	1.00
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	
6.00	Hospital Adults & Peds. Swing Bed NF			40	44.00	0 00	0	
7. 00	Total Adults and Peds. (exclude observation			40	14, 60	0.00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31. 00		6	2, 19	0. 00	0	8.00
9. 00	CORONARY CARE UNIT	31.00		O	2, 17	0.00	J	9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14. 00	Total (see instructions)			46	16, 79	0.00	•	
15. 00	CAH visits						0	
16.00	SUBPROVIDER - I PF	44 00						16.00
17.00	SUBPROVIDER - IRF	41. 00 42. 00		0		0	0	
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY	42.00		U	'		0	18. 00 19. 00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY	101.00					0	
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30.00						24. 10
25. 00	CMHC - CMHC							25. 00
26.00	MHP PEDIATRICS	88.00					0	
26. 01	MHP OBGYN	88. 01					0	
26. 02 26. 25	MHP FIM FEDERALLY QUALIFIED HEALTH CENTER	88. 02 89. 00						
27. 00	Total (sum of lines 14-26)	69.00		46			U	27.00
28. 00	Observation Bed Days			40			0	
29. 00	Ambul ance Trips						Ĭ	29.00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	3 3 1			0		0		32.00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							22.00
33.00	LTCH non-covered days LTCH site neutral days and discharges							33. 00 33. 01
33. UI	TETOT SITE HEUTER days and dischalges		l		I	1	I	J 33. UT

Provider CCN: 15-0097 Peri od: From 01/01/2018 | Worksheet S-3 Part I To 12/31/2018 | Date/Ti me Prepared: Peri od:

						5/23/2019 3:1	7 pm
	·	I/P Days	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	
		,		·		•	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	3, 631	261	8, 423			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	1, 452	1, 821				2.00
3. 00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO I RF Subprovi der	0	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	3, 631	261	8, 423			7. 00
	beds) (see instructions)		_				
8. 00	I NTENSI VE CARE UNI T	616	0	1, 511			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSI VE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	4 0 4 7	0/4	0.004	0.00	,,,,,	13.00
14.00	Total (see instructions)	4, 247	261	9, 934	0. 00	698. 24	1
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - I PF	0	0	_	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	٥	0	0	0. 00 0. 00	0.00	1
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY		U	U	0.00	0.00	18. 00 19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	7, 698	836	13, 269	0. 00	0. 08	•
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	7,090	030	13, 209	0.00	0.00	23.00
24. 00	HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)			17			24.00
25. 00	CMHC - CMHC			17			25.00
26. 00	MHP PEDIATRICS	84	752	19, 035	0. 00	16. 77	26.00
26. 00	MHP OBGYN	310	2. 688	8, 499			
26. 02		14, 936	10, 219	59, 811	0.00	73. 37	26.02
26. 25		14, 930	10, 219	39, 611	0.00	l e	1
27. 00		١	O	0	0.00	801. 50	27.00
28. 00			144	523		001.30	28.00
29. 00	Ambulance Trips	o	144	323			29.00
30. 00	Employee discount days (see instruction)	١		0			30.00
31. 00	Employee discount days (see Fristraction)			0			31.00
32. 00	Labor & delivery days (see instructions)	o	15	46			32.00
32. 00	Total ancillary labor & delivery room		13	1 0			32.00
JZ. UI	outpatient days (see instructions)						32.01
33 00	LTCH non-covered days	n					33.00
	LTCH site neutral days and discharges	o					33. 01
55.51	1 = 1 = 1 = 10 at at at adjo and at condition	١		1	I	ı	, 50.0.

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared:

				10) 12/31/2018	5/23/2019 3:1	
		Full Time		Di sch	arges	0, 20, 20., 0	, p
		Equi val ents			. 5		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	'	Workers				Pati ents	
		11. 00	12. 00	13.00	14.00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	1, 129	76	2, 749	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			361	495		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	C	1, 129	76	2, 749	14.00
15.00	CAH visits						15.00
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF	0.00	C	0	0	0	17.00
18. 00	SUBPROVI DER	0.00	C)	0	0	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGI CAL CENTER (D. P.)						23.00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	MHP PEDIATRICS	0. 00					26. 00
26. 01	MHP OBGYN	0. 00					26. 01
26. 02	MHP FIM	0. 00					26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0	l		33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION MAJOR HOSPITAL Provider CCN: 15-0097

		W	A		1 11 11	7 12/31/2010	5/23/2019 3: 1	
		Wkst. A Line Number	Amount Reported	Reclassificat	Adj usted Sal ari es	Paid Hours Related to	Average Hourly Wage	
		114201	nopor tou	Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst. A-6)	3)	col. 4	col . 5)	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1. 00	Total salaries (see	200.00	52, 096, 508	0	52, 096, 508	1, 669, 566. 25	31. 20	1. 00
	instructions)					0.00		
2. 00	Non-physician anesthetist Part A		0	0		0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		0	0	О	0. 00	0. 00	3.00
4. 00	B Physician-Part A -		482, 477	0	482, 477	2, 575. 00	187. 37	4. 00
	Admi ni strati ve		102, 111	_				
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 1, 474, 682	0	1	0. 00 8, 810. 00	0. 00 167. 39	4. 01 5. 00
3.00	Physician-Part B		1, 474, 002	Ĭ	1, 474, 002	0,010.00	107.37	3.00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0. 00	0. 00	6. 00
	servi ces							
7. 00	Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	0	o	0. 00	0. 00	7. 01
	residents (in an approved							
8. 00	programs) Home office and/or related		0	0	0	0. 00	0. 00	8. 00
	organi zati on personnel		O					
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 4, 964, 901	0 180, 839	0 5, 145, 740	0. 00 115, 276. 00	0. 00 44. 64	
10.00	instructions)		4, 904, 901	100, 637	5, 145, 740	115, 276. 00	44.04	10.00
11 00	OTHER WAGES & RELATED COSTS		2// 012	1 0	2// 012	7 224 00	40.00	11 00
11. 00	Contract Labor: Direct Patient Care		366, 013	0	366, 013	7, 336. 00	49. 89	11. 00
12.00	Contract Labor: Top Level		0	0	0	0. 00	0. 00	12. 00
	management and other management and administrative							
	servi ces			_				
13. 00	Contract Labor: Physician-Part A - Administrative		992, 205	0	992, 205	6, 235. 00	159. 13	13. 00
14.00	Home office and/or related		0	О	0	0. 00	0. 00	14.00
	organization salaries and wage-related costs							
14. 01	Home office salaries		0	0	0	0. 00	0. 00	14. 01
14. 02 15. 00	Related organization salaries		0	0	0	0. 00 0. 00		14. 02 15. 00
15.00	Home office: Physician Part A - Administrative		U	"		0.00	0.00	15.00
16. 00	Home office and Contract		0	0	0	0. 00	0. 00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		14, 541, 132	0	14, 541, 132			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
	(see instructions)		· ·					
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 304, 223	0	1, 304, 223			19. 00 20. 00
	A		O					
21. 00	Non-physician anesthetist Part		0	0	0			21.00
22. 00	Physician Part A -		51, 149	0	51, 149			22. 00
22. 01	Administrative Physician Part A - Teaching		0					22. 01
23. 00	Physician Part B		165, 957		165, 957			23. 00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50	Home office wage-related		0	0	0			25. 50
25. 51	(core) Related organization		Ω	0	0			25. 51
	wage-related (core)		O					
25. 52	Home office: Physician Part A - Administrative -		0	0	0			25. 52
	wage-related (core)							
25. 53	Home office & Contract Physicians Part A - Teaching -		0	0	0			25. 53
	wage-related (core)							

Provider CCN: 15-0097

| Period: | Worksheet S-3 | From 01/01/2018 | Part | I | To | 12/31/2018 | Date/Time Prepared:

					1	o 12/31/2018	Date/lime Pre 5/23/2019 3:1	
	·	Wkst. A Line	Amount	Recl assi fi cat	Adjusted	Pai d Hours	Average	/ pili
		Number	Reported	i on of	Sal ari es	Related to	Hourly Wage	
			,	Sal ari es	(col.2 ± col.	Salaries in	(col . 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				A-6)	ĺ		ĺ	
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARI	ES						
26.00	Employee Benefits Department	4.00	609, 251	0	609, 251	11, 687. 00	52. 13	26. 00
27.00	Administrative & General	5. 00	8, 729, 560	-180, 839	8, 548, 721	256, 385. 00	33. 34	27.00
28.00	Administrative & General under		839, 150	0	839, 150	6, 070. 00	138. 25	28. 00
	contract (see inst.)							
29.00	Maintenance & Repairs	6. 00	0	0	0	0.00	0. 00	29. 00
30.00	Operation of Plant	7. 00	1, 235, 800	0	1, 235, 800	46, 724. 00	26. 45	30.00
31.00	Laundry & Linen Service	8. 00	34, 700	0	34, 700	2, 218. 00	15. 64	31.00
32.00	Housekeepi ng	9. 00	1, 378, 050	0	1, 378, 050	82, 982. 00	16. 61	32.00
33.00	Housekeeping under contract		290, 030	0	290, 030	7, 016. 00	41. 34	33.00
	(see instructions)							
34.00	Di etary	10.00	799, 518	-640, 100	159, 418	10, 468. 00	15. 23	34.00
35.00	Dietary under contract (see		247, 141	0	247, 141	3, 532. 00	69. 97	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	640, 100	640, 100	43, 356. 00	14. 76	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0. 00	37.00
38.00	Nursing Administration	13. 00	626, 438	0	626, 438	17, 392. 00	36. 02	38. 00
39.00	Central Services and Supply	14. 00	267, 863	-267, 863	0	0.00	0. 00	39. 00
40.00	Pharmacy	15. 00	1, 101, 761	0	1, 101, 761	25, 399. 00	43. 38	40.00
41.00	Medical Records & Medical	16. 00	941, 868	0	941, 868	42, 872. 00	21. 97	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0. 00		42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0. 00	43.00

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0097	Period: Worksheet S-3

						From 01/01/2018 To 12/31/2018	Date/Time Pre	
		Worksheet A	Amount	Recl assi fi cat	Adiusted	Pai d Hours	5/23/2019 3:1	/ pm
					,		Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Sal ari es in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		51, 998, 147	0	51, 998, 147	1, 677, 374. 25	31. 00	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 964, 901	180, 839	5, 145, 740	115, 276. 00	44. 64	2.00
	instructions)							
3.00	Subtotal salaries (line 1		47, 033, 246	-180, 839	46, 852, 407	1, 562, 098. 25	29. 99	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 358, 218	0	1, 358, 218	13, 571. 00	100. 08	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		14, 592, 281	0	14, 592, 281	0.00	31. 15	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		62, 983, 745	-180, 839	62, 802, 906	1, 575, 669. 25	39. 86	6.00
7. 00	Total overhead cost (see		17, 101, 130					7. 00
	instructions)		,,	110,702	12,002,120	1127 1011 00		
	1.1.51.451.51.57	1		I	ı	1		

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0097	Peri od: From 01/01/2018 To 12/31/2018 Worksheet S-3 Part IV Date/Time Prepared:

	10 12/31/2018	5/23/2019 3:1	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	2, 417, 680	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		l
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		l
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	9, 494, 691	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8.03	Heal th Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	49, 754	
	Life Insurance (If employee is owner or beneficiary)	81, 066	
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	176, 707	
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00		148, 253	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		l
	TAXES		
	FICA-Employers Portion Only	3, 595, 816	
	Medicare Taxes - Employers Portion Only	0	18.00
19. 00	Unempl oyment Insurance	84, 880	
20. 00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))	_	
	1 19 11 11 11 11 11 11 11 11 11 11 11 11	0	22.00
	Tuition Reimbursement	13, 614	
24. 00		16, 062, 461	24.00
25 62	Part B - Other than Core Related Cost		25 00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	ΟĮ	25. 00

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0097	Peri od: Worksheet S-3 From 01/01/2018 Part V

		Ť	o 12/31/2018	Date/Time Pre 5/23/2019 3:1	pared: 7 pm
	Cost Center Description		Contract	Benefit Cost	
			Labor		
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1. 00	Total facility's contract labor and benefit cost		0	0	1.00
2. 00	Hospi tal		0	0	2.00
3. 00	Subprovi der - IPF				3.00
4. 00	Subprovi der - I RF		0	0	4.00
5. 00	Subprovi der - (0ther)		0	0	5.00
6. 00	Swing Beds - SNF		0	0	6.00
7. 00	Swing Beds - NF		0	0	7. 00
8. 00	Hospi tal -Based SNF				8.00
9. 00	Hospi tal -Based NF				9.00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	11.00
12.00	Separately Certified ASC				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC		0	0	14.00
14. 01	Hospital-Based Health Clinic RHC 1		0	0	14. 01
14. 02	Hospital-Based Health Clinic RHC 2		0	0	14. 02
15.00	Hospital-Based Health Clinic FQHC		0	0	15.00
16.00	Hospi tal -Based-CMHC				16.00
17.00	Renal Dialysis				17.00
18.00	Other		0	0	18. 00

Heal th	Financial Systems	MAJOR HO	ISPI TAI		In lie	u of Form CMS-2	2552-10
	IEALTH AGENCY STATISTICAL DATA	W/ SOR TIC			eriod: rom 01/01/2018	Worksheet S-4	
			Component		o 12/31/2018		
					Home Health	PPS	7 piii
					Agency I		
0. 00	County				1.	00	0.00
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
	HOME HEALTH AGENCY STATISTICAL DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	Home Health Aide Hours	0					1.00
2. 00	Unduplicated Census Count (see instructions)	0.00	312.00		0.00 oyees (Full Ti		2.00
			er of hours in work week	Staff	Contract	Total	
		,					
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES)	1. 00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		0.00	l .		l	3.00
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.00		l	4. 00 5. 00
6. 00	Direct Nursing Service			8. 79		l	6.00
7.00	Nursing Supervisor Physical Therapy Service			0.00		l	7.00
8. 00 9. 00	Physical Therapy Supervisor			2. 52 0. 90			8. 00 9. 00
10.00	Occupational Therapy Service			0. 45			10.00
11.00	Occupational Therapy Supervisor			0.00		1	
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0. 01 0. 00		1	12. 00 13. 00
14. 00	Medical Social Service			0.05		l .	1
15. 00	Medical Social Service Supervisor			0.00			•
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			2. 06 0. 00		l	•
18. 00	Other (specify)			0.00			l
10.00	HOME HEALTH AGENCY CBSA CODES			1 2	ı		10.00
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost			2			19. 00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			26900			20.00
20.00	during this cost reporting period (line 20			26900			20.00
20. 01	contains the first code).			99915			20. 01
20.01	<u> </u>		pi sodes				20.01
		Without Outliers	With Outliers	LUPA Epi sodes	PEP Only Epi sodes	Total (cols. 1-4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	3, 443	332	67	35	3, 877	21.00
22. 00	Skilled Nursing Visit Charges	771, 110		1			1
23. 00	Physical Therapy Visits	2, 097		8	17	2, 229	23. 00
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	443, 610 562					24. 00 25. 00
26. 00	Occupational Therapy Visit Charges	125, 296				145, 812	1
27. 00	Speech Pathology Visits	21	1	1			1
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	4, 760 44		1		4, 987 57	28. 00 29. 00
30.00	Medical Social Service Visit Charges	13, 376		1		l .	1
31. 00	Home Health Aide Visits	762		1			1
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	85, 344 6, 929		1			1
33. 00	29, and 31)	0, 727	017		0,	7,070	33.00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 1, 443, 496	126, 900	-		0 1, 604, 037	34.00 35.00
	30, 32, and 34)						
36. 00	Total Number of Episodes (standard/non outlier)	368		26	6	400	36. 00
37.00	Total Number of Outlier Episodes		14		0		37.00
38. 00	Total Non-Routine Medical Supply Charges	28	0	0	0] 28	38. 00

	Financial Systems	MAJOR H				eu of Form CMS		552-1
10SPI	FAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0097	Period: From 01/01/2018	Worksheet S	-8	
			Component	CCN: 15-8529	To 12/31/2018		rep	ared
			· ·		5110	5/23/2019 3	<u>: 17</u>	pm
					RHC I			
					1	. 00	-	
	Clinic Address and Identification					. 00	_	
. 00	Street				2451 INTELLIP	LEX DRIVE,	\neg	1.0
					SUITE 240			
				ty	State	ZIP Code	4	
2. 00	City, State, ZIP Code, County		SHELBYVI LLE	00	2.00	3. 00 N 46176	+	2.0
. 00	city, State, Zir code, county		BILLDIVILLE			140170	+	2.0
						1. 00	\top	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban			0	3. 0
					nt Award	Date	4	
					1. 00	2. 00	_	
1. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Ac+)		T			_	4. 0
5. 00	Migrant Health Center (Section 329(d), PHS A						ł	5. 0
. 00	Health Services for the Homeless (Section 34							6. 0
. 00	Appal achi an Regi onal Commi ssi on	,					l	7.0
3. 00	Look-Alikes							8.0
. 00	OTHER (SPECIFY)						\perp	9.0
					1.00	2.00	+	
0. 00	Does this facility operate as other than a h	osni tal _hased	RHC or FOHC2 F	nter "V" for	1. 00 N	2. 00	0	10. C
0.00	yes or "N" for no in column 1. If yes, indic							10.0
	2. (Enter in subscripts of line 11 the type o							
	hours.)						\perp	
			nday		londay	Tuesday	+	
		from 1.00	2. 00	3.00	4. 00	from 5.00	+	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	3.00	+	
1. 00	CLINIC			07: 30	18: 00	07: 30		11. 0
				•				
	To the second se				1.00	2. 00	4	
2.00	1 3				N			12.0
3. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col				N		١	13.0
	number of providers included in this report.							
	numbers below.		,					
					ider name	CCN number	\perp	
	TRUO (FRUO				1. 00	2. 00	4	
4.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits		14.0
		1. 00	2.00	3.00	4.00	5. 00	3	
15. 00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	3.00	+	15. 0
	GME cost? Enter "Y" for yes or "N" for no in							
	column 1. If yes, enter in columns 2, 3 and							
	4 the number of program visits performed by							
	Intern & Residents for titles V, XVIII, and							
	XIX, as applicable. Enter in column 5 the number of total visits for this provider.							
	(see instructions)							
			Cou	unty		•		
				00				
			SHELBY				_	2. 0
2. 00	City, State, ZIP Code, County		M = -1	esday	Thu	rsday		
2. 00	City, State, ZIP Code, County	Tuesday						
2. 00	City, State, ZIP Code, County	to	from	to	from	to		
2. 00	Facility hours of operations (1)							

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 15-0097	Peri od:	Worksheet S-8	1
				From 01/01/2018		
		Component	CCN: 15-8529	To 12/31/2018		
					5/23/2019 3:1	/ pm
				RHC I		
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 30	17: 00				11.00

	Financial Systems	MAJOR HO				eu of Form CMS		552-1
IOSPI I	AL-BASED RHC/FQHC STATISTICAL DATA			CCN: 15-0097 CCN: 15-8531	Peri od: From 01/01/2018 To 12/31/2018	B Date/Time P	rep	
					RHC II	5/23/2019 3:	: 17	pm
					1			
	Taran di Santa di Sa				1.	. 00	_	
00	Clinic Address and Identification				2451 INTELLIP	EV DDIVE	\dashv	1 0
. 00	Street				SUITE 230	LEX DRIVE,		1. 0
			Ci	ty	State	ZIP Code		
				00	2. 00	3.00	\perp	
. 00	City, State, ZIP Code, County		SHELBYVI LLE		1 1 1	V 46176	+	2. 0
						1.00	\top	
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for				0	3. 0
				Gra	nt Award	Date	\perp	
	Source of Federal Funds				1. 00	2.00	+	
. 00	Community Health Center (Section 330(d), PHS	Act)					_	4. 0
. 00	Migrant Health Center (Section 329(d), PHS A	ct)						5.00
. 00	Health Services for the Homeless (Section 34)	O(d), PHS Act)						6.0
'. 00 3. 00	Appalachian Regional Commission Look-Alikes							7. 00 8. 00
0. 00	OTHER (SPECIFY)							9. 0
0.00	Door this facility apprets as other than a h	anital based	DUC on FOUCA F	nton "V" for	1.00	2. 00	0	10.0
0. 00	Does this facility operate as other than a house or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type of hours.)	ate number of	other operation	ns in column				10.0
	11001 3.)	Sur	nday	N	londay	Tuesday	\top	
		from	to	from	to	from	\Box	
	Facility hours of operations (1)	1. 00	2. 00	3.00	4. 00	5. 00	+	
1. 00	CLINIC		08: 00		17: 00	08: 00		11. 0
2 00				110	1.00	2. 00	+	10.0
2.00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. In numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	er 9, section umn 2 the	N N			12. 0 13. 0
				Prov	ider name	CCN number		
4 60	Duo (Folio				1. 00	2. 00		11.5
4.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits		14. 0
		1. 00	2.00	3.00	4.00	5. 00	,	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and			3.00	55	1.00	T	15. 0
	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and							
	XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							
				unty				
	City, State, ZIP Code, County		SHELBY 4.	. 00			+	2. 0
00	orty, State, ZIF Code, County	Tuesday	-	esday	Thu	rsday		2.0
2. 00							\rightarrow	
. 00		to	from	to	from	to		
. 00	Facility hours of operations (1)		from 7.00	8. 00	9.00	to 10.00	\pm	

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-:	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	
		Component		From 01/01/2018 To 12/31/2018		
	_			RHC II		
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

SUITE 200 City State 71P Code 1.00 2.00 3.00		Financial Systems	MAJOR HO				eu of Form CMS	
Street Substitute Street Substitute Substitute	HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA				From 01/01/2018	Date/Time Pr	epared
1.00						RHC III	5/23/2019 3:	17 pm
Community Heal th Center (Section 330(d), PHS Act) Surgan Heal th Center (Section 330(d), PHS Act) Surgan Heal th Center (Section 320(d), PHS Act) Surgan Heal th Center (Section Heal th Ce								
1.00 Street		Clinia Address and Identification				1.	00	
City State ZIP Code	1. 00						EX DRIVE,	1.0
2.00 City State ZIP Code County SHELBYVILLE IN 6176 1.00 2.00 3.00 HOSPITAL-BASED FORCS ONLY: Designation - Enter "R" for rural or "U" for urban 0 Carant Award Date 1.00 2.00 2.00 3.00 Migrant Health Center (Section 330(d), PHS Act) Migrant Health Center (Section 329(d), PHS Act) Migrant Health Center (Section 320(d), PHS Act) Migrant Migrant Migrant Migrant Migrant Migrant Migrant Migrant Migrant				Ci	ty		ZIP Code	
1.00					00			
	2. 00	City, State, ZIP Code, County		SHELBYVI LLE		I N	46176	2.0
							1 00	+
Source of Federal Funds	3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban			0 3.0
Source of Federal Funds								
Community Heal th Center (Section 330(d), PHS Act)		C C. F. I I. F I.				1. 00	2. 00	
Migrant Health Center (Section 329(d), PHS Act)	4 00		Ac+)		T		I	4.0
Health Services for the Homeless (Section 340(d), PHS Act)								5.0
Appalachian Regional Commission Appalachian Regional								6. (
2.00 OTHER (SPECIFY)	7. 00		,					7.0
1.00 2.00 1.00 2.00								8.0
10.00 Does this facility operate as other than a hospital-based RHC or FGHC? Enter "" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday	9. 00	OTHER (SPECIFY)						9. (
10,00 Does this facility operate as other than a hospital-based RHC or FGHC? Enter "" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday						1 00	2 00	+
Ves or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday	10.00	Does this facility operate as other than a he	ospi tal -based	RHC or FQHC? E	nter "Y" for			0 10.0
Sunday Monday Tuesday From to		yes or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type o	ate number of	other operation	ns in column			
1.00 2.00 3.00 4.00 5.00		110di 3.)	Sur	nday	M	londay	Tuesday	
Facility hours of operations (1)							from	
11.00 CLINIC			1. 00	2. 00	3. 00	4. 00	5. 00	_
1.00 2.00 1.00 2.00 1.00 2.00 1.00 1.00 2.00 1.00	11 00				07:00	17:00	07:00	11.0
Have you received an approval for an exception to the productivity standard? Statis a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section Statis a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section Statis a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section Statis and solve the number of providers included in this report. List the names of all providers and numbers below. Provider name CCN number Statis S	11.00	CETHIC		1	07.00	17.00	07.00	11.
13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30. 8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provider name						1. 00	2. 00	
Provider name CCN number 1.00 2.00		Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	er 9, section mn 2 the			0 13.0
14.00 RHC/FQHC name, CCN number Y/N V XVIII XIX Total Visits 1.00 2.00 3.00 4.00 5.00 15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 City, State, ZIP Code, County Tuesday Tuesday Wednesday Thursday To from from to from from from to from from from from from from from fro		Trainibot of bottom			Provi	der name	CCN number	
Y/N V XVIII XIX Total Visits						1. 00	2. 00	
1.00 2.00 3.00 4.00 5.00 15.00 15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00	14. 00	RHC/FQHC name, CCN number	V /N	V	VVIII I	VIV	Total Visita	14.0
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 2.00 City, State, ZIP Code, County Tuesday Tuesday Tuesday Wednesday Thursday to from to from to 6.00 7.00 8.00 9.00 10.00								-
number of total visits for this provider. (see instructions)	15. 00	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by		2.00	3.00	4.00	3.00	15. (
County 4.00		number of total visits for this provider.						
2.00 City, State, ZIP Code, County SHLEBY Tuesday Wednesday Thursday to from to from to 6.00 7.00 8.00 9.00 10.00								
Tuesday Wednesday Thursday to from to from to 6.00 7.00 8.00 9.00 10.00	2 00	Oltro Ctata 71D Cada Const			00			1
to from to from to 6.00 7.00 8.00 9.00 10.00	2. 00	CITY, State, ZIP Code, County	Tuocday		oeday	Thur	eday	2.0
6.00 7.00 8.00 9.00 10.00					1			
		Facility hours of operations (1)						

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 15-0097	Peri od:	Worksheet S-8	3
			0011 45 0500	From 01/01/2018		
		Component	CCN: 15-8532	To 12/31/2018	Date/lime Pre 5/23/2019 3:1	
					3/23/2019 3. 1	7 pili
			_	RHC III		
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	17: 00				11.00

nour tr	Financial Systems MAJOR HOSPITA	۱L		In Lie	u of Form CMS-2	2552-10
HOSPI 7	TAL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CC	N: 15-0097	Peri od:	Worksheet S-1	0
				From 01/01/2018 To 12/31/2018	Date/Time Pre	nared:
				10 12/01/2010	5/23/2019 3: 1	7 pm
					1. 00	
	Uncompensated and indigent care cost computation				1.00	
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by Li	ne 202 colum	ın 8)	0. 307004	1.00
1.00	Medicaid (see instructions for each line)	raca by ir	110 202 COT UIII	0)	0.007001	1.00
2. 00	Net revenue from Medicaid				14, 439, 628	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.00
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplement			ai d?	Υ	4.00
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from	om Medicai	d		0	5.00
6. 00	Medi cai d charges				71, 621, 154	6.00
7.00	Medicaid cost (line 1 times line 6)	lina 7 min	us sum of Li	noo 2 and E. if	21, 987, 981	7.00
8. 00	Difference between net revenue and costs for Medicaid program (< zero then enter zero)	iine / min	ius suiii oi TT	nes 2 and 5; 11	7, 548, 353	8. 00
	Children's Health Insurance Program (CHIP) (see instructions for	r each lin	ie)			
9. 00	Net revenue from stand-alone CHIP				0	9.00
10.00	Stand-al one CHIP charges				0	10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12. 00	,	line 11 mi	nus line 9;	if < zero then	0	12.00
	enter zero)		S	`		
12 00	Other state or local government indigent care program (see insti				0	13.00
13.00	Net revenue from state or local indigent care program (Not included Charges for patients covered under state or local indigent care				0	14.00
14.00	10)	program (Not Theradea	THE THES O OF	U	14.00
15. 00	1 ()			0	15.00
16. 00			program (li	ne 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHII instructions for each line)	P and stat	e/Local indi	gent care progra	ıms (see	
17. 00	Private grants, donations, or endowment income restricted to ful	ndi ng char	ity care		0	17.00
18. 00	Government grants, appropriations or transfers for support of he	ospital op	erati ons		0	18.00
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local	i ndi gent	care program	s (sum of lines	7, 548, 353	19.00
	8, 12 and 16)				T	
			Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)	
		+	1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	5.00	
20. 00	Charity care charges and uninsured discounts for the entire fac	ility	7, 153, 25	618, 542	7, 771, 800	20.00
21. 00	(see instructions) Cost of patients approved for charity care and uninsured discou	nts (see	2, 196, 07	79 618, 542	2, 814, 621	21.00
Z 1. UU	instructions)	1113 (300	2, 170, 07	010, 342	2,014,021	21.00
22. 00	Payments received from patients for amounts previously written	off as		o o	0	22.00
	chari ty care					
	Cost of shority core (Line 21 minus Line 22)		2, 196, 07	79 618, 542	2, 814, 621	
23. 00	Cost of charity care (line 21 minus line 22)					23. 00
23. 00	cost of charity care (fine 21 minus fine 22)					23. 00
					1. 00	
	Does the amount on line 20 column 2, include charges for patien		ond a Length	of stay limit		
24. 00	Does the amount on line 20 column 2, include charges for patien imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the	program?	-	-	1. 00	24.00
24. 00 25. 00	Does the amount on line 20 column 2, include charges for patien imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the stay limit	program? e indigent	care progra	-	1.00 N	24. 00 25. 00
24. 00 25. 00 26. 00	Does the amount on line 20 column 2, include charges for patien imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see ins	program? e indigent tructions)	care progra	-	1.00 N 0 7,331,722	24. 00 25. 00 26. 00
24. 00 25. 00 26. 00 27. 00	Does the amount on line 20 column 2, include charges for patien imposed on patients covered by Medicaid or other indigent care of line 24 is yes, enter the charges for patient days beyond the stay limit. Total bad debt expense for the entire hospital complex (see ins Medicare reimbursable bad debts for the entire hospital complex.	program? e indigent tructions) (see inst	care progra	-	1. 00 N 0 7, 331, 722 401, 181	24. 00 25. 00 26. 00 27. 00
24. 00 25. 00 26. 00 27. 00 27. 01	Does the amount on line 20 column 2, include charges for patien imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see ins Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see	program? e indigent tructions) (see inst	care progra	-	1. 00 N 0 7, 331, 722 401, 181 617, 202	24. 00 25. 00 26. 00 27. 00 27. 01
24. 00 25. 00 26. 00 27. 00 27. 01 28. 00	Does the amount on line 20 column 2, include charges for patien imposed on patients covered by Medicaid or other indigent care of the line 24 is yes, enter the charges for patient days beyond the stay limit. Total bad debt expense for the entire hospital complex (see insome Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (so Non-Medicare bad debt expense (see instructions)	program? e indigent tructions) (see inst ee instruc	care progra	m's length of	1. 00 N 0 7, 331, 722 401, 181 617, 202 6, 714, 520	24. 00 25. 00 26. 00 27. 00 27. 01 28. 00
23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00 30. 00	Does the amount on line 20 column 2, include charges for patien imposed on patients covered by Medicaid or other indigent care of the patient 24 is yes, enter the charges for patient days beyond the stay limit. Total bad debt expense for the entire hospital complex (see insomedicare reimbursable bad debts for the entire hospital complex (see insomedicare allowable bad debts for the entire hospital complex (some Medicare bad debt expense (see instructions). Cost of non-Medicare and non-reimbursable Medicare bad debt expense.	program? e indigent tructions) (see inst ee instruc	care progra	m's length of	1. 00 N 0 7, 331, 722 401, 181 617, 202	24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00

	FINANCIAL SYSTEMS	MAJUK HUSI		N. 15 0007 5		Wassissan A	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	IF EXPENSES	Provi der CC		Period: From 01/01/2018	Worksheet A	
					o 12/31/2018		
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	5/23/2019 3: 1 Reclassi fi ed	/ pm
	cost center bescription	Sararres	Other	+ col . 2)	i ons (See	Tri al Bal ance	
					A-6)	(col. 3 +-	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS		0 4/4 004	0.4/4.004		0 4/4 004	1 4 00
1.00	00100 CAP REL COSTS-BLDG & FIXT 00300 OTHER CAPITAL RELATED COSTS		9, 461, 391	9, 461, 391	1	9, 461, 391	1.00 3.00
3. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	609, 251	12, 630, 222	13, 239, 473	0	13. 239. 473	4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	8, 729, 560	13, 939, 510	22, 669, 070		22, 318, 396	5.00
7. 00	00700 OPERATION OF PLANT	1, 235, 800	1, 722, 253	2, 958, 053		2, 958, 053	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	34, 700	243, 678			278, 378	
9.00	00900 HOUSEKEEPI NG	1, 378, 050	781, 322	2, 159, 372	0	2, 159, 372	9.00
10.00	01000 DI ETARY	799, 518	1, 313, 506			421, 321	
11.00	01100 CAFETERI A	0	0	(1,0,1,700	1, 691, 703	
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	626, 438	394, 687	1, 021, 125		1, 021, 125	
15. 00	01500 PHARMACY	267, 863 1, 101, 761	351, 715 8, 597, 297	619, 578 9, 699, 058		824 9, 699, 058	14.00 15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	941, 868	385, 855	1, 327, 723		1, 327, 723	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	711,000	555, 555	1,027,720	,	1,027,720	10.00
30.00	03000 ADULTS & PEDIATRICS	5, 148, 119	1, 349, 385	6, 497, 504	25, 834	6, 523, 338	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 209, 671	245, 475	1, 455, 146	0	1, 455, 146	31.00
41.00	04100 SUBPROVI DER - I RF	0	0	C	_	0	
42. 00	04200 SUBPROVI DER	0	0	C	0	0	42.00
FO 00	ANCILLARY SERVICE COST CENTERS	2 27/ 427	2 424 57/	4 700 000	272 072	F 071 07F	
50. 00 52. 00	O5000 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM	2, 376, 427	2, 421, 576	4, 798, 003	273, 972	5, 071, 975 0	50.00 52.00
53. 00	05300 ANESTHESI OLOGY	2, 684, 914	590, 254	3, 275, 168		3, 275, 168	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 811, 184	3, 382, 260	6, 193, 444		6, 193, 444	
56. 00	05600 RADI OI SOTOPE	0	0	0, 1, 0, 1, 1	o	0	
56. 01	05601 ONCOLOGY	1, 235, 299	2, 788, 045	4, 023, 344	0	4, 023, 344	56. 01
57.00	05700 CT SCAN	260, 619	805, 937	1, 066, 556	0	1, 066, 556	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	376, 009	506, 376	882, 385	0	882, 385	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59.00
60.00	06000 LABORATORY	1, 985, 250	4, 083, 031	6, 068, 281	0	6, 068, 281	
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	935, 364	212, 834	1, 148, 198		0 1, 148, 198	60. 01 65. 00
65. 01	06501 SLEEP LAB	508, 049	211, 979	720, 028		720, 028	
66. 00	06600 PHYSI CAL THERAPY	1, 711, 642	312, 948	· ·		2, 024, 590	
69.00	06900 ELECTROCARDI OLOGY	671, 872	1, 754, 288	2, 426, 160		2, 426, 160	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	122, 252	3, 636, 620	3, 758, 872	-1, 767, 744	1, 991, 128	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	1, 767, 744	1, 767, 744	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 MHP PEDIATRICS	771, 500	1, 475, 322	2, 246, 822	. 0	2, 246, 822	88.00
88. 01	08801 MHP OBGYN	620, 175	1, 105, 031	1, 725, 206		1, 725, 206	
88. 02	08802 MHP FI M	3, 289, 550	4, 518, 658			7, 808, 208	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	((((((((((((((((((((1	0	
90.00	09000 CLI NI C	981, 345	547, 524	1, 528, 869	0	1, 528, 869	
	09100 EMERGENCY	2, 389, 736	1, 940, 911	4, 330, 647	318, 948	4, 649, 595	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	1, 317, 821	256, 327	1, 574, 148	8 0	1, 574, 148	92.0
95 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	٥	٥	C) O	0	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	o	Ö	(_	0	
	10000 I &R SERVICES-NOT APPRVD PRGM	o	ő	C	o		100.00
	10100 HOME HEALTH AGENCY	1, 428, 066	329, 437	1, 757, 503		1, 757, 503	
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE		0	C			113.00
118.00		48, 559, 673	82, 295, 654	130, 855, 327	-350, 674	130, 504, 653	118.00
100.00	NONREI MBURSABLE COST CENTERS		ما			0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(190. 00 190. 01
100 01		U	0	(350, 674	350, 674	
	19001 SHELBY COUNTY MEDICAL CENTER	٥			, 000, 07 1		
190.05	19005 MARKETI NG	0	205. 734	205. 734	l ol	205. /34	1190. 0
190. 05 190. 07		0 0 60, 421	205, 734 131, 917	205, 734 192, 338		205, 734 192, 338	
190. 05 190. 07 190. 08	19005 MARKETI NG 19007 I -74 CAMPUS	ō			0		190. 08
190. 05 190. 07 190. 08 190. 09 190. 11	19005 MARKETING 19007 I -74 CAMPUS 19008 RAMPART 19009 INTELLIPLEX DEVELOPMENT 19011 MHP ADMIN BUILDING	0 60, 421 0 39, 702	131, 917 62, 935 51, 229	192, 338 62, 935 90, 931	0 0 0	192, 338 62, 935 90, 931	190. 08 190. 09 190. 1
190. 05 190. 07 190. 08 190. 09 190. 11 190. 16	19005 MARKETING 19007 I -74 CAMPUS 19008 RAMPART 19009 INTELLIPLEX DEVELOPMENT 19011 MHP ADMIN BUILDING 19016 RENOVO	60, 421 0	131, 917 62, 935	192, 338 62, 935	0 0 0 0	192, 338 62, 935 90, 931 190, 939	190. 08 190. 09 190. 1 190. 1
190. 05 190. 06 190. 06 190. 11 190. 16 190. 17	19005 MARKETING 19007 I -74 CAMPUS 19008 RAMPART 19009 INTELLIPLEX DEVELOPMENT 19011 MHP ADMIN BUILDING 19016 RENOVO 19017 I MA	0 60, 421 0 39, 702 96, 770	131, 917 62, 935 51, 229 94, 169 0	192, 338 62, 935 90, 931 190, 939	0 0 0 0 0	192, 338 62, 935 90, 931 190, 939 0	190. 08 190. 09 190. 19 190. 10 190. 1
190. 05 190. 07 190. 08 190. 09 190. 11 190. 16 190. 17	19005 MARKETING 19007 I -74 CAMPUS 19008 RAMPART 19009 INTELLIPLEX DEVELOPMENT 19011 MHP ADMIN BUILDING 19016 RENOVO 19017 I MA 19018 MD SOLUTIONS	0 60, 421 0 39, 702	131, 917 62, 935 51, 229	192, 338 62, 935 90, 931	0 0 0 0 0 0	192, 338 62, 935 90, 931 190, 939 0 907, 278	190. 08 190. 09 190. 19 190. 10 190. 18
190. 05 190. 07 190. 08 190. 09 190. 11 190. 16 190. 17 190. 18	19005 MARKETING 19007 I -74 CAMPUS 19008 RAMPART 19009 INTELLIPLEX DEVELOPMENT 19011 MHP ADMIN BUILDING 19016 RENOVO 19017 I MA 19018 MD SOLUTIONS 19019 MHCD	0 60, 421 0 39, 702 96, 770	131, 917 62, 935 51, 229 94, 169 0	192, 338 62, 935 90, 931 190, 939	0 0 0 0 0 0 0 0	192, 338 62, 935 90, 931 190, 939 0 907, 278	190. 08 190. 09 190. 16 190. 16 190. 18 190. 18
190. 05 190. 07 190. 09 190. 11 190. 16 190. 17 190. 18 190. 19	19005 MARKETING 19007 I -74 CAMPUS 19008 RAMPART 19009 I NTELLI PLEX DEVELOPMENT 19011 MHP ADMIN BUILDING 19016 RENOVO 19017 I MA 19018 MD SOLUTIONS 19019 MHCD 19200 PHYSICIANS' PRIVATE OFFICES	0 60, 421 0 39, 702 96, 770 0 452, 947 0	131, 917 62, 935 51, 229 94, 169 0 454, 331 0	192, 338 62, 935 90, 931 190, 939 0 907, 278		192, 338 62, 935 90, 931 190, 939 0 907, 278 0	190. 08 190. 09 190. 16 190. 16 190. 18 190. 18 190. 19
190. 05 190. 07 190. 08 190. 11 190. 16 190. 17 190. 18 190. 19 192. 00	19005 MARKETING 19007 I -74 CAMPUS 19008 RAMPART 19009 I NTELLI PLEX DEVELOPMENT 19011 MHP ADMIN BUILDING 19016 RENOVO 19017 I MA 19018 MD SOLUTIONS 19019 MHCD 19200 PHYSICIANS' PRIVATE OFFICES 19201 HOSPITALIST	0 60, 421 0 39, 702 96, 770 0 452, 947 0 0 2, 700, 274	131, 917 62, 935 51, 229 94, 169 0 454, 331 0 0 812, 308	192, 338 62, 935 90, 931 190, 939 0 907, 278 0 3, 512, 582		192, 338 62, 935 90, 931 190, 939 0 907, 278 0 0 3, 512, 582	190. 08 190. 09 190. 11 190. 16 190. 17 190. 18 190. 19 192. 00
190. 05 190. 07 190. 08 190. 11 190. 16 190. 17 190. 18 190. 19 192. 00	19005 MARKETING 19007 I -74 CAMPUS 19008 RAMPART 19009 I NTELLI PLEX DEVELOPMENT 19011 MHP ADMIN BUILDING 19016 RENOVO 19017 I MA 19018 MD SOLUTIONS 19019 MHCD 19200 PHYSICIANS' PRIVATE OFFICES 19201 HOSPITALIST 07950 OTHER NONREIMBURSABLE COST CENTERS	0 60, 421 0 39, 702 96, 770 0 452, 947 0	131, 917 62, 935 51, 229 94, 169 0 454, 331 0	192, 338 62, 935 90, 931 190, 939 0 907, 278 0 3, 512, 582 259, 271		192, 338 62, 935 90, 931 190, 939 0 907, 278 0 3, 512, 582 259, 271	190. 08 190. 09 190. 11 190. 16 190. 18 190. 19 192. 00 192. 01 194. 00

 Health Financial
 Systems
 MAJOR

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 15-0097

Period: Worksheet A From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/23/2019 3:17 pm

				5/23/2019 3: 1	
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8)	For		
			Allocation		
	DENERAL DERIVINE COOT DENTERO	6. 00	7. 00		
1 00	GENERAL SERVICE COST CENTERS	E 40, 40E	0.017.0//	T	1 00
1. 00 3. 00	00100 CAP REL COSTS-BLDG & FIXT	-543, 425	8, 917, 966	1	1. 00 3. 00
4. 00	00300 OTHER CAPITAL RELATED COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	0 -5, 016	0 13, 234, 457	l .	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	-1, 241, 150	21, 077, 246		5.00
7. 00	00700 OPERATION OF PLANT	1, 241, 130	2, 958, 053		7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE	l o	278, 378		8.00
9. 00	00900 HOUSEKEEPI NG	O	2, 159, 372		9.00
10.00	1 1	-195, 873	225, 448		10.00
11.00	01100 CAFETERI A	-973, 305	718, 398	3	11.00
13.00		-76, 061	945, 064		13.00
14. 00		0	824	l e e e e e e e e e e e e e e e e e e e	14. 00
15. 00		-245, 439	9, 453, 619		15.00
16. 00		-1, 777	1, 325, 946)	16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	150,000	/ 272 120		20.00
30. 00 31. 00	1 I	-150, 200 -48, 189	6, 373, 138 1, 406, 957		30. 00 31. 00
41. 00	1	-40, 109	1, 400, 937		41.00
42. 00		0	0	l e e e e e e e e e e e e e e e e e e e	42.00
72.00	ANCILLARY SERVICE COST CENTERS	<u> </u>		<u>/ </u>	42.00
50.00		-725, 788	4, 346, 187	1	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESI OLOGY	-2, 400, 704	874, 464		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-1, 168, 893	5, 024, 551		54.00
56.00	1	0	0		56.00
56. 01	1	-267, 125	3, 756, 219	l control of the cont	56. 01
57.00	1	-220, 326	846, 230		57.00
58.00		-74, 123	808, 262	l e e e e e e e e e e e e e e e e e e e	58.00
59.00	· · · · · · · · · · · · · · · · · · ·	330,050	0 5 720 222		59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	-329, 059 0	5, 739, 222		60. 00 60. 01
65. 00		-49, 920	1, 098, 278		65.00
65. 01	06501 SLEEP LAB	-34, 613	685, 415		65. 01
66. 00	1 1	-102, 855	1, 921, 735		66.00
69.00		-133, 110	2, 293, 050		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-168, 068	1, 823, 060		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 767, 744		72.00
73. 00		0	0		73.00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	1	476, 711	2, 723, 533		88.00
88. 01	1	324, 825	2, 050, 031	l control of the cont	88. 01
88. 02 89. 00	1	1, 077, 396	8, 885, 604		88. 02 89. 00
90.00	1	-511, 786	1, 017, 083		90.00
91.00	1	-1, 019, 077	3, 630, 518		91.00
92. 00	1	1,017,077	0,000,010		92.00
92. 01		0	1, 574, 148	3	92. 01
	OTHER REIMBURSABLE COST CENTERS				
95.00		0	0		95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0)	97.00
	0 10000 I&R SERVICES-NOT APPRVD PRGM	0	4 750 005		100.00
101.0	0 10100 HOME HEALTH AGENCY	-7, 108	1, 750, 395	0	101.00
112 0	SPECIAL PURPOSE COST CENTERS 0 11300 INTEREST EXPENSE	0	0	N	113.00
118. 0	1	-8, 814, 058	121, 690, 595		118.00
110.0	NONREI MBURSABLE COST CENTERS	-0,014,030	121, 070, 373	<u>' </u>	1110.00
190. 0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	1 19001 SHELBY COUNTY MEDICAL CENTER	0	0		190. 01
190.0	5 19005 MARKETI NG	0	350, 674		190. 05
190.0	7 19007 I -74 CAMPUS	0	205, 734		190. 07
	8 19008 RAMPART	0	192, 338	3	190. 08
	9 19009 INTELLIPLEX DEVELOPMENT	0	62, 935		190. 09
	1 19011 MHP ADMIN BUILDING	0	90, 931		190. 11
	6 19016 RENOVO	-7, 200	183, 739		190. 16
	7 19017 I MA	0	0		190. 17
	8 19018 MD SOLUTIONS	22 013	907, 278		190. 18
	9 19019 MHCD 0 19200 PHYSICIANS' PRIVATE OFFICES	-33, 012	-33, 012		190. 19 192. 00
	1/19201/HOSPI TALI ST	-1, 686, 618	1, 825, 964		192.00
	007950 OTHER NONREIMBURSABLE COST CENTERS	-6, 955	252, 316		194.00
200. 0		-10, 547, 843			200.00
			•	•	•

Heal th	Financial Systems		MAJOR H	OSPI TAL		In Lieu	ı of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provi der (CCN: 15-0097	Peri od:	Worksheet A-	-6
						From 01/01/2018 To 12/31/2018	Date/Time Pr	conorod:
						10 12/31/2016	5/23/2019 3:	17 pm
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3.00	4. 00	5. 00				
	A - CAFETERIA							
1.00	CAFETERI A	1100	64 <u>0, 1</u> 00	<u>1, 051, 6</u> 03				1.00
	0		640, 100	1, 051, 603				
	B - CS&R OTHER							
1.00	ADULTS & PEDIATRICS	30. 00	11, 184	14, 650				1.00
2.00	OPERATING ROOM	50.00	118, 604	155, 368				2. 00
3.00	EMERGENCY	91.00	138, 075	180, 873				3. 00
	0		267, 863	350, 891				
	C - MARKETING							
1.00	MARKETI NG	190. 05	180, 839	169, 835				1.00
	0		180, 839	169, 835				
	D - IMPLANTABLE DEVICES RECLA	ASS						
1.00	IMPL. DEV. CHARGED TO	72. 00	55, 222	1, 712, 522				1.00
	PATI ENT							
	0		55, 222	1, 712, 522				
500.00	Grand Total: Increases		1, 144, 024	3, 284, 851				500.00
	•	•	•					•

Heal th	Financial Systems		MAJOR HO	SPI TAL		In Lie	u of Form CMS-	-2552-10
RECLAS	SIFICATIONS			Provi der		Period: From 01/01/2018 To 12/31/2018	Worksheet A- Date/Time Pr 5/23/2019 3:	epared:
		Decreases					0, 20, 201, 0.	, p
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.	.]		
	6. 00	7. 00	8. 00	9. 00	10.00			
	A - CAFETERIA							
1.00	DI ETARY	10. 00	640, 100	<u>1, 051, 6</u> 03	S (D		1.00
	0		640, 100	1, 051, 603	3			
	B - CS&R OTHER					_		
1.00	CENTRAL SERVICES & SUPPLY	14. 00	267, 863	350, 891	(0		1.00
2.00		0.00	0	C)	0		2.00
3.00		0. 00	0_) (0		3.00
	0		267, 863	350, 891				
	C - MARKETING							
1.00	ADMI NI STRATI VE & GENERAL	500	18 <u>0, 8</u> 39	16 <u>9, 8</u> 35	<u> </u>	0		1.00
	0		180, 839	169, 835				_
	D - IMPLANTABLE DEVICES RECLA							
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	55, 222	1, 712, 522	2	0		1.00
	PATI ENTS				L			
	0		55, 222	1, 712, 522				
500.00	Grand Total: Decreases		1, 144, 024	3, 284, 851				500.00

					o 12/31/2018	Date/Time Pre 5/23/2019 3:1	
				Acqui si ti ons		3/23/2019 3. 1	/ pili
		Beginning	Purchases	Donati on	Total	Disposals and	
		Bal ances	. u. o.i.asso	501.011 011		Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	2, 900, 662	0	C	0	0	1.00
2.00	Land Improvements	11, 256, 655	170, 863	C	170, 863	0	2.00
3.00	Buildings and Fixtures	49, 820, 954	10, 359, 523	C	10, 359, 523	5, 070, 562	3.00
4.00	Building Improvements	59, 299, 564	2, 866, 222	C	2, 866, 222	0	4. 00
5.00	Fixed Equipment	6, 856, 522	112, 649	C	112, 649	0	5.00
6.00	Movable Equipment	47, 933, 556	4, 948, 722	C	4, 948, 722	276, 232	6.00
7.00	HIT designated Assets	0	0	C	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	178, 067, 913	18, 457, 979	C	18, 457, 979	5, 346, 794	8.00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	178, 067, 913	18, 457, 979	C	18, 457, 979	5, 346, 794	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
	DART I ANNUALO OF GUANGES IN CARLEY AGOS	6.00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	2, 900, 662	0				1.00
2.00	Land Improvements	11, 427, 518	0				2.00
3.00	Buildings and Fixtures	55, 109, 915	0				3.00
4.00	Building Improvements	62, 165, 786	0				4.00
5.00	Fixed Equipment	6, 969, 171	0				5.00
6.00	Movable Equipment	52, 606, 046	0				6.00
7.00	HIT designated Assets	101 170 000	0				7.00
8.00	Subtotal (sum of lines 1-7)	191, 179, 098	0				8.00
9.00	Reconciling Items	101 170 000	0				9.00
10. 00	Total (line 8 minus line 9)	191, 179, 098	0				10.00

Heal th	Financial Systems	MAJOR HO	SPI TAL		In Lie	eu of Form CMS-	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der 0		Period: From 01/01/2018 To 12/31/2018		pared:
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10. 00	11. 00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FLXT	6, 374, 898	(3, 086, 49	3 0	0	1.00
3.00	Total (sum of lines 1-2)	6, 374, 898	(3, 086, 49	3 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	9, 461, 391		-		1.00
3.00	Total (sum of lines 1-2)	0	9, 461, 391	1			3.00

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2018		
				Го 12/31/2018	Date/Time Prep 5/23/2019 3:1	
	COME	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1. 00	2.00	col. 2) 3.00	4.00	5. 00	
PART III - RECONCILIATION OF CAPITAL COS		2.00	3.00	4.00	3.00	
1. 00 CAP REL COSTS-BLDG & FLXT	191, 179, 099	0	191, 179, 099	1. 000000	0	1.00
3.00 Total (sum of lines 1-2)	191, 179, 099		191, 179, 09	1. 000000	0	3.00
	ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
	6. 00	ed Costs 7.00	through 7) 8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COS		7.00	8.00	9.00	10.00	
1. 00 CAP REL COSTS-BLDG & FLXT	0	0		6, 354, 824	0	1.00
3.00 Total (sum of lines 1-2)	0	O	(6, 354, 824		3.00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	•		
		instructions)		ed Costs (see instructions)	9 through 14)	
	11. 00	12. 00	13. 00	14.00	15. 00	
PART III - RECONCILIATION OF CAPITAL COS						
1. 00 CAP REL COSTS-BLDG & FLXT	2, 563, 142		•	0	8, 917, 966	1.00
3.00 Total (sum of lines 1-2)	2, 563, 142	0		0	8, 917, 966	3.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES MAJOR HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0097 Peri od: From 01/01/2018 To 12/31/2018 Worksheet A-8 Date/Time Prepared: 5/23/2019 3:17 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted

				To/From Which the Amount is t			
		5					
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	Investment income - CAP REL	В	-523, 351	CAP REL COSTS-BLDG & FIXT	1. 00	11	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)						
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time		О		0. 00	0	4. 00
F 00	discounts (chapter 8)				0.00	0	F 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6. 00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	А	_8 005	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
7.00	stations excluded) (chapter	^	-0,003	ADMINISTRATIVE & GENERAL	3.00	0	7.00
0.00	21)				0.00	0	0.00
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-6, 303, 531			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
10.00	(chapter 23)	4.0.1	4 007 404				40.00
12. 00	Related organization transactions (chapter 10)	A-8-1	1, 887, 421			0	12. 00
13.00	Laundry and linen service		0		0. 00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee	В	-397, 048	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
13.00	and others				0.00	O	13.00
16. 00	Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
10.00	abstracts				0.00	J	10.00
19. 00	Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
19. 01	Nursing and allied health		0		0. 00	0	19. 01
	education (tuition, fees, books, etc.)						
20.00	Vendi ng machi nes		0		0. 00	0	20. 00
21. 00	Income from imposition of		0		0. 00	0	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	О	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
20.00	physicians' compensation			3551 55.115. 25.3154			20.00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
20.00	COSTS-BLDG & FLXT			CAL REE COSTS-BEDG & TTAT	1.00	0	20.00
27. 00	Depreciation - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		n	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0. 00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	67. 00		30. 00
	limitation (chapter 14)						

Health Financial Systems MAJOR HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0097 Peri od: Worksheet A-8 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/23/2019 3:17 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Cost Center Description Amount Line # Wkst. A-7 Ref. (2) 1. 00 2.00 3.00 4.00 5. 00 30.99 Hospice (non-distinct) (see O ADULTS & PEDIATRICS 30.00 30.99 instructions) 0 *** Cost Center Deleted *** 31.00 Adjustment for speech A - 8 - 368.00 31.00 pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for 32.00 0.00 32.00 Depreciation and Interest 33.00 CASE MANAGEMENT -7, 910 ADMINISTRATIVE & GENERAL 33.00 В 5.00 0 FOOD AND NUTRITION 34.00 В -8, 525 DI ETARY 10.00 34.00 DIABETIC ED -71,361 NURSING ADMINISTRATION 34.01 В 13.00 34.01 35.00 CAFETERIA - EMP -576, 257 CAFETERI A 11.00 35.00 Α -20,074 CAP REL COSTS-BLDG & FIXT MH OTHER REVENUES RENTAL 36.00 B 1.00 36.00 LNCOME MH INFO. SYSTEMS CONTRACT -311, 866 ADMINISTRATIVE & GENERAL 37.00 37.00 В 5.00 LABOR 38.00 MH PATIENT ACCESS CONTRACT В -7, 694 ADMINISTRATIVE & GENERAL 5.00 38.00 LABOR MH ACCOUNTING CONTRACT LABOR -115, 910 ADMINISTRATIVE & GENERAL 40 00 40.00 B 5.00 0 41.00 MH ADMINISTRATION CONTRACT -233, 225 ADMINISTRATIVE & GENERAL 41.00 В 5.00 42.00 MH EDUCATION CLASS REVENUE В -34, 567 ADMINISTRATIVE & GENERAL 5.00 0 42.00 MH ACCOUNTING VENDOR REBATES -22, 592 ADMINISTRATIVE & GENERAL 44.00 В 5.00 44.00 45.00 MH OTHER REVENUES PURCHASE В -5, 561 ADMINISTRATIVE & GENERAL 5.00 45.00 DI SCOUNTS 45.01 MH OTHER REVENUES В 3, 808 ADMINISTRATIVE & GENERAL 5.00 45.01 REAPPOINTMENT FEES -3, 200 NURSING ADMINISTRATION 45.02 MH CL NUTR/DIAB ED CLASS В 13.00 45.02 REVENUE MH PHARMACY VENDOR REBATES -8, 791 PHARMACY 45.03 В 15.00 45.03 MH PHARMACY CONTRACT LABOR 45 04 -747 PHARMACY 15.00 45.04 B -1, 777 MEDICAL RECORDS & LIBRARY 45.05 MH OTHER REVENUES XEROX AND В 16.00 45.05 COPYL NG 45.06 MH INPATIENT-AMU OTHER INCOME В -1, 250 ADULTS & PEDIATRICS 30.00 45.06 -48, 552 PHYSI CAL THERAPY 45.07 MH REHAB SVCS-SWK CONTRACT 45.07 В 66.00 LABOR 45.08 MH CAR MGT & REHAB CONTRACT -53, 328 ELECTROCARDI OLOGY 69.00 45.08 B LABOR 45.09 MH CENTRAL SUPPLY VENDOR -50, 755 MEDICAL SUPPLIES CHARGED TO 71.00 45.09 В REBATES PATI ENTS 45. 10 MH MHP FIM OTHER INCOME -6, 503 MHP FIM 88.02 45.10 B MH MED. SPEC. CNTR RENTAL -220, 713 CLI NI C 45.11 В 90.00 45.11 INCOME 45. 12 MEALS ON WHEELS Α -187, 348 DI ETARY 10.00 45.12 I HHA/AHA DUES -6, 556 ADMINISTRATIVE & GENERAL 45.13 45.13 Α 5.00 O PROMOTIONAL GLETS -149 EMPLOYEE BENEFITS DEPARTMENT 4.00 45 14 Α 45 14 45. 15 PROMOTIONAL GIFTS Α -1, 951 ADMINISTRATIVE & GENERAL 5.00 45.15 PROMOTIONAL GIFTS -1, 403 NURSING ADMINISTRATION 45.16 Α 13.00 45.16 PROMOTIONAL GIFTS -663 ADULTS & PEDIATRICS 45.17 30.00 45.17 Α -3, 958 RADI OLOGY-DI AGNOSTI C 45 18 PROMOTIONAL GIFTS Α 54.00 45 18 45. 19 PROMOTIONAL GIFTS -3, 641 ONCOLOGY 56.01 45.19 Α PROMOTIONAL GIFTS -1, 349 RESPIRATORY THERAPY 45.20 Α 65.00 45.20 -564 SLEEP LAB PROMOTIONAL GIFTS 45.21 Α 65.01 45.21 45 22 PROMOTIONAL GIFTS Α -9, 311 PHYSI CAL THERAPY 66.00 45 22 PROMOTIONAL GIFTS -2, 043 ELECTROCARDI OLOGY 69.00 45.23 45.23 Α PROMOTIONAL GIFTS -1,555 MHP PEDIATRICS 88.00 45. 24 45. 24 Α PROMOTIONAL GIFTS -126MHP OBGYN 45.25 Α 88.01 45.25 45. 26 PROMOTIONAL GIFTS -472 HOME HEALTH AGENCY 101.00 45.26 Α -1, 808 OTHER NONREI MBURSABLE COST 45.27 PROMOTIONAL GIFTS Α 194.00 45.27 CENTERS 45.28 ADVERTISING EXPENSE -1, 219 ADMI NI STRATI VE & GENERAL 45.28 Α 5.00 0 45. 29 ADVERTISING EXPENSE -84 ONCOLOGY 56.01 45.29 Α ADVERTISING EXPENSE -1,001 PHYSI CAL THERAPY 45.30 45.30 Α 66.00 45.31 ADVERTISING EXPENSE -193 MHP PEDIATRICS 88.00 45.31 Α -112 MHP OBGYN ADVERTISING EXPENSE 45.32 Α 88.01 45.32 45.33 COMMUNITY OUTREACH Α -484, 226 ADMINISTRATIVE & GENERAL 5.00 45.33 -97 NURSING ADMINISTRATION 45. 34 HAF EXPENSE Α 13.00 45.34

-235, 901 PHARMACY

15 00

45.35

Α

45. 35 HAF EXPENSE

				''	0 12/31/2010	5/23/2019 3:1	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					•		
Cost (Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
3331	56e. 5656p	(2)	711104111	0001 0011101	20 "	Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
45. 36 HAF EXPENSE		A A		ADULTS & PEDIATRICS	30.00	0.00	45. 36
45. 37 HAF EXPENSE		A		INTENSIVE CARE UNIT	31. 00	0	45. 37
45. 38 HAF EXPENSE		A		OPERATING ROOM	50.00	0	45. 38
45. 39 HAF EXPENSE		Ä		ANESTHESI OLOGY	53. 00	0	45. 39
45. 40 HAF EXPENSE		A		RADI OLOGY-DI AGNOSTI C	54. 00	0	45. 40
						0	
45. 41 HAF EXPENSE		A		ONCOLOGY	56. 01	0	45. 41
45. 42 HAF EXPENSE		A	-216, 570		57. 00	0	45. 42
45. 43 HAF EXPENSE		A	-74, 123	MAGNETIC RESONANCE IMAGING	58. 00	0	45. 43
				(MRI)		_	
45. 44 HAF EXPENSE		A		LABORATORY	60. 00	0	45. 44
45. 45 HAF EXPENSE		A		RESPI RATORY THERAPY	65. 00	0	45. 45
45.46 HAF EXPENSE		A		SLEEP LAB	65. 01	0	45. 46
45. 47 HAF EXPENSE		A		PHYSI CAL THERAPY	66. 00	0	45. 47
45.48 HAF EXPENSE		Α	-49, 794	ELECTROCARDI OLOGY	69. 00	0	45. 48
45.49 HAF EXPENSE		A	-117, 313	MEDICAL SUPPLIES CHARGED TO	71.00	0	45. 49
				PATI ENTS			
45.50 HAF EXPENSE		A	-1, 404	CLINIC	90.00	0	45.50
45.51 HAF EXPENSE		A	-629, 100	EMERGENCY	91.00	0	45. 51
45.52 HAF EXPENSE		A	-6, 636	HOME HEALTH AGENCY	101.00	0	45. 52
45.53 HAF EXPENSE	· ·	A	-33, 012	MHCD	190. 19	0	45. 53
45.54 HAF EXPENSE		Α	-19, 585	HOSPI TALI ST	192. 01	0	45. 54
45.55 HAF EXPENSE		A		OTHER NONREIMBURSABLE COST	194. 00	0	45. 55
			·	CENTERS			
45. 56 OTHER ADJUS	TMENTS (SPECIFY)		0		0.00	0	45. 56
(3)	,						
45. 57 OTHER ADJUS	TMENTS (SPECIFY)		0		0.00	0	45. 57
(3)	,						
	TMENTS (SPECIFY)		0		0.00	0	45. 58
(3)	,						
	TMENTS (SPECIFY)		0		0.00	0	45. 59
(3)	, ,						
	of lines 1 thru 49)		-10, 547, 843				50.00
	o Worksheet A,						
col umn 6, I							
	all chanter referen	ocas in this co	lumn nertain t	o CMS Pub 15_1			

- (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.

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	В	0. 00 MMG	100.00	6.00
7. 00		0.00	0.00	7.00
8. 00		0.00	0.00	8.00
9. 00		0.00	0.00	9.00
10. 00		0.00	0.00	10.00
100.00 G. Other	r (financial or		10	00.00
non-fi na	ancial) specify:			

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

Worksheet A-8, column 2,

line 12.

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider. B. Corporation, partnership, or other organization has financial interest in provider.
- Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

Heal th	Financial Syste	ems			MAJOR HOSPI	TAL			In Lie	u of Form CMS-	-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI (ONS AND HOME	Provi der	CCN:	15-0097	Peri od:	Worksheet A-8	8-1
OFFI CE	COSTS								From 01/01/2018		
									To 12/31/2018		
	N-+	WI+ A 7 D-6							L	5/23/2019 3:	17 pm
		Wkst. A-7 Ref.									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
		RED AND ADJUSTI	MENTS RE	QUI RED AS A	RESULT OF TRA	ANSACTI ONS	S WIT	H RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:										
1. 00	478, 459	0									1.00
2.00	325, 063	0									2.00
3.00	1, 083, 899	0									3.00
4.00	0	0									4.00
5.00	1, 887, 421										5.00
* The	amounts on lin	es 1-4 (and sub	scri pts	as appropri	ate) are tran	nsferred i	n det	ail to Wo	rksheet A, columr	1 6. lines as	•
									rganization or ho		t which
									cated in column 4		
		ani zati on(s)									
		me Office									
	dila/ oi lio	MIC 0111 CC									
	Type of	Busi ness									
	, ype oi	Du3111033									

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

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

6. 00	6.00
7. 00	7.00
8. 00	8.00
9. 00	9.00
10.00	10.00
6. 00 7. 00 8. 00 9. 00 10. 00 100. 00	100.00

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

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

6.00

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/23/2019 3:17 pm

							5/23/2019 3:1	7 pm
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		EMPLOYEE BENEFITS DEPARTMENT	34, 901	0	,	179, 000	349	1.00
2.00		ADMINISTRATIVE & GENERAL	26, 395	0	26, 395	179, 000	264	2.00
3.00	50.00	OPERATING ROOM	380, 000	380, 000	0	0	0	3.00
4.00	53.00	ANESTHESI OLOGY	2, 642, 083	2, 159, 606	482, 477	239, 400	2, 575	4.00
5.00	54. 00	RADI OLOGY-DI AGNOSTI C	982, 811	958, 811	24, 000	271, 900	160	5.00
6.00	56. 01	ONCOLOGY	241, 675	214, 592	27, 083	271, 900	162	6.00
7. 00	57. 00	CT SCAN	3, 756	3, 756	0	0	0	7.00
8.00	60.00	LABORATORY	106, 039	0	106, 039	260, 300	1, 325	8.00
9.00	66. 00	PHYSI CAL THERAPY	7, 500	0	7, 500	179, 000	72	9.00
10.00	69. 00	ELECTROCARDI OLOGY	27, 945	27, 945		0	0	10.00
11.00		CLINIC	340, 529			179, 000	591	11.00
12.00	91.00	EMERGENCY	675, 000			179, 000	3, 312	12.00
13.00		RENOVO	7, 200			0	0	13.00
14. 00		HOSPI TALI ST	1, 667, 033			0	0	14. 00
200.00			7, 142, 867			_	8 810	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
	mkst. // Erne //	I denti fi er			Memberships &		of Malpractice	
		Tuerrer er	Li iiii t	Li mi t	Continuing	Share of col.	Insurance	
				Li iiii t	Education	12	Trisul direc	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		EMPLOYEE BENEFITS DEPARTMENT	30, 034				0	1. 00
2. 00		ADMINISTRATIVE & GENERAL	22, 719			0	0	2. 00
3. 00		OPERATING ROOM	22, , 1 ,			0	0	3. 00
4. 00		ANESTHESI OLOGY	296, 373		_	0	0	
5. 00		RADI OLOGY-DI AGNOSTI C	20, 915			0	0	
6. 00		ONCOLOGY	21, 177			n	0	6. 00
7. 00		CT SCAN	21, 177			0	0	
8. 00		LABORATORY	165, 816			0	0	8. 00
9. 00		PHYSI CAL THERAPY	6, 196			0	0	9. 00
10. 00		ELECTROCARDI OLOGY	0, 170			0	0	10.00
11. 00		CLI NI C	50, 860		-	0	0	11. 00
12.00		EMERGENCY	285, 023			0	0	12.00
13. 00		RENOVO	203, 023			0	0	13. 00
14. 00	•	HOSPI TALI ST			-	0	0	14. 00
200.00	192.01	HUSPITALISI	899, 113			0	1	200.00
200.00	Wkst. A Line #	Cost Contor/Dhysisian	Provi der	Adjusted RCE	RCE	Adi uatmant	U	200.00
	WKSt. A LINE #	Cost Center/Physician Identifier		Limit	Di sal I owance	Adjustment		
		rdentifier	Component Share of col.	LIIIII t	Di Sai i Owance			
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00	1.00	EMPLOYEE BENEFITS DEPARTMENT	15.00			4, 867		1. 00
2. 00		ADMINISTRATIVE & GENERAL				3, 676		2. 00
		OPERATING ROOM	1	,				
3.00			0		J	380, 000		3.00
4. 00		ANESTHESI OLOGY	0			2, 345, 710		4.00
5. 00		RADI OLOGY-DI AGNOSTI C	0	==,				5.00
6. 00		ONCOLOGY	0					6.00
7.00		CT SCAN	0	1		3, 756		7.00
8. 00		LABORATORY	0	165, 816		0		8.00
9.00		PHYSI CAL THERAPY	0			1, 304		9.00
10.00		ELECTROCARDI OLOGY	0			27, 945		10.00
11. 00		CLINIC	0			289, 669		11.00
12. 00		EMERGENCY	0			389, 977		12.00
13. 00		RENOVO	0		_	7, 200		13.00
14.00		HOSPI TALI ST	0		-	1, 667, 033		14.00
200.00			0	899, 113	635, 346	6, 303, 531		200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0097

					Ť	o 12/31/2018	Date/Time Pre 5/23/2019 3:1	
				CAPI TAL			372372014 3. 1	/ piii
				RELATED COSTS				
		Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI V	
			for Cost Allocation		BENEFITS DEPARTMENT		E & GENERAL	
			(from Wkst A		DELYMENT			
			col. 7)	1.00	4.00		5.00	
	CENED	AL SERVICE COST CENTERS	0	1.00	4.00	4A	5. 00	
1. 00		CAP REL COSTS-BLDG & FIXT	8, 917, 966	8, 917, 966				1.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	13, 234, 457	36, 253	13, 270, 710			4. 00
5.00		ADMINISTRATIVE & GENERAL	21, 077, 246					5.00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	2, 958, 053 278, 378			3, 747, 562 328, 211		7. 00 8. 00
9. 00		HOUSEKEEPI NG	2, 159, 372		•			•
10.00		DI ETARY	225, 448					
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION	718, 398 945, 064					1
14. 00		CENTRAL SERVICES & SUPPLY	945, 004 824					1
15. 00	01500	PHARMACY	9, 453, 619	95, 532	283, 976	9, 833, 127	2, 324, 817	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	1, 325, 946	69, 076	242, 764	1, 637, 786	387, 217	16. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	6, 373, 138	810, 465	1, 329, 795	8, 513, 398	2, 012, 797	30.00
31. 00		INTENSIVE CARE UNIT	1, 406, 957	127, 273				•
		SUBPROVI DER - I RF	0	1				
42. 00		SUBPROVI DER LARY SERVI CE COST CENTERS	0	0	0	0	0	42.00
50. 00		OPERATING ROOM	4, 346, 187	761, 692	643, 087	5, 750, 966	1, 359, 684	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
53.00	1	ANESTHESI OLOGY	874, 464	15, 484				1
54. 00 56. 00		RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	5, 024, 551	285, 577 0		6, 034, 702	1, 426, 766 0	54. 00 56. 00
56. 01	1	ONCOLOGY	3, 756, 219	1	1	_		•
57.00	1	CT SCAN	846, 230	l '				
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI)	808, 262			970, 297		58. 00 59. 00
60.00		CARDI AC CATHETERI ZATI ON LABORATORY	5, 739, 222	0 177, 836	1	6, 428, 750	0 1, 519, 930	1
60. 01		BLOOD LABORATORY	0	0	0	0	0	60. 01
65.00		RESPI RATORY THERAPY	1, 098, 278	142, 356				•
65. 01 66. 00		SLEEP LAB PHYSI CAL THERAPY	685, 415 1, 921, 735	364, 914	130, 948 441, 171			1
69. 00		ELECTROCARDI OLOGY	2, 293, 050					1
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 823, 060					
		IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	1, 767, 744	0				72.00
73.00		TIENT SERVICE COST CENTERS	0	0		0	0	73.00
88. 00	08800	MHP PEDIATRICS	2, 723, 533	226, 236	198, 852	3, 148, 621	744, 419	88. 00
88. 01		MHP OBGYN	2, 050, 031	133, 671				1
88. 02 89. 00		MHP FIM FEDERALLY QUALIFIED HEALTH CENTER	8, 885, 604 0					
	1	CLINIC	1, 017, 083					1
91.00	09100	EMERGENCY	3, 630, 518					91.00
		OBSERVATION BEDS (NON-DISTINCT PART) OBSERVATION BEDS (DISTINCT PART)	1 574 140	227 210	220 //4	0	FO(221	92.00
92. 01		REIMBURSABLE COST CENTERS	1, 574, 148	227, 318	339, 664	2, 141, 130	506, 221	92. 01
95.00		AMBULANCE SERVICES	0	0	0	0	0	95.00
		DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
	1	I&R SERVICES-NOT APPRVD PRGM HOME HEALTH AGENCY	0 1, 750, 395	0 197, 524	368, 080	2, 315, 999		100.00
101.00		AL PURPOSE COST CENTERS	1, 730, 373	177, 324	300,000	2, 313, 777	347, 303	1101.00
		INTEREST EXPENSE						113.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	121, 690, 595	7, 813, 304	12, 312, 490	119, 627, 713	22, 597, 590	118. 00
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23, 211	0	23, 211	5, 488	190. 00
	1	SHELBY COUNTY MEDICAL CENTER	0	0	1	0		190. 01
	1	MARKETI NG	350, 674	l '	46, 611			1
	1	I-74 CAMPUS RAMPART	205, 734 192, 338		15, 573	205, 734 547, 976		
		INTELLIPLEX DEVELOPMENT	62, 935		0	62, 935		1
190. 11	19011	MHP ADMIN BUILDING	90, 931	71, 085			40, 724	190. 11
		RENOVO	183, 739	300, 875	24, 942	509, 556		190. 16 190. 17
190. 17 190. 18		MD SOLUTIONS	907, 278) o	116, 746	1, 024, 024		1
190. 19	19019	MHCD	-33, 012	0	0	-33, 012	0	190. 19
		PHYSICIANS' PRIVATE OFFICES	0		0	0 500 075		192.00
	1	HOSPITALIST OTHER NONREIMBURSABLE COST CENTERS	1, 825, 964 252, 316					1
174.00	101750	OTHER MONKET MIDDINGABLE COST CENTERS	232, 310	1 337,770	1 40, 127	030, 221	150,043	11 /7. 00

Health Financial Systems	MAJOR HO	SPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	Provi der CCN: 15-0097		Worksheet B /2018 Part I /2018 Date/Time Prepa 5/23/2019 3:17		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL		
	0	1. 00	4. 00	4A	5. 00		
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 TOTAL (cum Lines 110 through 201)	125 720 402	0 017 044	12 270 7	0 0 0	0	200. 00	
202.00 TOTAL (sum lines 118 through 201)	125, 729, 492	8, 917, 966	13, 270, 7	10 125, 729, 492	24, 048, 021	J202. 00	

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Ti me Prepared: 5/23/2019 3:17 pm

			10	12/31/2010	5/23/2019 3:1	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
OFNEDAL CERVILOR COCT OFNITERS	7. 00	8. 00	9. 00	10. 00	11. 00	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT	4, 633, 587					7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	24, 788	430, 597				8. 00
9. 00 00900 HOUSEKEEPI NG	49, 295	0				9. 00
10. 00 01000 DI ETARY	27, 055	0	19, 338	431, 128		10.00
11. 00 01100 CAFETERI A	110, 563	0	79, 025	0	1, 507, 325	11.00
13.00 01300 NURSING ADMINISTRATION	48, 845	0	34, 912	0	23, 216	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	60, 649	0	43, 349	0	0	14.00
15. 00 01500 PHARMACY	57, 914	0	41, 394	0	33, 905	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	41, 876	0	29, 931	0	57, 229	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	101 001	470.000	054 470	0.5 550	011.000	
30. 00 03000 ADULTS & PEDI ATRI CS	491, 324	170, 322	351, 172	365, 552	214, 822	30.00
31. 00 03100 INTENSIVE CARE UNIT	77, 156	0	55, 147	65, 576	57, 272	31.00
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER	0	0	0	0	0	41. 00 42. 00
ANCILLARY SERVICE COST CENTERS	U	0	l o	U _I	0	42.00
50. 00 05000 OPERATING ROOM	461, 755	105, 420	330, 039	0	108, 950	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	Ö	0	52.00
53. 00 05300 ANESTHESI OLOGY	9, 387	0	6, 709	o	21, 098	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	173, 123	65, 520		0	113, 730	54.00
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	56.00
56. 01 05601 ONCOLOGY	373, 488	52, 026	266, 951	0	51, 325	56. 01
57.00 05700 CT SCAN	39, 140	0	27, 975	0	8, 937	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	39, 477	0	28, 216	0	14, 863	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	107, 808	0	77, 056	0	111, 664	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	86, 299	15, 043	61, 682	0	40, 233	65.00
65. 01 06501 SLEEP LAB	221 210	U E E07	150 114	0	(2.025	65. 01 66. 00
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	221, 219 22, 858	5, 587 0		0	62, 025 25, 663	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	65, 183	0	46, 590	0	5, 534	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	05, 105	0	40, 370	0	4, 559	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	j o	0	-	Ö	0	73.00
OUTPATIENT SERVICE COST CENTERS			,	-,		
88. 00 08800 MHP PEDIATRICS	137, 149	0	98, 027	0	46, 559	88. 00
88. 01 08801 MHP OBGYN	81, 034	0	57, 919	0	36, 209	88. 01
88. 02 08802 MHP FI M	452, 124	0	323, 156	0	203, 709	88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C	189, 892	0	135, 725	0	45, 170	90.00
91. 00 09100 EMERGENCY	256, 968	16, 679	183, 668	O	109, 695	91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 01 O9201 OBSERVATION BEDS (DISTINCT PART)	127 005	0	00 404	o	E2 102	92. 00 92. 01
92. 01 O9201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	137, 805		98, 496	U	52, 182	92.01
95. 00 09500 AMBULANCE SERVI CES	0	0	O	0	0	95. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	Ö	l o	o		100.00
101.00 10100 HOME HEALTH AGENCY	119, 743	0	85, 587	o		101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 963, 917	430, 597	2, 780, 258	431, 128	1, 448, 549	118. 00
NONRE MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14, 071	0	10, 057	0		190. 00
190. 01 19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	0		190. 01
190. 05 19005 MARKETI NG	14, 989	0	10, 713	0	· ·	190. 05
190. 07 19007 I -74 CAMPUS	0	0	147 240	0		190.07
190. 08 19008 RAMPART	206, 155	0	147, 349	0		190. 08 190. 09
190. 09 19009 I NTELLI PLEX DEVELOPMENT 190. 11 19011 MHP ADMI N BUI LDI NG	43, 093	0	30, 801	0		190. 09
190. 16 19016 RENOVO	182, 397	0	130, 369	0		190. 11
190. 17 19017 I MA	102, 377	0	130, 309	0		190. 10
190. 18 19018 MD SOLUTIONS	0	0		Ö		190. 18
190. 19 19019 MHCD	0	Ö	Ö	ol		190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	Ö	Ö	l o	ol		192.00
192. 01 19201 HOSPI TALI ST	4, 197	0	3, 000	o	34, 835	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	204, 768	0	146, 358	o		194.00
200.00 Cross Foot Adjustments				l		200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	4, 633, 587	430, 597	3, 258, 905	431, 128	1, 507, 325	202. 00

			Io	12/31/2018	Date/lime Pre 5/23/2019 3:1	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	, piii
· ·	ADMI NI STRATI O	SERVICES &		RECORDS &		
	N	SUPPLY	15.00	LI BRARY		
GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	24. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 OO700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 574, 735					11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	1, 574, 735	228, 715				14.00
15. 00 01500 PHARMACY	l ő	0	12, 291, 157			15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	o	O	0	2, 154, 039		16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	294, 046	0	0	89, 231	12, 502, 664	30. 00
31. 00 03100 INTENSIVE CARE UNIT	78, 392	0	0	26, 350	2, 642, 361	31.00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00 O4200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS	0	0]	0	U	0	42.00
50. 00 05000 OPERATING ROOM	149, 128	0	0	304, 367	8, 570, 309	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	o	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	28, 878	0	0	11, 107	2, 033, 178	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	151, 636	8, 089, 217	54.00
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	56.00
56. 01 05601 0NCOLOGY	70, 252	0	0	99, 058	6, 712, 814	56. 01
57. 00 05700 CT SCAN	0	0	0	165, 415	1, 450, 653	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION		0	0	62, 623	1, 344, 880 0	58. 00 59. 00
60. 00 06000 LABORATORY		0	0	246, 068	8, 491, 276	60.00
60. 01 06001 BLOOD LABORATORY	l ő	ő	0	0	0, 171, 270	60. 01
65. 00 06500 RESPI RATORY THERAPY	55, 070	0	0	39, 186	2, 129, 553	65.00
65. 01 06501 SLEEP LAB	27, 981	0	0	25, 589	1, 062, 943	65. 01
66. 00 06600 PHYSI CAL THERAPY	0	0	0	47, 693	3, 867, 390	66. 00
69. 00 06900 ELECTROCARDI OLOGY	35, 127	0	0	75, 500	3, 271, 411	69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	123, 506	0	64, 853	2, 714, 054	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENT 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	105, 209	12 201 157	53, 429	2, 366, 481	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	J O	0	12, 291, 157	243, 661	12, 534, 818	73. 00
88. 00 08800 MHP PEDI ATRI CS	63, 729	0	0	19, 724	4, 258, 228	88. 00
88. 01 08801 MHP 0BGYN	49, 561	0	0	13, 282	3, 135, 633	88. 01
88.02 08802 MHP FIM	278, 831	0	0	55, 631	14, 270, 291	88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C	61, 827	0	0	11, 412	2, 401, 611	90.00
91. 00 09100 EMERGENCY	150, 147	0	0	299, 841	6, 835, 547	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART)	71, 425	0	0	32, 510	3, 039, 769	92. 00 92. 01
OTHER REIMBURSABLE COST CENTERS	71,423	U _I	U	32, 510	3, 039, 709	92.01
95. 00 09500 AMBULANCE SERVICES	0	0	0	O	0	95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	O	0	0	0	97.00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY	74, 237	0	0	15, 873	3, 159, 004	101. 00
SPECIAL PURPOSE COST CENTERS						112 00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 488, 631	228, 715	12, 291, 157	2, 154, 039	116, 884, 085	113.00
NONREI MBURSABLE COST CENTERS	1, 400, 031	220, 715	12, 271, 137	2, 154, 037	110, 664, 065	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	52, 827	190. 00
190.01 19001 SHELBY COUNTY MEDICAL CENTER	o	О	0	0		190. 01
190. 05 19005 MARKETI NG	0	0	0	0	555, 172	
190. 07 19007 I -74 CAMPUS	0	0	0	0	254, 375	
190. 08 19008 RAMPART	7, 104	0	0	0	1, 043, 330	
190. 09 19009 INTELLIPLEX DEVELOPMENT	4 005	0	0	0	77, 815	
190. 11 19011 MHP ADMIN BUILDING 190. 16 19016 RENOVO	4, 095 11, 052	0	0	0	293, 953 961, 922	
190. 17 19017 I MA	11,032	0	0	0		190. 10
190. 18 19018 MD SOLUTIONS	0	0	0	0	1, 266, 131	
190. 19 19019 MHCD	l ol	ő	Ö	ol	-33, 012	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	o	0	192. 00
192. 01 19201 HOSPI TALI ST	47, 681	0	0	О	3, 216, 482	
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	16, 172	0	0	0	1, 156, 412	
200.00 Cross Foot Adjustments		_ ا				200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	1, 574, 735	0 228, 715	12, 291, 157	2, 154, 039	0 125, 729, 492	201.00
202. 00 TOTAL (Suil TITIES TTO THE OUGH 201)	1,374,730	220, 715	12, 271, 137	2, 104, 039	123, 127, 492	₁ 202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MAJOR HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0097 | Peri od: | Worksheet B | From 01/01/2018 | Part I | Date/Ime | Prepared: |

Cost Center Description				To 12/31/2018 Date/Time Pre	
CONTRICT CONTRICT CONTRICT	Cost Center Description	Intern &	Total	372072017 0.1	, piii
STEPADAM SPRINGE COST CENTERS 25.00 26.09					
COMPANY CONTINUES CONTIN					
CREATED SERVICE CREAT CHATTERS 1.00 CREATED AND ALL COSTS AUGUST FAVIT 4.00 CREATED AND SERVICE TO					
STATEMENT SERVICE COST CENTRES 1.00 CODIC CHARLOYSE BERGET IS DEPARTMENT			26, 00		
4. 00 00400 EMPETITES BEPARTES BEPARTES BEPARTE					
5.00					1.00
0.0000 0.0000 0.					
B. 00 0000000 LANDREW A LINEN STRYLEGE	· ·				
0.000 0.000 0.000 0.000 0.000 0.000 1.000 0.000 1.000 0.000 1.000 0.000 1.000 0.000 1.000 0.000 1.000 0.00	•				
10.00 01000 DETARY					
11.00 01100 CAFETERIA 11.00					
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 10500 INDICATE RECORDS & LIBRARY 15.00 10500 INDICATE RECORDS & LIBRARY 15.00 10500 INDICATE ROUTINE SERVICE COST CENTERS 12.502,664 31.00 10500 INTIRAL YEAR SERVICE COST CENTERS 12.502,664 31.00 41.00					
15.00 OSOD PHARMACY	13.00 01300 NURSING ADMINISTRATION				13.00
16. 00					
IMPATT ENT ROUTH NE SERVICE COST CENTERS 30.00 30.00 30.00 03.00 0					
30.00					16.00
31.00			12 502 664		20.00
1.0 04100 SUBPROVIDER - I FIF 0 0 0 42.00					
MICHILARY SERVICE COST CENTERS So. 00 S. 570, 309 S. 570, 309 S. 500 S.					
50.00	42. 00 04200 SUBPROVI DER	0	0		42.00
Section Sect					
53.00 05300 ANESTHESIOLOGY 0 2,033,178 53.00 56.00 05600 ARDIOLOGY-DIAGNOSTIC 0 8,089,217 54.00 56.00 05600 ARDIOLOGY-DIAGNOSTIC 0 8,089,217 54.00 56.00 05600 ARDIOLOGY-DIAGNOSTIC 0 0 0 0 0 56.00 05600 ARDIOLOGY-DIAGNOSTIC 0 0 1,450,653 57.00 05700 CT SCAN 0 1,450,653 57.00 0 0 0 0 0 0 0 0 0					
54.00 05400 RADI OLOCY - DI AGNOSTI C 0 8,089; 217 0 56.00 56.00 05600 RADI OLOCY - D 0 0 0 0 56.00 05600 RADI OLOCY - D 0 0 0 0 0 56.00 05600					
56. 00 05600 RADIO ISOTOPE 0 0 5.6. 00					
		1			
1.	· ·				
99.00 0.05900 CARDIA C CATHETER ZATION 0 0 0 0.00		O			
0.0 0 0 0 0 0 0 0 0	58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	1, 344, 880		58.00
0.00 0.0001 0.000 0.800 0.800 0.		0	-1		
65. 00 0.0500 RESPIRATORY THERAPY 0 2, 129, 553 65. 00 66. 00 0.0600 SEEPI LAB 0 0.1 0.062, 943 65. 01 66. 01 0.060 0.0600 PHYSI CAL THERAPY 0 3, 867, 390 66. 00 0.0600 PHYSI CAL THERAPY 0 3, 867, 390 67. 00 0.0710 0.00 DECETROROADIO LOCKY 0 3, 271, 411 77. 00 0.0710 MPD LOCK CHARGED TO PATI ENTS 0 2, 714, 0.054 77. 00 0.0720 MPD LOCK CHARGED TO PATI ENTS 0 2, 714, 0.054 77. 00 0.0720 MPD LOCK CHARGED TO PATI ENTS 0 12, 534, 818 73. 00 0.0730 DRUGS CHARGED TO PATI ENTS 0 12, 534, 818 73. 00 0.0730 DRUGS CHARGED TO PATI ENTS 0 12, 534, 818 73. 00 0.0730 DRUGS CHARGED TO PATI ENTS 0 14, 258, 228 88. 01 0.0800 MHP PEDI ATRICS 0 4, 258, 228 88. 00 0.0800 MHP PEDI ATRICS 0 4, 258, 228 88. 00 0.0800 MHP PEDI ATRICS 0 4, 258, 228 88. 00 0.0900 EEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.0900 EEDERALLY QUALIFIED HEALTH CENTER 0 0 0.0900 0.0900 CLINIC 0.0900 0.0000 0.0000 0.00		0	8, 491, 276		
65. 01 0.6501 SLEEP LAB		· -	2 120 552		
66. 00 06600 PHYSI CAL THERAPY 0 3, 867, 390 66. 00 06. 00 06900 LECTROCARDIOLOGY 0 3, 271, 4111 69, 90. 00 071, 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 2, 714, 054 71, 00 72, 00 07300 DRUBC CHARGED TO PATIENTS 0 2, 366, 481 72, 200 07300 DRUBC CHARGED TO PATIENTS 0 12, 534, 818 73, 00 07300 DRUBC CHARGED TO PATIENTS 0 12, 534, 818 73, 00 07300 DRUBC CHARGED TO PATIENTS 0 12, 534, 818 73, 00 07300 DRUBC CHARGED TO PATIENTS 0 12, 534, 818 73, 00 07300 DRUBC CHARGED TO PATIENTS 0 14, 270, 291 88, 00 88, 01 88,		· -			
69 0 0 0 0 0 0 0 0 0 0		· ·			
71. 00 07100 MCDI CAL SUPPLIES CHARGED TO PATIENTS 0 2, 714, 054 72, 00 72, 00 73, 00 073,		o			
73.00 07300 DRICES CHARGED TO PATIENTS 0 12,534,818 73.00 0810 MIPP PEDIATRICS SERVICE COST CENTERS 88.00 08800 MIPP PEDIATRICS 0 4,258,228 88.00 08801 MIPP PEDIATRICS 0 4,258,228 88.01 88.01 888.01 888.02 88.00 08800 MIPP PEDIATRICS 0 14,270,291 88.01 88.02 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 99.00 09900 CLINIC 99.00 99.00 09900 CLINIC 99.00 99.00 99.00 09900 CLINIC 99.00 99.0		0			
OUTPATIENT SERVICE COST CENTERS 88. 00 88. 01 88.00 88. 01 88.00 89. 00 4. 258, 228 88. 00 88. 01 88.00 88. 01 88. 02 88. 02 88. 02 88. 02 88. 02 88. 02 88. 02 88. 02 88. 02 88. 03 88. 02 88. 03 88. 03 88. 03 88. 04 88. 02 88. 02 88. 03 88. 04 88. 02 88. 00 89. 00 90. 00 9					
88. 00		0	12, 534, 818		73. 00
88. 01 08801 MHP OBGYN			1 250 220		00 NN
88. 02 08802 MHP FIM 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 91. 00 09100 PEDERACLY QUALIFIED HEALTH CENTER 90. 00 99000 CLINIC 91. 00 09100 PEDERACLY QUALIFIED HEALTH CENTER 91. 00 09200 085ERVATION BEDS (NON-DISTINCT PART) 92. 00 09200 085ERVATION BEDS (DISTINCT PART) 92. 00 09201 095ERVATION BEDS (DISTINCT PART) 95. 00 09201 095ERVATION BEDS (DISTINCT PART) 97. 00 09700 DURABLE MEDICAL EQUIP-SOLLD 98. 00 09700 DURABLE MEDICAL EQUIP-SOLLD 99. 00 100. 00 10000 16X SERVICES-NOT APPRVD PRGM 99. 00 00 00 00 00 00 00 00 00 00 00 00 00					
89.00 09900 CLINIC 0 0 0 0 0 0 0 0 0					
91.00 09100 EMERGENCY 0 6, 835, 547 91.00 92.00 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 0 3, 039, 769 92.00 92.00 095ERVATI ON BEDS (DISTINCT PART) 0 3, 039, 769 92.00 09500 AMBLANCE SERVICES 0 0 0 95.00 09500 AMBLANCE SERVICES 0 0 0 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 100.00 10000 1 aR SERVICES-NOT APPRVD PRGM 0 0 0 0 101.00 1000 HEALTH AGENCY 0 3, 159, 004 101.00 0000 EALTH AGENCY 0 3, 159, 004 101.00 0000 EALTH AGENCY 0 3, 159, 004 118.00 113.00 1 NTEREST EXPENSE 113.00 1100 1000 EALTH AGENCY 0 116, 884, 085 118.00 1000 01 FT, FLOWER, COFFEE SHOP & CANTEEN 0 555, 172 190.00 190.01 190.0		O			
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 3, 039, 769 92. 01 97. 00 070000 070000 070000 070000 070000 070000 070000 0700000 0700000 07000000 070000000 0700000000		0	2, 401, 611		90.00
92. 01 O9201 OBSERVATION BEDS (DISTINCT PART)			6, 835, 547		
OTHER REIMBURSABLE COST CENTERS 95.00 970.			2 020 740		
95. 00 97. 00 970.00 070		l ol	3, 039, 769		92.01
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 100.00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 10MB HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 118.00 100.00 118		0	0		95.00
101. 00 10100 HOME HEALTH AGENCY 0 3, 159, 004 101. 00	97.00 09700 DURABLE MEDICAL EQUIP-SOLD		Ö		
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 0 116,884,085 118.00 119.00 1		0	0		100.00
113.00		0	3, 159, 004		101. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 116, 884, 085 118. 00 100					112 00
NONRE MBURSABLE COST CENTERS 190.00 19000 GI FT. FLOWER. COFFEE SHOP & CANTEEN 0 0 0 190.01 190.01 190.01 190.01 190.05 190.05 190.05 190.05 190.05 190.05 1-74 CAMPUS 0 254, 375 190.05 190.05 190.08 190.08 190.08 190.08 190.08 190.09 190.09 100.01 100.			116 004 005		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 190. 01 190. 01 190. 01 190. 01 190. 05 190. 05 190. 07 190. 07 190. 07 190. 07 190. 07 190. 07 190. 07 190. 07 190. 07 190. 07 190. 07 190. 07 190. 07 190. 07 190. 07 190. 08 190. 08 190. 08 190. 08 190. 08 190. 08 190. 08 190. 08 190. 09 19009 INTELLI PLEX DEVELOPMENT 0 77, 815 190. 09 190. 11 190. 11 190. 11 190. 11 190. 11 190. 16 190. 16 190. 17 190. 17 190. 18 190. 18 190. 18 190. 18 190. 19		l ol	110, 004, 000		116.00
190. 01 19001 19001 19001 19001 19001 19001 19001 19001 19000		O	52, 827		190. 00
190. 07 19007 1 - 74 CAMPUS 0 254, 375 190. 07 190. 08 19008 RAMPART 0 1, 043, 330 190. 08 190. 09 19009 I NTELLI PLEX DEVELOPMENT 0 77, 815 190. 09 190. 11 19011 MHP ADMI N BUI LDI NG 0 293, 953 190. 11 190. 16 19016 RENOVO 0 961, 922 190. 17 19017 I MA 0 0 190. 17 19018 MD SOLUTI ONS 0 1, 266, 131 190. 18 19018 MD SOLUTI ONS 0 1, 266, 131 190. 18 19018 MHCD 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 192. 00 19200 HOSPI TALI ST 0 3, 216, 482 192. 01 194. 00 200. 00 Cross Foot Adjustments 0 0 0 200. 00 0 200. 00 0 200. 00 0 200. 00 0 200. 00 0 200. 00 0 200. 00 200. 00 0 2		o	0		
190. 08 19008 RAMPART		0	555, 172		190. 05
190. 09 19009 1 NTELLI PLEX DEVELOPMENT 0 77, 815 190. 09 190. 11 19011 MHP ADMI N BUI LDI NG 0 293, 953 190. 11 190. 16 190. 16 190. 16 190. 17 19017 I MA 0 0 0 190. 17 190. 18 19018 MD SOLUTI ONS 0 1, 266, 131 190. 19 19019 MHCD 0 -33, 012 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192. 00 19200 HOSPI TALI ST 0 3, 216, 482 192. 01 194. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0		· ·			
190. 11 19011 19011 19011 19016 19016 190. 16 19016 190. 16 19016 190. 16 19016 190. 16 19017 19017 1 MA		0			
190. 16 19016 RENOVO 0 961, 922 190. 16 190. 17 19017 I MA 0 0 0 190. 17 19018 I MD SOLUTI ONS 0 1, 266, 131 190. 19 19019 MHCD 0 -33, 012 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 192. 01 19201 HOSPI TALI ST 0 3, 216, 482 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 1, 156, 412 000. 00 Cross Foot Adjustments 0 0 0 200. 00		0			
190. 17 19017 IMA				-	
190. 18 19018 MD SOLUTIONS 0 1, 266, 131 190. 18 190. 19 19019 MHCD 0 -33, 012 190. 19 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 192. 00 192. 01 19201 HOSPI TALI ST 0 3, 216, 482 192. 01 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 1, 156, 412 194. 00 200. 00 Cross Foot Adjustments 0 0 0			01, 722		
190. 19 19019 MHCD		ا	1, 266, 131		
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 192. 00 192. 01 19201 HOSPI TALI ST 0 3, 216, 482 192. 01 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 1, 156, 412 194. 00 200. 00 Cross Foot Adjustments 0 0 0		0	1		
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 1,156,412 194.00 200.00 Cross Foot Adjustments 0 0 0 0 0		0	0		
200.00 Cross Foot Adjustments 0 0 200.00		0			
		0			
201. 00 mogative cost centers 0 0 0 201.00					
	201.00 megative cost centers	<u> </u>	U		201.00

Health Fina	ancial Systems	MAJOR HOS	SPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOC	ATION - GENERAL SERVICE COSTS		Provi der Co	CN: 15-0097	Peri od: From 01/01/2018	Worksheet B Part I		
					To 12/31/2018	Date/Time Pre 5/23/2019 3:1		
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total					
202.00	TOTAL (sum Lines 118 through 201)	25. 00	26. 00 125. 729. 492				202.00	
ZUZ. UU	TIDIAL (Sull LINES TIG UILOUUIL ZUL)	U	120.729.492				1202.00	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Part | Part | Prepared: | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0097

					10) 12/31/2018	Date/lime Pre 5/23/2019 3:1	
		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIV E & GENERAL	<i>y</i> p
			0	1.00	2A	4. 00	5. 00	
		AL SERVICE COST CENTERS						
1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00	00400 00500 00700 00800 00900 01000 01100	CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA	0 0 0 0 0	36, 253 767, 348 470, 985 40, 889 81, 315 44, 629 182, 380	767, 348 470, 985 40, 889 81, 315 44, 629 182, 380	36, 253 6, 023 870 24 970 112 451	773, 371 28, 493 2, 495 19, 736 2, 366 8, 103	11.00
13.00		NURSI NG ADMI NI STRATI ON	0	80, 573		441	9, 026	•
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	100, 045 95, 532		0 776	767 74, 761	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	69, 076		663	12, 452	16.00
		IENT ROUTINE SERVICE COST CENTERS	-				,	
30. 00		ADULTS & PEDIATRICS	0			3, 632	64, 727	30.00
31.00		INTENSIVE CARE UNIT	0	127, 273	·	852	14, 035	1
41. 00 42. 00	1	SUBPROVI DER - I RF SUBPROVI DER	0	0		0	0 0	41. 00 42. 00
42.00		LARY SERVICE COST CENTERS	U	0	<u> </u>	0	0	42.00
50.00		OPERATI NG ROOM	0	761, 692	761, 692	1, 757	43, 725	50.00
52.00		DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53.00	1	ANESTHESI OLOGY	0	15, 484		1, 890		•
54. 00 56. 00		RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	0	285, 577 0	1	1, 979 0	45, 882 0	54. 00 56. 00
56. 01		ONCOLOGY	0	616, 091		870	35, 663	
57.00		CT SCAN	0	64, 564		183	1	1
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	65, 120	65, 120	265	7, 377	58. 00
59.00		CARDI AC CATHETERI ZATI ON	0	177 02/	1	1 200	0	59.00
60. 00 60. 01	4	LABORATORY BLOOD LABORATORY	0	177, 836	177, 836	1, 398	48, 878 0	60. 00 60. 01
65. 00		RESPI RATORY THERAPY	0	142, 356	142, 356	658		•
65. 01	06501	SLEEP LAB	0	0	0	358	6, 207	65. 01
66. 00	1	PHYSI CAL THERAPY	0	364, 914		1, 205	l	1
69.00		ELECTROCARDI OLOGY	0	37, 706		473	l	1
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	0	107, 524 0		47 39	14, 810 13, 548	1
73. 00		DRUGS CHARGED TO PATIENTS	Ö	Ö		0	0	73.00
		TIENT SERVICE COST CENTERS						
88. 00		MHP PEDIATRICS	0	226, 236		543		88.00
88. 01 88. 02		MHP OBGYN MHP FIM	0	133, 671 745, 806		437 2, 316	17, 818 79, 710	
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	743,800		2, 310	79,710	89.00
90.00	09000	CLINIC	0	313, 238	313, 238	691	12, 038	90.00
		EMERGENCY	0	423, 884	423, 884	1, 780	35, 779	
92. 00 92. 01		OBSERVATION BEDS (NON-DISTINCT PART) OBSERVATION BEDS (DISTINCT PART)	0	227 210	0 227, 318	928	16, 279	92. 00 92. 01
9 2. U I		REIMBURSABLE COST CENTERS	0	227, 318	227, 310	720	10, 279	72.01
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
	1	I&R SERVICES-NOT APPRVD PRGM HOME HEALTH AGENCY	0	0 197, 524	0 197, 524	0 1, 005	l	100.00
101.00		AL PURPOSE COST CENTERS	U	197, 324	197, 324	1,005	17,009	101.00
113.00		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7, 813, 304	7, 813, 304	33, 636	726, 729	118. 00
		I MBURSABLE COST CENTERS	_					
		GIFT, FLOWER, COFFEE SHOP & CANTEEN SHELBY COUNTY MEDICAL CENTER	0	23, 211	23, 211	0		190. 00 190. 01
		MARKETING	0	24, 725	24, 725	127		190.01
		I -74 CAMPUS	Ö	0	0	0		190. 07
		RAMPART	0	340, 065	340, 065	43		190. 08
		I NTELLI PLEX DEVELOPMENT	0	0	0	0		190. 09
		MHP ADMIN BUILDING RENOVO	0	71, 085 300, 875		28 68		190. 11 190. 16
190. 10			0	300,873	300, 875	00		190. 10
		MD SOLUTIONS	Ö	Ö	ol ol	319		190. 18
190. 19			0	0	0	0		190. 19
		PHYSICIANS' PRIVATE OFFICES	0	0 000	0	1 001		192.00
		HOSPITALIST OTHER NONREIMBURSABLE COST CENTERS		6, 923 337, 778		1, 901 131	19, 227 4, 852	194. 00
200.00		Cross Foot Adjustments		337,770	0	.51		200.00
			'		'			

Health Financial Systems	MAJOR HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B		
				From 01/01/2018			
				To 12/31/2018		pared:	
					5/23/2019 3:1	7 pm	
		CAPI TAL					
		RELATED COSTS					
Cost Center Description	Directly	BLDG & FIXT	Subtotal	EMPLOYEE	ADMI NI STRATI V		
·	Assigned New			BENEFITS	E & GENERAL		
	Capi tal			DEPARTMENT			
	Related Costs			32.7			
	0	1. 00	2A	4. 00	5. 00		
201.00 Negative Cost Centers		0		0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	0	8, 917, 966	8, 917, 96	6 36, 253	773, 371	202. 00	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0097

Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	Date/Time Pre 5/23/2019 3:1 CAFETERIA	
	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	11. 00	
GENERAL SERVI CE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FIXT 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVICE COST CENTERS	500, 348 2, 677 5, 323 2, 921 11, 939 5, 274 6, 549 6, 254 4, 522	46, 085 0 0 0 0 0 0 0	107, 344 637 2, 603 1, 150 1, 428 1, 363 986	50, 665 0 0 0 0 0	205, 476 3, 165 0 4, 622 7, 801	1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
30. 00 03000 ADULTS & PEDI ATRI CS	53, 055	18, 229	11, 568	42, 959	29, 287	30.00
31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER ANCILLARY SERVICE COST CENTERS	8, 332 0 0	0 0 0	1, 816 0 0	7, 706 0 0	7, 807 0 0	31. 00 41. 00 42. 00
50. 00 05000 OPERATING ROOM	49, 862	11, 283	10, 871	0	14, 852	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OI SOTOPE 56. 01 05601 ONCOLOGY	0 1, 014 18, 694 0 40, 330	0 0 7, 012 0 5, 568	0 8, 793	0 0 0 0	0 2, 876 15, 503 0 6, 996	52. 00 53. 00 54. 00 56. 00 56. 01
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	4, 226 4, 263	0	921 929	0	1, 218 2, 026	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0 11, 641	0	0 2, 538	0	0 15, 222	59. 00 60. 00
60. 01 06001 BL00D LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY 65. 01 06501 SLEEP LAB	9, 319	1, 610 0	2, 032 0	0	5, 485 0	65. 00 65. 01
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	23, 888 2, 468	598 0	5, 208 538	0	8, 455 3, 498	66. 00 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 039	0	1, 535	o	754	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	621 0	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS				-1		
88. 00 08800 MHP PEDI ATRI CS 88. 01 08801 MHP 0BGYN	14, 810 8, 750	0	3, 229 1, 908	0	6, 347 4, 936	88. 00 88. 01
88.02 08802 MHP FIM	48, 822	0	10, 644	o	27, 769	88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0 20, 505	0	0 4, 471	0	0 6, 157	89. 00 90. 00
91. 00 09100 EMERGENCY	27, 748	1, 785		O	14, 953	91.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 0BSERVATION BEDS (DISTINCT PART)	14, 881	0	3, 244	0	7, 113	92. 00 92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00	0	0	0	0	0	95. 00 97. 00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	12, 930	0	2, 819	O _I	0	101. 00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	428, 036	46, 085		50, 665	197, 463	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 SHELBY COUNTY MEDICAL CENTER	1, 519 0	0	331 0	0		190. 00 190. 01
190. 05 19005 MARKETI NG	1, 619	0	353	0	1, 048	190. 05
190. 07 19007 I -74 CAMPUS 190. 08 19008 RAMPART	22, 261	0	0 4, 853	0		190. 07 190. 08
190. 09 19009 I NTELLI PLEX DEVELOPMENT	0	0	0	0		190. 09
190. 11 19011 MHP ADMI N BUI LDI NG 190. 16 19016 RENOVO	4, 653 19, 696	0	1, 015 4, 294	0		190. 11 190. 16
190. 17 19017 IMA 190. 18 19018 MD SOLUTI ONS	0	0	0	0		190. 17 190. 18
190. 19 19019 MHCD		0	0	0	0	190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 HOSPI TALI ST	0 453	0	0 99	0		192. 00 192. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	22, 111	0	4, 821	o		194. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	n	0	n	n	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	500, 348	46, 085	107, 344	50, 665		

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Part | Part | Prepared: | Part |

			10	12/31/2010	Date/lime Pre 5/23/2019 3:1	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	, , , , , ,
	ADMI NI STRATI O	SERVICES &		RECORDS &		
	N 13. 00	SUPPLY 14. 00	15. 00	LI BRARY 16. 00	24.00	
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00	24.00	
1. 00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00 00700 0PERATI ON OF PLANT						7.00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9. 00 10. 00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	99, 629					13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	108, 789				14.00
15. 00 01500 PHARMACY	0	0	183, 308			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	95, 500		16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	18, 603	0	0	3, 958	1, 056, 483	30.00
31. 00 03100 NTENSI VE CARE UNI T	4, 960	0	0	1, 169	173, 950	31.00
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER	0	0	0	0	0	41. 00 42. 00
ANCI LLARY SERVI CE COST CENTERS	J	<u> </u>	<u> </u>	<u> </u>		42.00
50. 00 05000 OPERATI NG ROOM	9, 435	0	0	13, 447	916, 924	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	О	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	1, 827	0	0	493	35, 833	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	6, 727	385, 450	54.00
56. 00 05600 RADI 01 SOTOPE	0	0	0	0	0	56.00
56. 01 05601 0NCOLOGY	4, 445	0	0	4, 394	723, 150	56. 01
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0	0	7, 338 2, 778	85, 885 82, 758	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0	0	2,778	02, 730	59.00
60. 00 06000 LABORATORY	0	o	0	10, 916	268, 429	60.00
60. 01 06001 BL00D LABORATORY	0	О	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	3, 484	0	0	1, 738	177, 948	65.00
65. 01 06501 SLEEP LAB	1, 770	0	0	1, 135	9, 470	65. 01
66. 00 06600 PHYSI CAL THERAPY	0	0	0	2, 116	427, 124	66.00
69. 00 06900 ELECTROCARDI OLOGY	2, 222	50.744	0	3, 349	69, 291	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	0 0	58, 746 50, 043	0	2, 877 2, 370	193, 332 66, 621	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0,043	183, 308	10, 809	194, 117	73.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	100,000	10,007	171,117	70.00
88. 00 08800 MHP PEDI ATRI CS	4, 032	0	0	875	280, 011	88. 00
88. 01 08801 MHP OBGYN	3, 136	0	0	589	171, 245	88. 01
88. 02 08802 MHP FI M	17, 641	0	0	2, 468	935, 176	88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	3, 912 9, 499	0	0	506	361, 518 534, 780	90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 499	U U	U	13, 302	334, 760	91.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	4, 519	o	0	1, 442	275, 724	92. 01
OTHER REIMBURSABLE COST CENTERS		- '	-	, , , ,		
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100. 00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	4, 697	U	O ₁	704	237, 288	101.00
113. 00 11300 I NTEREST EXPENSE				I		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	94, 182	108, 789	183, 308	95, 500	7, 662, 507	
NONREI MBURSABLE COST CENTERS				,	.,	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	25, 237	190. 00
190. 01 19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	0		190. 01
190. 05 19005 MARKETI NG	0	0	0	0	31, 081	
190. 07 19007 I - 74 CAMPUS	0	0	0	0		190. 07
190. 08 19008 RAMPART 190. 09 19009 INTELLIPLEX DEVELOPMENT	449	0	0	0	372, 544	190. 08
190. 09 19009 INTELLIPLEX DEVELOPMENT 190. 11 19011 MHP ADMIN BUILDING	259	0	0	0	78, 758	
190. 16 19016 RENOVO	699	0	0	o o	330, 607	
190. 17 19017 I MA	0	Ö	0	0		190. 17
190. 18 19018 MD SOLUTIONS	0	О	0	0	8, 105	190. 18
190. 19 19019 MHCD	0	0	0	0	0	190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
192. 01 19201 HOSPI TALI ST	3, 017	0	Ō	0	36, 369	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 200.00 Cross Foot Adjustments	1, 023	O	0	0	370, 716	194. 00 200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0	0			200.00
202.00 TOTAL (sum lines 118 through 201)	99, 629	108, 789	183, 308	95, 500	8, 917, 966	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Part | Part | Prepared: | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0097

Control Cont				10 12/31/2018 Date/1i	me Prepared: 019 3:17 pm
SERBERT SERVICE OST CENTERS	Cost Center Description	Residents Cost & Post Stepdown	Total	3720720	317 3. 17 pm
1.00 001000 CAP REL COSTS-BLIC & FIXT	1	25. 00	26. 00		
4. 00 00000 DOSEPHICATE SERVETTS DEPARTMENT					1 00
5.00					•
0.00000 0.00000 0.00000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000					•
1.00	i i				•
10.00 01000 DETARY	8.00 00800 LAUNDRY & LINEN SERVICE				8. 00
11.00 01100 CAFETERIA 11.00 13.00					9. 00
13.00 0300 MURSING ADMINISTRATION 13.00 14.00 140.00					•
14.00 OHADQ CENTRAL SERVICES & SUPPLY 15.00 OHADQ THE RECORDS & LIBRARY 15.00 OHADQ THE RECORDS & OHADQ THE RECO					•
15.00 01500 PHARMACY					
16. 00					•
30.00					•
31.00	INPATIENT ROUTINE SERVICE COST CENTERS				
11.00 04100 SUBPROVIDER - I FIR		1			•
		1			I
MOLL LARY SERVICE COST CENTERS		1	- 1		
50.00		l ol	U		42.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 55.00		0	916, 924		50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC 0 385, 450 0 55.00 0 56.00 0 0 0 0 0 0 0 0 0		0			
56. 00 05600 RADIO ISOTOPE 0		0	35, 833		
57.00 05700 CT SCAN		1	- 1		
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 82,758 55. 00 55. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 66. 00	· ·	1			
59.00 0.5900 CARDIA C CATHETER ZATION 0 0 6.00					•
0.00 0.0001 0.000 0.800 0.800 0.		1			•
65. 00 0.0500 RESPIRATIORY THERAPY 0 177, 948 0.65. 01 0.050 SLEEP LAB 0 0.470 0.65. 01 0.050 0.0500 SLEEP LAB 0 0.470 0.65. 01 0.050 0.0500 ELECTROCADRO IO.05Y 0.0 0		0	268, 429		60.00
65. 01 0.6501 SLEEP LAB		0	0		•
66. 00 06600 PMSYS CAL THERAPY 0 427, 124 66. 00		0			
69. 00 06900 060000 06000 060000 060000 060000 060000 060000 0600000 060000 0600000 060000000 0600000000		0			•
171.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 193.332 71.00 72.00		1			•
17.2 00 07.200 IMPL DEV. CHARGED TO PATIENT 0 66, 6.21 73. 00 73. 00 07.000 DRUGS CHARGED TO PATIENTS 0 194, 117 73. 00 0.000 DRUGS CHARGED TO PATIENTS 0 194, 117 73. 00 0.000					•
OUTPATLENT SERVICE COST CENTERS 280.011 88.00 8800 MHP P DED ATRI CS 0 280.011 88.01 88.01 88.01	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	66, 621		72. 00
88. 00 08800 MHP PEDI ATRICS 0 280, 011 88. 00 88. 01 08801 MHP DBGYN 0 171, 245 88. 01 88. 01 88. 01 88. 01 88. 02 08802 MHP FIM 0 0 935, 176 88. 02 88. 02 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 09. 00 09000 CLI NI C 0 361, 518 99. 00 09. 00 09000 CLI NI C 0 534, 780 91. 00 92. 00 09200 085ERVATI ON BEDS (NON-DISTINCT PART) 0 09201 085ERVATI ON BEDS (NON-DISTINCT PART) 0 275, 724 92. 01 09201 085ERVATI ON BEDS (DISTINCT PART) 0 275, 724 92. 01 09201 085ERVATI ON BEDS (DISTINCT PART) 0 079. 00 09700		0	194, 117		73.00
88. 01 08801 MHP OBGYN 88. 02 088002 MHP FIM 90. 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 095ERVATION BEDS (NON-DISTINCT PART) 92. 00 09201 OBSERVATION BEDS (NON-DISTINCT PART) 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 95. 00 09500 AMBULANCE SERVICES 95. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			200 011		99 00
88. 02 08802 MHP FIM 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 91. 00 09100 PEDERACLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 91. 00 09100 PEDERACLY QUALIFIED HEALTH CENTER 91. 00 09100 PEDERACLY QUALIFIED HEALTH CENTER 92. 00 09200 08SERVATION BEDS (NON-DISTINCT PART) 92. 00 09201 09SERVATION BEDS (DISTINCT PART) 95. 00 09201 09SERVATION BEDS (DISTINCT PART) 95. 00 09700 DURBALE MEDICAL EQUIP-SOLLD 97. 00 09700 DURBALE MEDICAL EQUIP-SOLLD 97. 00 09700 DURBALE MEDICAL EQUIP-SOLLD 97. 00 09700 DURBALE MEDICAL EQUIP-SOLLD 98. 00 09700 DURBALE MEDICAL EQUIP-SOLLD 99. 00 09700 DURBALE MEDICAL EQUIP-SOLLD 99. 00 09700 DURBALE MEDICAL EQUIP-SOLLD 99. 00 100. 00 10000 IAR SERVICES-NOT APPRVD PRGM 99. 00 09700 DURBALE MEDICAL EQUIP-SOLLD 99. 00 100. 00 10000 IAR SERVICES-NOT APPRVD PRGM 99. 00 09700 DURBALE MEDICAL EQUIP-SOLLD 99. 00 100. 00 10000 IAR SERVICES-NOT APPRVD PRGM 99. 00 100. 00 10000 IAR SERVICES-NOT APPRVD PRGM 99. 00 100. 00 10000 IAR SERVICES-NOT APPRVD PRGM 99. 00 100. 00 10000 IAR SERVICES-NOT APPRVD PRGM 99. 00 10000 INDEX INDEX SERVICES-NOT					•
89.00 09900 CLINIC 0 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 0900000000		0			•
91. 00 09100 EMERGENCY 0 534,780 91. 00 92. 00 92.00 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 0 275,724 92. 01 09201 095ERVATI ON BEDS (DISTINCT PART) 0 275,724 92. 01 09201 095ERVATI ON BEDS (DISTINCT PART) 0 275,724 92. 01 09500 AMBLANCE SERVICES 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 100. 01 100.	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 275, 724 92. 01 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 275, 724 92. 01 97. 00 09500 AMBULANCE SERVI CES 0 0 0 97. 00 09700 DURABLE MEDICAL EQUI P-SOLD 0 0 0 97. 00 010000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 237, 288 101. 00 118. 00 SPECI AL PURPOSE COST CENTERS 113. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 7, 662, 507 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 190. 00 19000 SHELBY COUNTY MEDICAL CENTER 0 0 190. 01 190. 01 19001 SHELBY COUNTY MEDICAL CENTER 0 0 190. 05 190. 07 19007 I -74 CAMPUS 0 372, 544 190. 07 190. 08 19008 RAMPART 0 372, 544 190. 08 190. 01 1901 MHP ADMI N BUI LDI NG 0 78, 758 190. 11 190. 10 1901 SHENDY OUNTY MEDICAL CENTER 0 0 190. 11 190. 11 1901 MHP ADMI N BUI LDI NG 0 330, 607 190. 11 190. 18 1901 MHP ADMI N BUI LDI NG 0 330, 607 190. 16 190. 191 1901 MHCD 0 0 0 190. 19 190. 191 1910 MHCD 0 0 0 190. 19 190. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 191. 01 19201 HOSPI TALLST 0 36, 369 192. 01 190. 00 Cross Foot Adjustments 0 0 0 0 200. 00 Cross Foot Adjustments 0 0 0		0			
92.01 09201 09ERVATION BEDS (DISTINCT PART) 0 275, 724 92.01			534, 780		
OTHER REIMBURSABLE COST CENTERS 95.00 970.		-	275 724		•
95. 00 97. 00 970.00 09500 MABULANCE SERVICES 0 0 0 0 97. 00 100.00 100		0	273, 724		72.01
100. 00 10000 1&R SERVICES-NOT APPRVD PRGM 0 237, 288 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 237, 288 101. 00 237, 288 101. 00 237, 288 101. 00 237, 288 101. 00 237, 288 101. 00 237, 288 101. 00 237, 288 101. 00 237, 288 101. 00 237, 288 101. 00 237, 288 237, 288 237, 288 237, 288 237, 288 238, 288, 288, 288, 288, 288, 288, 288,		0	0		95.00
101. 00			0		
113.00 11300 INTEREST EXPENSE 113.00	i i	1	0		
113.00		l 0	237, 288		101.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 7, 662, 507 118. 00 1900					113.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 190. 01 190. 01 190. 01 190. 01 190. 05 190. 05 190. 07 19007 GOOT GOOT	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	7, 662, 507		
190. 01 19001 19001 19001 19001 19001 19001 19001 19001 190					
190. 05		0	25, 237		
190. 07 19007 1 - 74 CAMPUS 190. 07 19008 19008 RAMPART 0 372, 544 190. 08 190. 09 19009 I NTELLI PLEX DEVELOPMENT 0 478 190. 09 190. 11 190. 11 190. 11 190. 11 190. 11 190. 11 190. 10 190. 10 190. 10 190. 10 190. 11 190.			31 081		
190. 08 19008 RAMPART 0 372, 544 190. 08 190. 09 19009 I NTELLI PLEX DEVELOPMENT 0 478 190. 09 190. 11 19011 MHP ADMI N BUI LDI NG 0 78, 758 190. 11 190. 16 190. 16 190. 17 19017 I MA 0 0 0 190. 17 19018 190. 18 19018 MD SOLUTI ONS 0 8, 105 190. 18 19018 MHCD 190. 19 19019 MHCD 0 0 190. 19 1					
190. 09 19009 I NTELLI PLEX DEVELOPMENT		0			
190. 16 19016 RENOVO	190. 09 19009 I NTELLI PLEX DEVELOPMENT	0	478		190. 09
190. 17 19017 1 MA		0			
190. 18 19018 MD SOLUTIONS 0 8, 105 190. 18 190. 19 19019 MHCD 0 0 190. 19 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 192. 00 192. 01 19201 HOSPI TALI ST 0 36, 369 192. 01 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 370, 716 194. 00 200. 00 Cross Foot Adjustments 0 0 0		0			
190. 19 19019 MHCD			-1		
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 192. 00 192. 01 19201 HOSPI TALI ST 0 36, 369 192. 01 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 370, 716 194. 00 200. 00 Cross Foot Adjustments 0 0 0			0, 105 N		
192. 01 19201 HOSPI TALI ST 0 36, 369 192. 01 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 370, 716 194. 00 200. 00 Cross Foot Adjustments 0 0 0 200. 00		l ől	Ö		I
200.00 Cross Foot Adjustments 0 0 200.00		0	36, 369		I
		1	· •		
ZUI. UU Negative Cost Centers U U 201. 00	, ,	-	- 1		• • • • • • • • • • • • • • • • • • •
	ZUI. UU Negative Cost Centers	ا	U		<u> </u> 201.00

Health Financ	cial Systems	MAJOR HOS	MAJOR HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION O	F CAPITAL RELATED COSTS		Provi der Co	CN: 15-0097	Peri od: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Pre 5/23/2019 3:1			
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total						
		25. 00	26. 00						
202 00	TOTAL (sum lines 118 through 201)		8 917 966				202 00		

0031 7	ELECTRICAL BASIS		Trovider c	F	rom 01/01/2018 to 12/31/2018	Date/Time Pre 5/23/2019 3:1	pared: 7 pm
	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SOUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4. 00	5A	5. 00	7. 00	
1 00	GENERAL SERVICE COST CENTERS	200 54/		I			1 00
1. 00 4. 00	OO100 CAP REL COSTS-BLDG & FIXT OO400 EMPLOYEE BENEFITS DEPARTMENT	288, 546 1, 173	51, 487, 257				1.00 4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	24, 828	8, 548, 721		101, 714, 483		5.00
7. 00	00700 OPERATION OF PLANT	15, 239	1, 235, 800			247, 306	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 323	34, 700			1, 323	8. 00
9.00	00900 HOUSEKEEPI NG	2, 631	1, 378, 050		_, -, -, -, -, -,	2, 631	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 444 5, 901	159, 418 640, 100		,	1, 444 5, 901	10.00 11.00
13. 00	01300 NURSING ADMINISTRATION	2, 607	626, 438			2, 607	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 237	0			3, 237	14.00
15.00	01500 PHARMACY	3, 091	1, 101, 761		,		15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	2, 235	941, 868	<u> </u>	1, 637, 786	2, 235	16.00
30.00	03000 ADULTS & PEDIATRICS	26, 223	5, 159, 303	C	8, 513, 398	26, 223	30.00
31.00	03100 INTENSIVE CARE UNIT	4, 118	1, 209, 671			4, 118	1
	04100 SUBPROVI DER - I RF	0	0	1	1	0	41.00
42. 00	04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS	0	0	C	0	0	42.00
50. 00	05000 OPERATING ROOM	24, 645	2, 495, 031		5, 750, 966	24, 645	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
53.00	05300 ANESTHESI OLOGY	501	2, 684, 914	[c	,	501	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 240	2, 811, 184	1	-,,	9, 240	
56. 00 56. 01	05600	19, 934	0 1, 235, 299	1	1	0 19, 934	56. 00 56. 01
57. 00	05700 CT SCAN	2, 089	260, 619			2, 089	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 107	376, 009			2, 107	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	1	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	5, 754	1, 985, 250	C	.,	5, 754 0	60. 00 60. 01
65. 00	06500 RESPIRATORY THERAPY	4, 606	935, 364	-	_	4, 606	
65. 01	06501 SLEEP LAB	0	508, 049		,	0	65. 01
66.00	06600 PHYSI CAL THERAPY	11, 807	1, 711, 642		, , , , ,	11, 807	1
69.00	06900 ELECTROCARDI OLOGY	1, 220	671, 872		_, -,	1, 220	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	3, 479	67, 030 55, 222		, , , , ,	3, 479 0	71.00 72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0			0	73.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 MHP PEDI ATRI CS	7, 320	771, 500			7, 320	
88. 01 88. 02	08801 MHP	4, 325 24, 131	620, 175 3, 289, 550		1 ' '	4, 325 24, 131	1
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	24, 131	3, 207, 330			24, 131	
90.00	09000 CLI NI C	10, 135	981, 345	C	1, 583, 260		
	09100 EMERGENCY	13, 715	2, 527, 811	C	4, 705, 938	13, 715	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	7, 355	1, 317, 821		2, 141, 130	7, 355	92. 00 92. 01
72.01	OTHER REIMBURSABLE COST CENTERS	7,333	1, 317, 021		2, 141, 130	7, 333	72.01
	09500 AMBULANCE SERVICES	0	0	C	0	0	
	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		1	0	
	10000 &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	6, 391	0 1, 428, 066	1	1		100. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	0, 371	1, 420, 000		2, 313, 777	0, 371]101.00
113.00	11300 NTEREST EXPENSE						113. 00
118.00		252, 804	47, 769, 583	-24, 048, 021	95, 579, 692	211, 564	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	751	0		23, 211	751	190. 00
	19001 SHELBY COUNTY MEDICAL CENTER	731	0				190.00
	19005 MARKETI NG	800	180, 839	C	422, 010	800	190. 05
	19007 I -74 CAMPUS	0	0	C	205, 734	0	190. 07
	19008 RAMPART 19009 INTELLIPLEX DEVELOPMENT	11, 003	60, 421 0		547, 976 62, 935		190. 08 190. 09
	19009 INTELLIPLEX DEVELOPMENT	2, 300	39, 702	-	172, 249		190. 09
	19016 RENOVO	9, 735	96, 770		1		190. 16
	19017 I MA	0	0	-	_		190. 17
	19018 MD SOLUTIONS		452, 947		, , , , , ,		190. 18
	19019 MHCD 19200 PHYSICIANS' PRIVATE OFFICES		0	33, 012 0			190. 19 192. 00
	19201 HOSPI TALI ST	224	2, 700, 274				192.00
194.00	07950 OTHER NONREI MBURSABLE COST CENTERS	10, 929	186, 721				

Health Fina	ancial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2018 Fo 12/31/2018		pared: 7 pm
	Cost Center Description	CAPITAL RELATED COSTS BLDG & FLXT	FMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
	oost center beschiptron	(SQUARE FEET)	BENEFITS	n	E & GENERAL	PLANT	
		(SQS/IIIC TEET)	DEPARTMENT		(ACCUM. COST)		
			(GROSS SALARI ES)		(1000	(040/1112 / 221)	
		1. 00	4.00	5A	5. 00	7. 00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	8, 917, 966	13, 270, 710		24, 048, 021	4, 633, 587	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	30. 906566	0. 257747		0. 236427	18. 736250	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)		36, 253		773, 371	500, 348	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000704		0. 007603	2. 023194	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Heal th Financial Systems MAJOR HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0097
Period: Worksheet B-1
From 01/01/2018
To 12/31/2018 Date/Time Prepared: 5/23/2019 3: 17 pm

			To	12/31/2018	Date/Time Pre 5/23/2019 3:1	
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	, piii
	LINEN SERVICE	(SQUARE FEET)	(PATIENT	(MANHOURS)	ADMI NI STRATI O	
	(POUNDS OF LAUNDRY)		DAYS)		N (MANHOURS)	
	8. 00	9. 00	10. 00	11. 00	13. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE	407, 910					8.00
9. 00 00900 HOUSEKEEPI NG	0	243, 352				9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	1, 444 5, 901	9, 934 0	1, 129, 186		10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	2, 607	0	1, 129, 180	861, 856	
14. 00 01400 CENTRAL SERVICES & SUPPLY	Ö	3, 237	Ö	0	0	14.00
15. 00 01500 PHARMACY	0	3, 091	0	25, 399	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	2, 235	0	42, 872	0	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	161, 348	26, 223	8, 423	160, 932	160, 932	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	4, 118	1, 511	42, 904	42, 904	1
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00 O4200 SUBPROVI DER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	99, 866	24, 645	0	81, 618	81, 618	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	Ö	01,010	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	501	0	15, 805	15, 805	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	62, 068	9, 240	0	85, 199	0	54.00
56. 00 05600 RADI 0I SOTOPE 56. 01 05601 ONCOLOGY	49, 285	19, 934	0	38, 449	0 38, 449	56. 00 56. 01
57. 00 05700 CT SCAN	0	2, 089	0	6, 695	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2, 107	0	11, 134	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0	5, 754	0	83, 651	0	60.00
65. 00 06500 RESPI RATORY THERAPY	14, 250	4, 606	0	30, 140	30, 140	60. 01 65. 00
65. 01 06501 SLEEP LAB	0	0	Ö	0	15, 314	1
66. 00 06600 PHYSI CAL THERAPY	5, 293	11, 807	0	46, 465	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 220	0	19, 225	19, 225	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	3, 479 0	0	4, 146 3, 415	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	- 1	Ö	0, 110	0	73.00
OUTPATIENT SERVICE COST CENTERS	I					
88. 00 08800 MHP PEDIATRICS	0	7, 320	0	34, 879	34, 879	88.00
88. 01 08801 MHP 0BGYN 88. 02 08802 MHP FIM	0	4, 325 24, 131	0	27, 125 152, 605	27, 125 152, 605	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	Ö	0	0	89.00
90. 00 09000 CLI NI C	0	10, 135	0	33, 838	33, 838	
91. 00 09100 EMERGENCY	15, 800	13, 715	0	82, 176	82, 176	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	7, 355	0	39, 091	39, 091	92. 00 92. 01
OTHER REIMBURSABLE COST CENTERS		7, 333	<u> </u>	37, 071	37, 071	72.01
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	1
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0		0	0		100. 00 101. 00
SPECIAL PURPOSE COST CENTERS		0, 371	<u> </u>	<u>0</u>	+0, 030	101.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	407, 910	207, 610	9, 934	1, 085, 155	814, 731	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	751	0	ام	0	190. 00
190. 01 19001 SHELBY COUNTY MEDICAL CENTER		/31	0	o		190.00
190. 05 19005 MARKETI NG	0	800	0	5, 757	0	190. 05
190. 07 19007 I -74 CAMPUS	0	0	0	0		190. 07
190. 08 19008 RAMPART 190. 09 19009 INTELLIPLEX DEVELOPMENT	0	11, 003	0	3, 888		190. 08 190. 09
190. 09 19009 INTELLIPLEX DEVELOPMENT 190. 11 19011 MHP ADMIN BUILDING		2, 300	0	2, 241		190. 09
190. 16 19016 RENOVO	0	9, 735	0	6, 049		190. 16
190. 17 19017 I MA	0	0	0	o		190. 17
190. 18 19018 MD SOLUTI ONS	0	0	0	o		190. 18
190. 19 19019 MHCD 192. 00 19200 PHYSICIANS' PRIVATE OFFICES			0	0		190. 19 192. 00
192. 01 19201 HOSPI TALI ST		224	o	26, 096		192.01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	10, 929	0	0		194. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	I	l l				201. 00

Heal th Fi	nancial Systems	MAJOR HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLO	CATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2018 To 12/31/2018		
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE	(SQUARE FEET)	(PATI ENT	(MANHOURS)	ADMINISTRATIO	
		(POUNDS OF		DAYS)		N	
		LAUNDRY)				(MANHOURS)	
		8. 00	9. 00	10.00	11. 00	13. 00	
202.00	Cost to be allocated (per Wkst. B,	430, 597	3, 258, 905	431, 12	8 1, 507, 325	1, 574, 735	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 055618	13. 391733	43. 39923	5 1. 334878	1. 827144	203. 00
204.00	Cost to be allocated (per Wkst. B,	46, 085	107, 344	50, 66	5 205, 476	99, 629	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 112978	0. 441106	5. 10016	1 0. 181968	0. 115598	205.00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

| Peri od: | Worksheet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0097

				-	To 12/31/2018 Date/Ti me Pi 5/23/2019 3:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	0,20,201,	, , , _p ,,,
		SERVICES & SUPPLY	(100% DRUGS TO PATIENTS)	RECORDS & LI BRARY		
		(100%	, , , , , , , ,	(GROSS		
		SUPPLI ES) 14. 00	15. 00	CHARGES) 16. 00	_	
	GENERAL SERVICE COST CENTERS	11.00	10.00	10. 00		
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
4. 00 5. 00	OO4OO EMPLOYEE BENEFITS DEPARTMENT OO5OO ADMINISTRATIVE & GENERAL					4. 00 5. 00
7. 00	00700 OPERATION OF PLANT					7. 00
8. 00 9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG					8. 00 9. 00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11. 00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	100				13. 00 14. 00
	01500 PHARMACY	0				15.00
	01600 MEDICAL RECORDS & LIBRARY	0	0	380, 724, 86	3	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	O	15, 770, 77	2	30.00
31. 00	03100 INTENSIVE CARE UNIT	0		4, 657, 11		31.00
	04100 SUBPROVI DER - I RF	0		(O	41.00
42. 00	04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS	0	0	(0	42.00
50. 00	05000 OPERATING ROOM	0	0	53, 812, 76	6	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	o	(D	52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0		1, 963, 03: 26, 800, 230		53. 00 54. 00
	05600 RADI OLOGY - DI AGNOSTI C		1	20, 800, 23	0	56.00
56. 01	05601 ONCOLOGY	0	0	17, 507, 520		56. 01
57. 00 58. 00	05700 CT SCAN	0		29, 235, 58		57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION		0	11, 068, 02	0	58. 00 59. 00
60.00	06000 LABORATORY	0		43, 490, 199	9	60.00
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0	1	6, 925, 70	0	60. 01 65. 00
65. 00	06501 SLEEP LAB		1	4, 522, 57		65. 00
	06600 PHYSI CAL THERAPY	0	o	8, 429, 31	1	66. 00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 54		13, 343, 980 11, 462, 13		69. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	46		9, 443, 01		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	100	43, 064, 80	4	73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 MHP PEDIATRICS	0	O	3, 486, 046	6	88.00
	08801 MHP OBGYN	0		2, 347, 530		88. 01
88. 02	08802 MHP FIM	0	o	9, 832, 210	0	88. 02
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	2, 016, 96	0	89. 00 90. 00
91. 00	09100 EMERGENCY	0	1	52, 994, 09		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	_	_			92.00
92. 01	O9201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	5, 745, 92	7	92. 01
	09500 AMBULANCE SERVICES	0	0	(o	95. 00
	09700 DURABLE MEDICAL EQUIP-SOLD	0		(0	97.00
	10000 &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0		2, 805, 33	0 9	100. 00 101. 00
	SPECIAL PURPOSE COST CENTERS			2,000,00	<u> </u>	
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	100	100	200 724 04		113.00
118.00	NONREIMBURSABLE COST CENTERS	100	100	380, 724, 86	3	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	190. 00
	19001 SHELBY COUNTY MEDICAL CENTER 19005 MARKETING	0	0	(0	190. 01 190. 05
	19007 I -74 CAMPUS		0	(190. 03
190. 08	19008 RAMPART	0	o	(O	190. 08
	19009 NTELLIPLEX DEVELOPMENT 19011 MHP ADMIN BUILDING	0	0	(0	190. 09 190. 11
	19016 RENOVO	0	0	(o o	190. 11
190. 17	19017 I MA	0	0	(0	190. 17
	19018 MD SOLUTIONS 19019 MHCD	0	0		טן	190. 18 190. 19
	19200 PHYSICIANS' PRIVATE OFFICES				o o	190. 19
192. 01	19201 HOSPI TALI ST	0	0	(O	192. 01
194. 00 200. 00	07950 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0	0	(U	194. 00 200. 00
201.00						201.00

Health Fin	ancial Systems	MAJOR HO	SPI TAL		In Lieu	u of Form CMS-2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der Co		Peri od: From 01/01/2018	Worksheet B-1
					To 12/31/2018	Date/Time Prepared: 5/23/2019 3:17 pm
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL		
		SERVICES &	(100% DRUGS	RECORDS &		
		SUPPLY	TO PATIENTS)	LI BRARY		
		(100%		(GROSS		
		SUPPLI ES)		CHARGES)		
		14. 00	15. 00	16. 00		
202. 00	Cost to be allocated (per Wkst. B, Part I)	228, 715	12, 291, 157	2, 154, 03	39	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	2, 287. 150000	122, 911. 57000 0	0. 00565	58	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	108, 789	183, 308	95, 50	00	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	1, 087. 890000	1, 833. 080000	0. 00025	51	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207. 00

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0097	Period: Worksheet C From 01/01/2018 Part I

				rom 01/01/2018 o 12/31/2018		pared: 7 pm
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	B, Part I,	,				
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	12, 502, 664		12, 502, 664	0	12, 502, 664	30.00
31. 00 03100 NTENSI VE CARE UNI T	2, 642, 361		2, 642, 361		2, 642, 361	31.00
41. 00 04100 SUBPROVI DER - I RF	2, 042, 301		2,042,301		2, 042, 301	41.00
42. 00 04200 SUBPROVI DER					0	
ANCI LLARY SERVI CE COST CENTERS	1 0			, O	0	42.00
50. 00 05000 OPERATING ROOM	8, 570, 309		8, 570, 309	ol	8, 570, 309	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	8, 370, 307		0, 370, 309		0, 370, 309	52.00
53. 00 05300 ANESTHESI OLOGY	_	l .	2 022 170	'l "		
+ I	2, 033, 178		2, 033, 178		2, 219, 282	
	8, 089, 217		8, 089, 217		8, 092, 302	
56. 00 05600 RADI OI SOTOPE	0 712 014		712 014	0	0	56.00
56. 01 05601 0NCOLOGY	6, 712, 814		6, 712, 814		6, 718, 720	
57. 00 05700 CT SCAN	1, 450, 653		1, 450, 653		1, 450, 653	1
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 344, 880	ł .	1, 344, 880		1, 344, 880	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1	0 404 074	′I	0	59.00
60. 00 06000 LABORATORY	8, 491, 276		8, 491, 276	0	8, 491, 276	1
60. 01 06001 BLOOD LABORATORY	0	_	(0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	2, 129, 553		_,,		2, 129, 553	
65. 01 06501 SLEEP LAB	1, 062, 943		1, 062, 943		1, 062, 943	
66. 00 06600 PHYSI CAL THERAPY	3, 867, 390	0	3, 867, 390		3, 868, 694	
69. 00 06900 ELECTROCARDI OLOGY	3, 271, 411		3, 271, 411		3, 271, 411	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 714, 054		2, 714, 054		2, 714, 054	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 366, 481		2, 366, 481		2, 366, 481	
73.00 O7300 DRUGS CHARGED TO PATIENTS	12, 534, 818		12, 534, 818	0	12, 534, 818	73. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 MHP PEDI ATRI CS	4, 258, 228		4, 258, 228		4, 258, 228	
88. 01 08801 MHP OBGYN	3, 135, 633		3, 135, 633		3, 135, 633	88. 01
88. 02 08802 MHP FIM	14, 270, 291		14, 270, 291		14, 270, 291	88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		C	′I "I	0	89. 00
90. 00 09000 CLI NI C	2, 401, 611		2, 401, 611		2, 459, 534	
91. 00 09100 EMERGENCY	6, 835, 547		6, 835, 547		7, 208, 028	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	730, 929		730, 929		730, 929	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	3, 039, 769		3, 039, 769	0	3, 039, 769	92. 01
OTHER REIMBURSABLE COST CENTERS				, ,		
95. 00 09500 AMBULANCE SERVICES	0	l .	C	1	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		C		0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0		C		0	
101.00 10100 HOME HEALTH AGENCY	3, 159, 004		3, 159, 004		3, 159, 004	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE	1					113.00
200.00 Subtotal (see instructions)	117, 615, 014		,		118, 241, 817	
201.00 Less Observation Beds	730, 929		730, 929		730, 929	
202.00 Total (see instructions)	116, 884, 085	0	116, 884, 085	626, 803	117, 510, 888	202. 00

Peri od: Worksheet C From 01/01/2018 Part I To 12/31/2018 Date/Ti me Prepared: 5/23/2019 3:17 pm Provider CCN: 15-0097

						5/23/2019 3: 1	7 pm
			Title	XVIII	Hospi tal	PPS	
	·		Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
	'	'	•	+ col. 7)	Ratio	Inpati ent	
				,		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•	•		
30.00	03000 ADULTS & PEDIATRICS	14, 282, 487		14, 282, 4	37		30.00
31.00	03100 INTENSIVE CARE UNIT	4, 657, 111		4, 657, 1	11		31.00
41.00	04100 SUBPROVI DER - I RF	0		, , , , ,	0		41.00
42.00	04200 SUBPROVI DER	o			0		42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	9, 368, 944	44, 443, 822	53, 812, 7	0. 159262	0.000000	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0.000000	0. 000000	1
53. 00	05300 ANESTHESI OLOGY	345, 724	1, 617, 308			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 072, 226	24, 728, 004			0. 000000	1
56. 00	05600 RADI OI SOTOPE	0	0.77207001		0.000000	0. 000000	
56. 01	05601 ONCOLOGY	13, 256	17, 494, 264	17, 507, 5		0. 000000	•
57. 00	05700 CT SCAN	4, 294, 372	24, 941, 209			0. 000000	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	913, 924	10, 154, 103			0. 000000	•
59. 00	05900 CARDI AC CATHETERI ZATI ON	713, 724	10, 154, 109		0. 000000	0. 000000	1
60.00	06000 LABORATORY	7, 147, 118	36, 343, 081			0.000000	
60. 00	06001 BLOOD LABORATORY	7, 147, 110	30, 343, 001		0. 193240	0.000000	1
65.00	06500 RESPIRATORY THERAPY	5, 669, 708	1, 255, 992			0.000000	
65. 01	06501 SLEEP LAB	3,007,700	4, 522, 573			0.000000	1
66. 00	06600 PHYSI CAL THERAPY	1, 295, 008	7, 134, 303			0. 000000	1
69.00	06900 ELECTROCARDI OLOGY	2, 149, 712	11, 194, 268			0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 610, 560	8, 851, 571			0.000000	1
71.00	07200 IMPL. DEV. CHARGED TO PATIENT	5, 058, 637	4, 384, 379			0.000000	1
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 141, 040	34, 923, 764			0.000000	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	0, 141, 040	34, 923, 704	43,004,0	0. 291009	0.000000	73.00
88. 00	08800 MHP PEDI ATRI CS	0	3, 486, 046	3, 486, 0	16		88. 00
88. 01	08801 MHP OBGYN		2, 347, 530				88. 01
88. 02	08802 MHP FIM		9, 832, 210				88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		9, 032, 210		0		89.00
90.00	09000 CLINIC	5, 338	-		-	0. 000000	
90.00	09100 EMERGENCY	1	2, 011, 624			0.000000	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 472, 910	44, 521, 186				1
92.00		1	1, 488, 285			0.000000	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	967, 708	4, 778, 219	5, 745, 9	27 0. 529030	0. 000000	92. 01
05 00	OTHER REIMBURSABLE COST CENTERS				0 000000	0.000000	05 00
95.00	09500 AMBULANCE SERVICES	0	0		0.000000	0.000000	l
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0. 000000	0. 000000	
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0 005 000	0.005.0	U		100.00
101.00	10100 HOME HEALTH AGENCY	0	2, 805, 339	2, 805, 3	39		101.00
110 00	SPECIAL PURPOSE COST CENTERS						110 00
	11300 I NTEREST EXPENSE	77 4/5 700	000 050 000	200 70.0			113.00
200.00	, ,	77, 465, 783	303, 259, 080	380, 724, 8	53		200.00
201.00		77 4/5 700	000 050 000	200 70.0			201.00
202.00	Total (see instructions)	77, 465, 783	303, 259, 080	380, 724, 8	D 		202. 00

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: Worksheet C From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

			10 12/31/2010	5/23/2019 3:17 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient		<u> </u>	
· ·	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00 03100 INTENSIVE CARE UNIT				31.00
41. 00 04100 SUBPROVI DER - I RF				41.00
42. 00 04200 SUBPROVI DER				42.00
ANCILLARY SERVICE COST CENTERS	<u>'</u>			
50. 00 05000 OPERATING ROOM	0. 159262			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	1. 130538			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 301949			54.00
56. 00 05600 RADI OI SOTOPE	0. 000000			56.00
56. 01 05601 0NCOLOGY	0. 383762			56. 01
57. 00 05700 CT SCAN	0. 049619			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 121510			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 195246			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 307486			65.00
65. 01 06501 SLEEP LAB	0. 235031			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 458957			66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 245160			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 236784			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 250606			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 291069			73.00
OUTPATIENT SERVICE COST CENTERS	0.27.007			70.00
88. 00 08800 MHP PEDIATRICS				88. 00
88. 01 08801 MHP OBGYN				88. 01
88. 02 08802 MHP FI M				88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90. 00 09000 CLINIC	1. 219425			90.00
91. 00 09100 EMERGENCY	0. 136016			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 491122			92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 529030			92. 01
OTHER REIMBURSABLE COST CENTERS	1 2: 2=:000			1-1-1
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000			97.00
100. 00 10000 &R SERVICES-NOT APPRVD PRGM				100.00
101. 00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
	1			1202.00

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0097	Period: Worksheet C

12/31/2018 Date/Time Prepared: 5/23/2019 3:17 pm Hospi tal Title XIX Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs (from Wkst. Adj Di sal I owance B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 12, 502, 664 12, 502, 664 0 12, 502, 664 30.00 03100 INTENSIVE CARE UNIT 2, 642, 361 2, 642, 361 0 31.00 2, 642, 361 31.00 41.00 04100 SUBPROVI DER - I RF ol 41.00 C 04200 SUBPROVI DER 42.00 0 0 0 42.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 8, 570, 309 8, 570, 309 0 8, 570, 309 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 2, 033, 178 186, 104 2, 219, 282 53 00 05300 ANESTHESI OLOGY 2 033 178 53 00 8, 089, 217 3, 085 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 089, 217 8, 092, 302 54.00 56.00 05600 RADI OI SOTOPE 56.00 05601 ONCOLOGY 5, 906 6, 718, 720 56.01 6, 712, 814 6, 712, 814 56, 01 57.00 05700 CT SCAN 1, 450, 653 1, 450, 653 0 1, 450, 653 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 344, 880 1, 344, 880 1, 344, 880 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 06000 LABORATORY 8, 491, 276 8, 491, 276 0 8, 491, 276 60 00 60 00 60.01 06001 BLOOD LABORATORY 0 60.01 0 06500 RESPIRATORY THERAPY 0 65.00 2, 129, 553 2, 129, 553 2, 129, 553 65.00 06501 SLEEP LAB 1,062,943 1, 062, 943 0 1,062,943 0 65.01 65.01 06600 PHYSI CAL THERAPY 66.00 3, 867, 390 3, 867, 390 1, 304 3, 868, 694 66,00 69.00 06900 ELECTROCARDI OLOGY 3, 271, 411 3, 271, 411 0 3, 271, 411 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 714, 054 2, 714, 054 0 2, 714, 054 71.00 72 00 07200 I MPL. DEV. CHARGED TO PATIENT 2, 366, 481 2, 366, 481 0 2, 366, 481 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 12, 534, 818 12, 534, 818 12, 534, 818 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 MHP PEDIATRICS 4, 258, 228 4, 258, 228 ol 4, 258, 228 88.00 08801 MHP OBGYN 88.01 3, 135, 633 3, 135, 633 0 3, 135, 633 88 01 88.02 08802 MHP FIM 14, 270, 291 14, 270, 291 0 14, 270, 291 88 02 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 90 00 09000 CLINIC 2, 401, 611 2, 401, 611 57, 923 2.459.534 90 00 91.00 09100 EMERGENCY 6, 835, 547 6, 835, 547 372, 481 7, 208, 028 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 730, 929 730, 929 730, 929 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 3, 039, 769 3, 039, <u>769</u> 92.01 3, 039, 769 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 3, 159, <u>004</u> 101. 00 3, 159, 004 3, 159, 004 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 626, 803 118, 241, 817 200. 00 Subtotal (see instructions) 117, 615, 014 0 117, 615, 014 201.00 Less Observation Beds 730, 929 730 929 730, 929 201. 00 202.00 Total (see instructions) 116, 884, 085 116, 884, 085 626, 803 117, 510, 888 202. 00

						5/23/2019 3:1	7 pm
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	•	'	•	+ col. 7)	Rati o	I npati ent	
				ĺ		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
LNPA	ATIENT ROUTINE SERVICE COST CENTERS						
	00 ADULTS & PEDIATRICS	14, 282, 487		14, 282, 48	7		30.00
	00 INTENSIVE CARE UNIT	4, 657, 111		4, 657, 11			31.00
	00 SUBPROVI DER – I RF	0			Ö		41.00
	00 SUBPROVI DER	l ol			o O		42.00
	ILLARY SERVICE COST CENTERS	-1			-		
	OO OPERATING ROOM	9, 368, 944	44, 443, 822	53, 812, 76	0. 159262	0.000000	50.00
	OO DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	
	OO ANESTHESI OLOGY	345, 724	1, 617, 308			0. 000000	
	00 RADI OLOGY-DI AGNOSTI C	2, 072, 226	24, 728, 004	26, 800, 23		0. 000000	
	OO RADI OI SOTOPE	0	21,720,001	20,000,20	0. 000000	0. 000000	
	01 ONCOLOGY	13, 256	17, 494, 264	17, 507, 52		0. 000000	
	OO CT SCAN	4, 294, 372	24, 941, 209			0.000000	
	OO MAGNETIC RESONANCE IMAGING (MRI)	913, 924				0.000000	
	00 CARDIAC CATHETERIZATION	913, 924	10, 154, 103	11,000,02	0. 000000	0.000000	
	OO LABORATORY	7 147 110	27 242 001	40 400 10			
		7, 147, 118	36, 343, 081	43, 490, 19		0.000000	
	01 BLOOD LABORATORY	5 ((0 700	4 055 000	, , , , , , , ,	0.000000	0.000000	
	00 RESPI RATORY THERAPY	5, 669, 708	1, 255, 992			0.000000	
	01 SLEEP LAB	4 205 200	4, 522, 573	4, 522, 57		0.000000	
	00 PHYSI CAL THERAPY	1, 295, 008	7, 134, 303			0. 000000	
	00 ELECTROCARDI OLOGY	2, 149, 712	11, 194, 268			0. 000000	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 610, 560	8, 851, 571			0. 000000	
	00 IMPL. DEV. CHARGED TO PATIENT	5, 058, 637	4, 384, 379			0. 000000	
	00 DRUGS CHARGED TO PATIENTS	8, 141, 040	34, 923, 764	43, 064, 80	0. 291069	0. 000000	73.00
	PATIENT SERVICE COST CENTERS						
	00 MHP PEDIATRICS	0	3, 486, 046			0. 000000	
	01 MHP OBGYN	0	2, 347, 530			0. 000000	
	02 MHP FIM	0	9, 832, 210	9, 832, 21		0. 000000	
	00 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0. 000000	0. 000000	
	00 CLI NI C	5, 338	2, 011, 624			0. 000000	
	OO EMERGENCY	8, 472, 910	44, 521, 186			0. 000000	
	OO OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 488, 285	1, 488, 28		0. 000000	
	01 OBSERVATION BEDS (DISTINCT PART)	967, 708	4, 778, 219	5, 745, 92	7 0. 529030	0. 000000	92. 01
	ER REIMBURSABLE COST CENTERS						
	00 AMBULANCE SERVICES	0	0		0.000000	0.000000	95.00
97. 00 0970	OO DURABLE MEDICAL EQUIP-SOLD	0	0		0.000000	0.000000	97.00
	00 1 & R SERVICES-NOT APPRVD PRGM	0	0		O		100.00
101.00 1010	OO HOME HEALTH AGENCY	o	2, 805, 339	2, 805, 33	9		101.00
	CLAL PURPOSE COST CENTERS	<u> </u>					
	00 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	77, 465, 783	303, 259, 080	380, 724, 86	3		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	77, 465, 783	303, 259, 080	380, 724, 86	3		202.00
'	•				,	•	•

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0097	Peri od: Worksheet C From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

			To 12/31/2018	Date/Time Prepar 5/23/2019 3:17 p
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30
31. 00 03100 INTENSIVE CARE UNIT				31
41. 00 04100 SUBPROVI DER - I RF				41
42. 00 04200 SUBPROVI DER				42
ANCI LLARY SERVI CE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52
53. 00 05300 ANESTHESI OLOGY	0. 000000			53
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54
56. 00 05600 RADI 0I SOTOPE	0. 000000			56
56. 01 05601 ONCOLOGY	0. 000000			56
57.00 05700 CT SCAN	0. 000000			57
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59
60. 00 06000 LABORATORY	0. 000000			60
60. 01 06001 BLOOD LABORATORY	0. 000000			60
65.00 06500 RESPIRATORY THERAPY	0. 000000			65
65. 01 06501 SLEEP LAB	0. 000000			65
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 MHP PEDIATRICS	0. 000000			88
88.01 08801 MHP OBGYN	0. 000000			88
88.02 08802 MHP FIM	0. 000000			88
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89
90. 00 09000 CLI NI C	0. 000000			90
91. 00 09100 EMERGENCY	0. 000000			91
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			92
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97
100. 00 10000 I &R SERVICES-NOT APPRVD PRGM	0.00000			100
101.00 10100 HOME HEALTH AGENCY				101
SPECIAL PURPOSE COST CENTERS				101
113. 00 11300 INTEREST EXPENSE				113
200.00 Subtotal (see instructions)				200
201.00 Less Observation Beds				201
202.00 Total (see instructions)				202
202.00 10101 (366 111311 0611 0113)	1			1202

Heal th	Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS	Provi der C	1	Period: From 01/01/2018 To 12/31/2018		
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal Related Cost	Swing Bed Adjustment	Reduced Capital	Total Patient Days	Per Diem (col. 3 /	
		(from Wkst.		Related Cost		col. 4)	
		B, Part II,		(col. 1 -			
		col. 26)		col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		Г	1	. 1		
30.00	ADULTS & PEDIATRICS	1, 056, 483		1, 056, 483			
31. 00	I NTENSI VE CARE UNI T	173, 950	_	173, 950	1, 511	115. 12	
41.00	SUBPROVI DER - I RF	0	0	(0	0. 00	
42.00	SUBPROVI DER	0	0	(0	0. 00	
200.00	Total (lines 30 through 199)	1, 230, 433		1, 230, 433	3 10, 457		200.00
	Cost Center Description	Inpatient	Inpatient				
		Program days	Program				
			Capital Cost (col. 5 x				
			col. 6)				
		6, 00	7.00	-			
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30.00	ADULTS & PEDIATRICS	3, 631	428, 821				30.00
31.00	INTENSIVE CARE UNIT	616				ļ	31.00
41.00	SUBPROVI DER - I RF	0				ļ	41.00
42.00	SUBPROVI DER	0	0				42.00
200.00	Total (lines 30 through 199)	4, 247	499, 735				200. 00

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/23/2019 3:1	pared: 7 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	916, 924	53, 812, 766			52, 755	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000		0	
53. 00 05300 ANESTHESI OLOGY	35, 833				1, 920	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	385, 450	26, 800, 230			18, 057	
56. 00 05600 RADI 0I SOTOPE	0	0	0. 00000		0	
56. 01 05601 0NCOLOGY	723, 150				5	
57. 00 05700 CT SCAN	85, 885	29, 235, 581	0. 00293	8 2, 227, 175	6, 543	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	82, 758	11, 068, 027	0. 00747	7 430, 522	3, 219	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0	0	59.00
60. 00 06000 LABORATORY	268, 429	43, 490, 199	0. 00617	2 3, 324, 701	20, 520	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	177, 948	6, 925, 700	0. 02569	4 2, 685, 838	69, 010	65.00
65. 01 06501 SLEEP LAB	9, 470	4, 522, 573	0. 00209	4 0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	427, 124	8, 429, 311	0. 05067	1 752, 014	38, 105	66.00
69. 00 06900 ELECTROCARDI OLOGY	69, 291	13, 343, 980		3 1, 001, 315	5, 200	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	193, 332	11, 462, 131	0. 01686		23, 874	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	66, 621	9, 443, 016	0. 00705	5 1, 838, 253	12, 969	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	194, 117	43, 064, 804	0.00450	8 3, 458, 225	15, 590	73.00
OUTPATIENT SERVICE COST CENTERS						1
88. 00 08800 MHP PEDIATRICS	280, 011	3, 486, 046	0. 08032	3 0	0	88. 00
88. 01 08801 MHP OBGYN	171, 245	2, 347, 530	0. 07294	7 0	0	88. 01
88. 02 08802 MHP FIM	935, 176	9, 832, 210	0. 09511	4 0	0	88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0 0	0	89.00
90. 00 09000 CLI NI C	361, 518	2, 016, 962	0. 17923	9 2, 787	500	90.00
91. 00 09100 EMERGENCY	534, 780	52, 994, 096	0. 01009	1 3, 923, 836	39, 595	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	61, 764	1, 488, 285	0. 04150		0	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	275, 724	5, 745, 927	0. 04798	6 245, 210	11, 767	92.01
OTHER REIMBURSABLE COST CENTERS			•			1
95. 00 09500 AMBULANCE SERVI CES						95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 00000	0 0	0	97.00
200.00 Total (lines 50 through 199)	6, 256, 550	358, 979, 926		25, 762, 298	319, 629	200.00

Health Financial Systems	MAJOR HOS	SPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provider C		Period: From 01/01/2018 To 12/31/2018		pared:
		Title	: XVIII	Hospi tal	PPS	•
Cost Center Description	Nursi ng School Post-Stepdown Adjustments	Nursi ng School	Allied Health Post-Stepdowr Adjustments	Allied Health	All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00	ZN	2.00	3.00	
30. 00	0 0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0		31. 00 41. 00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	(col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6. 00	7. 00	8. 00	
30. 00 03000 ADULTS & PEDI ATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVI DER 1 RF 42. 00 04200 SUBPROVI DER 200. 00 Total (Lines 30 through 199)	0 0	000000000000000000000000000000000000000		0.00 0.00 0.00	0	31. 00 41. 00
Cost Center Description INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					30.00
31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER 200. 00 Total (lines 30 through 199)	0 0					31. 00 41. 00 42. 00 200. 00

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS Provi der CCN: 15-0097	Peri od: Worksheet D Part IV To 12/31/2018 Date/Time Prepared: 12/31/2018 Date/Time Prepared: 12/3/2018 Date/Time Prepared: 12

					10 12/31/2018	5/23/2019 3:1	pareu: 7 mm
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
56. 01	05601 ONCOLOGY	0	0		0 0	0	56. 01
57.00	05700 CT SCAN	0	0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		o o	0	59.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		o o	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	0		o o	0	65.00
65. 01	06501 SLEEP LAB	0	0		o o	0	65. 01
66.00	06600 PHYSI CAL THERAPY	0	0		o o	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	0		o o	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		o o	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						1
88.00	08800 MHP PEDIATRICS	0	0		0 0	0	88. 00
88. 01	08801 MHP OBGYN	0	0		0 0	0	88. 01
88. 02	08802 MHP FIM	0	0		0	0	88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89. 00
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			o	0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		o o	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES						95. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
200.00	Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems MAJOR HOSPI			I TAL	In Lieu	ı of Form CMS-2552-10
	APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provi der CCN: 15-0097	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

				1	To 12/31/2018	Date/Time Pre	
			Ti +Lo	xVIII	Hospi tal	5/23/2019 3: 1 PPS	/ pili
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	cost center bescription	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col . 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
		3331	.,	and 4)	0011 0)	551.77	
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	<u> </u>			<u> </u>		
50.00	05000 OPERATING ROOM	0	0	(53, 812, 766	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0	(1, 963, 032	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(26, 800, 230	0.000000	54.00
56.00	05600 RADI 0I SOTOPE	0	0	(0	0.000000	56.00
56. 01	05601 ONCOLOGY	0	0	(17, 507, 520	0.000000	56. 01
57.00	05700 CT SCAN	0	0	(29, 235, 581	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(11, 068, 027	0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0.000000	59.00
60.00	06000 LABORATORY	0	0	(43, 490, 199	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	(0	0.000000	60. 01
65.00	06500 RESPIRATORY THERAPY	0	0	(6, 925, 700	0.000000	65.00
65. 01	06501 SLEEP LAB	0	0	(4, 522, 573	0.000000	65. 01
66.00	06600 PHYSI CAL THERAPY	0	0	(8, 429, 311	0.000000	66.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(13, 343, 980	0.000000	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(11, 462, 131	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(9, 443, 016	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(43, 064, 804	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 MHP PEDIATRICS	0	0	(3, 486, 046		
	08801 MHP OBGYN	0	0	(2, 347, 530		
	08802 MHP FIM	0	0	(9, 832, 210		
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0	0.000000	89. 00
	09000 CLI NI C	0	0	(2, 016, 962		
91.00	09100 EMERGENCY	0	0	(52, 994, 096	0.000000	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(.,,		
	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	(5, 745, 927	0.000000	92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		9	0.000000	1
200.00	Total (lines 50 through 199)	0	0	(358, 979, 926		200. 00

Health Financial Systems	MAJOR HOSP	In Lieu	ı of Form CMS-2	2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCIL THROUGH COSTS	LARY SERVICE OTHER PASS	Provider Co		Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Pre 5/23/2019 3:1	pared: 7 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through	Outpatient Program Charges	Outpatient Program Pass-Through	

			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8	, and the second	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.000000	3, 096, 147	0	10, 346, 752	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	105, 199	0	419, 626	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 255, 560	0	5, 916, 906	0	54.00
56.00	05600 RADI 0I SOTOPE	0. 000000	0	0	0	0	56.00
56. 01	05601 ONCOLOGY	0. 000000	110	0	7, 269, 276	0	56. 01
57.00	05700 CT SCAN	0. 000000	2, 227, 175	0	6, 835, 748	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	430, 522	0	2, 845, 499		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0. 000000	3, 324, 701	0	3, 976, 373	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	0	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0. 000000	2, 685, 838	0	208, 052	0	65.00
65. 01	06501 SLEEP LAB	0. 000000	0	0	975, 426	0	65. 01
66.00	06600 PHYSI CAL THERAPY	0. 000000	752, 014	0	51, 735	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	1, 001, 315	0	3, 990, 905	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 415, 406	0	1, 950, 887	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	1, 838, 253	0	1, 492, 365	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	3, 458, 225		15, 061, 108		73.00
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 MHP PEDIATRICS	0. 000000	0	0	0	0	88. 00
88. 01	08801 MHP OBGYN	0. 000000	0	0	0	0	88. 01
88. 02	08802 MHP FIM	0. 000000	0	0	0	0	88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	o	0	0	89. 00
90.00	09000 CLI NI C	0. 000000	2, 787	0	681, 757	0	90.00
91.00	09100 EMERGENCY	0. 000000	3, 923, 836	0	8, 688, 048	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	0	978, 465	0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	245, 210	0	868, 380	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES						95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0	0	0	0	97.00
200.00	Total (lines 50 through 199)		25, 762, 298	0	72, 557, 308	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0097 Peri od: Worksheet D From 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/23/2019 3:17 pm Title XVIII Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To Subject To inst.) Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1. 00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 159262 10, 346, 752 1, 647, 844 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 52.00 1. 035733 53.00 05300 ANESTHESI OLOGY 419, 626 434, 620 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.301834 5, 916, 906 0 0 0 0 1, 785, 923 54.00 56.00 05600 RADI OI SOTOPE 0.000000 0 56.00 2, 787, 222 0 56.01 05601 ONCOLOGY 0.383425 7, 269, 276 56.01 0 57.00 05700 CT SCAN 0.049619 6, 835, 748 339, 183 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0. 121510 2, 845, 499 0 0 0 345, 757 58.00 0 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 0 0 06000 LABORATORY 0.195246 3, 976, 373 60.00 776, 371 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 60.01 06500 RESPIRATORY THERAPY 0 65.00 0.307486 208, 052 0 0 63, 973 65.00 229, 255 06501 SLEEP LAB 0. 235031 0 65 01 975, 426 65 01 66.00 06600 PHYSI CAL THERAPY 0.458803 51, 735 0 23, 736 66.00 69.00 06900 ELECTROCARDI OLOGY 0. 245160 3, 990, 905 0 0 978, 410 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 236784 1, 950, 887 713 461, 939 71.00 373, 996 07200 IMPL. DEV. CHARGED TO PATIENT 1, 492, 365 72 00 0 250606 955 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 291069 15, 061, 108 0 18,012 4, 383, 822 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 MHP PEDIATRICS 0.000000 0 88.00 08801 MHP OBGYN 0.000000 88.01 88.01 0 08802 MHP FIM 88.02 0.000000 0 88.02 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 89.00 0 09000 CLI NI C 1. 190707 90.00 681.757 0 0 811.773 90.00 8, 688, 048 0 1, 120, 645 09100 EMERGENCY 0.128987 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.491122 978, 465 0 0 480, 546 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0.529030 868, 380 0 459, 399 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 0 95.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 97.00 0 200.00 Subtotal (see instructions) 72, 557, 308 1,668 18.012 17.504.414 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00

72, 557, 308

1,668

18, 012

17, 504, 414 202. 00

Only Charges

Net Charges (line 200 - line 201)

202.00

					10 12/31/2018	Date/lime Prepared 5/23/2019 3:17 pm	
			Title	XVIII	Hospi tal	PPS	
		Cos		XVIII	1103pi tui	110	
	Cost Center Description	Cost	Cost				
	5551 5511to.	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
ANCI L	LARY SERVICE COST CENTERS						_
50.00 05000	OPERATING ROOM	0	0			50.0	00
52.00 05200	DELIVERY ROOM & LABOR ROOM	O	0			52.0	00
53.00 05300	ANESTHESI OLOGY	O	0			53.0	00
54.00 05400	RADI OLOGY-DI AGNOSTI C	0	0			54.0	00
56.00 05600	RADI OI SOTOPE	o	0			56.0	00
56. 01 05601	ONCOLOGY	o	0			56.0	01
57.00 05700	CT SCAN	o	0			57.0	00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	o	0			58.0	00
59.00 05900	CARDI AC CATHETERI ZATI ON	o	0			59.0	00
60.00 06000	LABORATORY	o	0			60.0	00
60. 01 06001	BLOOD LABORATORY	o	0			60.0	01
65.00 06500	RESPI RATORY THERAPY	o	0			65.0	00
65. 01 06501	SLEEP LAB	o	0			65.0	01
66.00 06600	PHYSI CAL THERAPY	o	0			66.0	00
69.00 06900	ELECTROCARDI OLOGY	o	0			69.0	00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	169	0			71.0	00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	239	0			72.0	00
73.00 07300	DRUGS CHARGED TO PATIENTS	o	5, 243			73.0	00
	TIENT SERVICE COST CENTERS						
88.00 08800	MHP PEDIATRICS	0	0			88.0	00
88. 01 08801	MHP OBGYN	0	0			88.0	01
88. 02 08802	MHP FIM	0	0			88.0	02
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0			89. 0	00
90.00 09000	CLINIC	0	0			90.0	00
91.00 09100	EMERGENCY	0	0			91.0	00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.0	00
92. 01 09201	OBSERVATION BEDS (DISTINCT PART)	O	0			92.0	01
OTHER	REIMBURSABLE COST CENTERS						
	AMBULANCE SERVICES	0				95.0	
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0			97.0	00
200. 00	Subtotal (see instructions)	408	5, 243			200. 0	00
201. 00	Less PBP Clinic Lab. Services-Program	0				201. 0	00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	408	5, 243			202.0	00

1. 00 2. 00	Cost Center Description PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS Inpatient days (including private room days and swing-bed days)	Provider CCN: 15-0097 Title XVIII	Peri od: From 01/01/2018 To 12/31/2018 Hospi tal	Worksheet D-1 Date/Time Pre 5/23/2019 3:1 PPS 1.00	pared:
1. 00 2. 00	PART I - ALL PROVIDER COMPONENTS	Title XVIII	To 12/31/2018	5/23/2019 3: 1 PPS	
1. 00 2. 00	PART I - ALL PROVIDER COMPONENTS	Title XVIII		5/23/2019 3: 1 PPS	
1. 00 2. 00	PART I - ALL PROVIDER COMPONENTS	Title XVIII	Hospi tal	PPS	
1. 00 2. 00	PART I - ALL PROVIDER COMPONENTS			1. 00	
1. 00 2. 00	NPATI ENT DAYS			1. 00	
1. 00 2. 00	NPATI ENT DAYS		•		
1. 00 2. 00	-				
2. 00	Inpatient days (including private room days and swing-bed da				l
				8, 946	
2 00	Inpatient days (including private room days, excluding swing			8, 946	
	Private room days (excluding swing-bed and observation bed d do not complete this line.	lays). If you have only p	rivate room days,	0	3. 00
	Semi-private room days (excluding swing-bed and observation		8, 423	4.00	
5. 00	Total swing-bed SNF type inpatient days (including private r reporting period		er 31 of the cost	0	
6. 00	Total swing-bed SNF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	7. 00
	reporting period				l
	Total swing-bed NF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable newborn days)	to the Program (excludin	g swing-bed and	3, 631	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.00
	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year,	enter 0 on this line)	-		l
	Swing-bed NF type inpatient days applicable to titles V or X through December 31 of the cost reporting period	IX only (including priva	te room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or X			0	13. 00
	after December 31 of the cost reporting period (if calendar			_	
	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	days)		14.00
	Total nursery days (title V or XIX only)				15.00
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00

Heal th	Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	<u> 2552</u> -10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Peri od: From 01/01/2018	Worksheet D-1	
					To 12/31/2018		
			Title	xVIII	Hospi tal	5/23/2019 3: 1 PPS	7 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	· ·	Inpatient	Inpati ent	Diem (col. 1		(col . 3 x	
		Cost 1.00	<u>Days</u> 2. 00	÷ col . 2) 3.00	4.00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	3.00	42.00
	Intensive Care Type Inpatient Hospital Units			1			
43.00	INTENSIVE CARE UNIT	2, 642, 361	1, 511	1, 748. 7	5 616	1, 077, 230	
44. 00 45. 00	BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT			•			46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3. line 200)			5, 688, 857	48. 00
49.00	Total Program inpatient costs (sum of lines			ons)		11, 840, 664	49. 00
F0 00	PASS THROUGH COST ADJUSTMENTS		(6	- WI - I - D	C De el el	400 705	F0 00
50. 00	Pass through costs applicable to Program inp	atient routine	services (Tro	m wkst. D, Su	m or Parts I and	499, 735	50.00
51.00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	319, 629	51.00
50.00	and IV)	50 51)					F0 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non ph	veician anost	hotist and	819, 364 11, 021, 300	
55.00	medical education costs (line 49 minus line		erateu, non-pri	ysi ci aii aliest	netist, and	11,021,300	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	•					
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	Ö	57.00
58. 00	Bonus payment (see instructions)	-				0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	odated by the	market basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	ser of 50% of		0	61. 00
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% o	f the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)				63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65.00
	instructions)(title XVIII only)			(=) (,, ,,
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(TITIE XVI	II only). For	0	66. 00
67. 00	,	e costs through	December 31	of the cost r	eporting period	0	67.00
	(line 12 x line 19)						,,,,,,,
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after L	December 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs ((line 67 + line	e 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N						
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	,		•)		70.00 71.00
72.00	Program routine service cost (line 9 x line		THE 70 : THE	2)			72.00
73.00	Medically necessary private room cost applic						73. 00
74.00	Total Program general inpatient routine serv			•	Dart II column		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (Irom	worksneet B,	Part II, Corumn		75. 00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77.00	Program capital-related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		provi den recon	ds)			78. 00 79. 00
80.00	Total Program routine service costs for comp				nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi	tati on					81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		13)				84.00
85.00	Utilization review - physician compensation	(see instructio					85. 00
86. 00			rough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					523	87. 00
88.00	Adjusted general inpatient routine cost per	diem (line 27 ÷				1, 397. 57	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)	1			730, 929	89. 00

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		pared: 7 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 056, 483	12, 502, 664	0. 08450	1 730, 929	61, 764	90.00
91.00 Nursing School cost	0	12, 502, 664	0.00000	0 730, 929	0	91.00
92.00 Allied health cost	0	12, 502, 664	0.00000	0 730, 929	0	92.00
93.00 All other Medical Education	0	12, 502, 664	0. 00000	0 730, 929	0	93.00

	Financial Systems MAJOR HOSE ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0097	Period:	u of Form CMS-2 Worksheet D-1	
COMITO	ATTOM OF THE ATTEMS OF ENATING COST	11 OVI del CCN. 13-0077	From 01/01/2018		
			To 12/31/2018	Date/Time Pre	
		Title XIX	Hospi tal	5/23/2019 3:1 Cost	7 pm
	Cost Center Description	TITLE XIX	поѕрі таі	COST	
	cost center bescription			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	ys, excluding newborn)		8, 946	1.00
2.00	Inpatient days (including private room days, excluding swind			8, 946	2.00
3.00	Private room days (excluding swing-bed and observation bed of	lays). If you have only p	rivate room days,	0	3.00
	do not complete this line.		•		
4.00	Semi-private room days (excluding swing-bed and observation			8, 423	4.00
5.00	Total swing-bed SNF type inpatient days (including private r	room days) through Decemb	er 31 of the cost	0	5.00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)			_	
7. 00	Total swing-bed NF type inpatient days (including private ro	oom days) through Decembe	r 31 of the cost	0	7. 00
0 00	reporting period Total swing-bed NF type inpatient days (including private ro	om daya) after December	21 of the cost	0	8. 00
8. 00	reporting period (if calendar year, enter 0 on this line)	oolii days) arter beceiliber	31 OF the Cost	Ü	8.00
9. 00	Total inpatient days including private room days applicable	to the Program (excluding	a swing-bed and	261	9.00
7. 00	newborn days)	to the rrogram (exertain)	g swifig bed and	201	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days)	0	10.00
	through December 31 of the cost reporting period (see instru	ıctions)	•		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year,				
12.00	Swing-bed NF type inpatient days applicable to titles V or X	(IX only (including priva	te room days)	0	12.00
	through December 31 of the cost reporting period				40.00
13.00	Swing-bed NF type inpatient days applicable to titles V or X			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Proc			0	14. 00
15. 00		gram (excruding swing-bed	uays)		15.00
16. 00	Nursery days (title V or XIX only)				16.00
10.00	SWING BED ADJUSTMENT			0	10.00
17 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	17.00
.,. 00	reporting period	oes in ough becomes of	0. 1 0001	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service	ces through December 31 o	f the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to service	ces after December 31 of	the cost	0. 00	20.00
21 00	reporting period			12 502 444	21 00
21 OO		nc I	1		i ∵)1 (\∩

	<u>'</u>	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn)	8, 946	1. C
2. 00	Inpatient days (including private room days, and swing-bed days, excluding newborn)	8, 946	
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.0
	do not complete this line.	_	
. 00	Semi-private room days (excluding swing-bed and observation bed days)	8, 423	4. C
. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. C
	reporting period		
. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.0
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. C
	reporting period	0	
3. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. C
. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	261	9.0
. 00	newborn days)	201	7. 0
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. C
	through December 31 of the cost reporting period (see instructions)	_	
1.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.0
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.0
	through December 31 of the cost reporting period		
3. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.0
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		١
	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. (
5.00	Total nursery days (title V or XIX only)	0	15.0
6. 00	Nursery days (title V or XIX only)	0	16. (
7 00	SWING BED ADJUSTMENT	0.00	17,
7. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0. 00	17.1
8. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	10 (
0.00	reporting period	0.00	10.
9. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. (
	reporting period		
0.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.0
	reporting period		
1. 00	Total general inpatient routine service cost (see instructions)	12, 502, 664	21. (
2. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.0
	5 x line 17)		
3. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line &	0	23.0
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.0
· - 00	7 x line 19)	0	ا مد
5. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.0
6 00	Total swing-bed cost (see instructions)	0	26. (
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12, 502, 664	
7.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	12, 302, 004	27.0
8 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. (
	Private room charges (excluding swing-bed charges)	0	
	Semi -pri vate room charges (excluding swing-bed charges)	0	30.
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
2. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	•
3. 00	Average semi-private room per diem charge (line 30 + line 4)	0. 00	•
1. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	1
5. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	•
5. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.
7. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		37.
	27 minus line 36)	, ===, == ,	
	PART II - HOSPI TAL AND SUBPROVIDERS ONLY		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1
8. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 397. 57	38.
9. 00	Program general inpatient routine service cost (line 9 x line 38)	364, 766	•
			•
0.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. (

	Financial Systems	MAJOR HOS				u of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der C		Peri od: From 01/01/2018	Worksheet D-1	
					To 12/31/2018	Date/Time Pre 5/23/2019 3:1	
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Program Cost	
	cost center bescription	I npati ent	Inpatient	Diem (col. 1		(col . 3 x	
		1.00	Days 2.00	÷ col . 2) 3.00	4. 00	col. 4) 5.00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT	2, 642, 361	1, 511	1, 748. 7	75 0	0	43.00
45. 00	BURN INTENSIVE CARE UNIT						45.00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					393, 133	
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructi	ons)		757, 899	49.00
50. 00	Pass through costs applicable to Program input	atient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50.00
			·				
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost exclu	J 1	elated, non-ph	ysician anest	hetist, and	0	53.00
	medical education costs (line 49 minus line 1 TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00						0	54.00
55. 00	Target amount per discharge						55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	rget amount (line 56 minus	line 53)	0	
58. 00	· · · · · · · · · · · · · · · · · · ·	ing cost and to	inger amount (TITIC 30 IIITIUS	11110 33)	0	1
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	rost renort ur	ndated by the	market hasket		0. 00	60.00
61.00	If line 53/54 is less than the lower of line					0.00	1
	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 instructions) .00 Relief payment (see instructions)						62.00
63.00							63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST	1. 11	-1 - 21 - C -11		1	-	
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65.00
66. 00	instructions) (title XVIII only)	no costo (lino	44 pluo lino	(E) (+: +1 o V)//	II anly) For	0	44 00
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (Tine	64 prus rine	bb)(title XVI	ii oniy). For	U	66.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost r	eporting period	0	67.00
69 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	o costs after D	ocombor 21 of	the cost ron	orting poriod	0	68.00
00.00	(line 13 x line 20)	e costs after b	becember 31 or	the cost rep	of tring period	O	08.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil)		70.00
71. 00	Adjusted general inpatient routine service of				,		71.00
72.00	Program routine service cost (line 9 x line	,	. (: 14	25)			72.00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine serv		•	•			73.00
75. 00	Capital -related cost allocated to inpatient				Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76.00
77. 00	Program capital-related costs (line 9 x line						77.00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78.00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			*.	nus line 70)		79.00
81.00	Inpatient routine service costs for compa		ost iimi tati 0	(11116 /0 1111	1143 1116 17)		81.00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 81	•				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		ıs)				83.00
85.00			ons)				85.00
	Total Program inpatient operating costs (sum	of lines 83 th					86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					Eas	87. OC
37.00	Adjusted general inpatient routine cost per		· line 2)			1, 397. 57	
88. 00	That do to a gonor at The att out to a time door por						

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 056, 483	12, 502, 664	0. 08450	1 730, 929	61, 764	90.00
91.00 Nursing School cost	0	12, 502, 664	0.00000	0 730, 929	0	91.00
92.00 Allied health cost	0	12, 502, 664	0.00000	0 730, 929	0	92.00
93.00 All other Medical Education	o	12, 502, 664	0. 00000	0 730, 929	0	93.00

	Financial Systems MAJOR HOSENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0097	Peri od:	u of Form CMS-2 Worksheet D-3	
INFAII	ENT ANCILLARY SERVICE COST AFFORTIONWENT	Flovide	CN. 15-0097	From 01/01/2018)
				To 12/31/2018		
		Ti tl e	e XVIII	Hospi tal	5/23/2019 3: 1 PPS	/ pm
	Cost Center Description	1	Ratio of Cos		Inpati ent	
	'		To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1			
30.00	03000 ADULTS & PEDIATRICS			4, 570, 923		30.00
	03100 INTENSIVE CARE UNIT			1, 765, 534		31.00
	04100 SUBPROVI DER - I RF			0		41.00
42. 00	04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS			0		42.00
50.00	05000 OPERATING ROOM		0. 15926	3, 096, 147	493, 099	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 00000	· · ·	493, 099	
53.00	05300 ANESTHESI OLOGY		1. 13053		118, 931	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 30194		379, 115	
56. 00	05600 RADI OI SOTOPE		0.00000		0	1
56. 01	05601 0NCOLOGY		0. 38376		42	
57. 00	05700 CT SCAN		0. 04961		110, 510	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 12151		52, 313	
59.00	05900 CARDI AC CATHETERI ZATI ON		0.00000		0	1
60.00	06000 LABORATORY		0. 19524	3, 324, 701	649, 135	60.00
60. 01	06001 BL00D LABORATORY		0.00000		0	60.01
65.00	06500 RESPI RATORY THERAPY		0. 30748	2, 685, 838	825, 858	65.00
65.01	06501 SLEEP LAB		0. 23503	31 0	0	65. 01
66.00	06600 PHYSI CAL THERAPY		0. 45895	752, 014	345, 142	66.00
69.00	06900 ELECTROCARDI OLOGY		0. 24516	1, 001, 315	245, 482	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 23678		335, 145	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 25060	· · ·	460, 677	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 29106	3, 458, 225	1, 006, 582	73.00
00 00	OUTPATIENT SERVICE COST CENTERS		0.00000	20	0	00.00
88. 00	08800 MHP PEDI ATRI CS		0.00000		0	
88. 01	08801 MHP OBGYN		0.00000		0	00.0.
88. 02	08802 MHP FIM		0.00000		0	
89. 00 90. 00	O8900 FEDERALLY QUALIFIED HEALTH CENTER O9000 CLINIC		0.00000		0 3, 399	07.00
91.00	09100 EMERGENCY		1. 21942 0. 13601		533, 704	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 13601	· · ·	533, 704	
92.00	09201 OBSERVATION BEDS (DISTINCT PART)		0. 49112		129, 723	
/Z. U I	OTHER REIMBURSABLE COST CENTERS		0. 32903	243, 210	127, 723	1 72.01
95.00	09500 AMBULANCE SERVICES					95.00
	09700 DURABLE MEDICAL EQUIP-SOLD		0.00000	00	0	
200 00				25 762 298	5 688 857	

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

95.00 0 97.00 5,688,857 200.00

201. 00 202. 00

25, 762, 298

25, 762, 298

200.00

201. 00 202. 00

Heal th	Financial Systems	MAJOR HOSPITAL		In lie	u of Form CMS-2	2552_10
	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet D-3	pared:
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 31. 00 41. 00 42. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER			515, 720 150, 365 0 0		30. 00 31. 00 41. 00 42. 00
	ANCILLARY SERVICE COST CENTERS					
50. 00 52. 00 53. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY		0. 15926 0. 00000 1. 03573	00	52, 129 0 50, 827	50.00 52.00 53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 30183		15, 633	
56. 00	05600 RADI OI SOTOPE		0. 00000		15,033	1
56. 01	05601 0NC0L0GY		0. 38342		284	56. 01
57.00	05700 CT SCAN		0. 04961		4, 886	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 12151	10 29, 034	3, 528	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 00000		0	59. 00
60.00	06000 LABORATORY		0. 19524		45, 696	
60. 01	06001 BLOOD LABORATORY		0.00000		0	60. 01
65.00	06500 RESPIRATORY THERAPY		0. 30748		46, 325	
65. 01	06501 SLEEP LAB		0. 23503		7 202	65. 01
66.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY		0. 45880 0. 2451 <i>6</i>		7, 293	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 23678		4, 421 30, 882	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 25060		0 30,002	72.00
	07300 DRUGS CHARGED TO PATIENTS		0. 29106		_	73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800 MHP PEDI ATRI CS		1. 22150	07	0	88. 00
88. 01	08801 MHP OBGYN		1. 33571	16 0	0	88. 01
88. 02	08802 MHP FIM		1. 45138	32 0	0	88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	89. 00
	09000 CLI NI C		1. 19070		0	90.00
91.00	09100 EMERGENCY		0. 12898		30, 448	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 49112		0	92.00
92. 01	O9201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0. 52903	30 43, 622	23, 077	92. 01

0.000000

1, 652, 118

1, 652, 118

95. 00 0 97. 00

201. 00 202. 00

393, 133 200. 00

OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

200.00

201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98)

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

Health Financial Systems	MAJOR HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0097	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/23/2019 3:17 pm

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments DRG Amounts Other than outlier payments for discharges occurring prior to October 1 (see 6, 258, 317 1.01 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 1, 982, 030 1.02 Instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 1, 982, 030 1.02 Instructions) DRG for federal specific operating payment for Model 4 BPCl for discharges occurring on or after 0 october 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCl for discharges occurring on or after 0 october 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCl for discharges occurring on or after 0 october 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCl for discharges occurring on or after 0 october 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCl for discharges occurring on or after 0 october 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCl (see instructions) DRG for federal specific operating payment for Model 4 BPCl (see instructions) DRG for federal specific operating payment for Model 4 BPCl (see instructions) DRG for federal specific operating payment for Model 4 BPCl (see instructions) DRG for federal specific operating payment for Model 4 BPCl (see instructions) DRG for federal specific operating payment for Model 4 BPCl (see instructions) DRG for federal specific operating payment for Model 4 BPCl (see instructions) DRG for federal specific operating payment for Model 4 BPCl (see instructions) DRG for federal specific discharges for Model 4 BPCl (see instructions) DRG for federal specific discharges for Model 4 BPCl (see instructions) DRG for federal specific discharges for Model 4 BPCl (see instructions) DRG for federal specific discharges for Model 4 BPCl (see instructions) DRG for federal specif				10 12/31/2010	5/23/2019 3: 1	
ART A - INPATIENT HOSPITAL SERVICES WIGHEN IPPS	-		Title XVIII	Hospi tal		
ART A - INPATIENT HOSPITAL SERVICES WIGHEN IPPS						
1.00 BR6 Amounts Other than Outlier Payments 0 1.00 1.01 BR6 Amounts other than outlier payments for discharges occurring prior to October 1 (see 4.288, 31) 1.01 1.01 BR6 Amounts other than outlier payments for discharges occurring on or after October 1 (see 1.992,030 1.02 1.02 1.03 1.03 1.04 1.05 1.03 1.04 1.05 1.03 1.04 1.05 1.03 1.04 1.05 1.0					1. 00	
DRS amounts other than outlier payments for discharges occurring prior to October 1 (see 0.288, 377 1.01 Instructions) 1.02 DRS amounts other than outlier payments for discharges occurring on or after October 1 (see 1.982,030 1.02 1.03 1.03 DRS amounts other than outlier payments for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 1.03 DRS for Forderal spacific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04 0.00 0.0						
Instructions 1.02 DRR commonts other than outflier payments for discharges occurring on or after October 1 (see 1,982,030 1.02 Instructions 1.03 DRR for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 0 1.03 DRR for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04 October 1 (see instructions) 118,586 2.00 Outflier payments for discharges. (see Instructions) 0 2.01 Outflier payments for discharges for Model 4 BPCI (see instructions) 0 2.01 Outflier payment for discharges for Model 4 BPCI (see instructions) 0 2.01 Outflier payment for discharges for Model 4 BPCI (see instructions) 0 2.01 Outflier payment for discharges for Model 4 BPCI (see instructions) 0 2.01 Outflier payment for discharges for Model 4 BPCI (see instructions) 0 2.01 Outflier payment for discharges for Model 4 BPCI (see instructions) 0 2.01 Outflier payment for discharges for Model 4 BPCI (see instructions) 0 2.01 Outflier payment for discharges for Model 4 BPCI (see instructions) 0 2.01 Outflier payment for discharges for Model 4 BPCI (see instructions) 0 2.01 Outflier payment for discharges for Model 4 BPCI (see instructions) 0 2.00 Outflier payment for discharges for Model 4 BPCI (see instructions) 0 0 0 0 0 0 0 0 0	1.00	DRG Amounts Other than Outlier Payments			0	1.00
DRS amounts other than outlier payments for discharges occurring on or after October 1 (see 1,982,030 1.02 Instructions) DRS for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1,082,030 1.02	1.01	DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 (see	6, 258, 317	1. 01
Instructions 1.03 Ref For Federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 0 1.03		instructions)				
1.03 1.03	1.02	DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	1, 982, 030	1.02
1 (see instructions) 1.00 Rofer Tederal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04		instructions)	-			
DRC for Federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04	1.03	DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	prior to October	0	1.03
October 1 (see Instructions) 118,586 2.00 2.01 2.00 2		1 (see instructions)				
2.00 Outlier payments for discharges. (see instructions)	1.04	DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	on or after	0	1.04
2.01 Outlier reconcilitation amount 0 2.01		October 1 (see instructions)			 -	
2.02 Outlier payment for discharges for Model 4 BPCI (see instructions) 0 2.02 4.00 Managed Care Simulated Payments 4.52 4.52 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 4.52 5.00 FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending or or before 12/31/1996, (see instructions) 0 5.00 6.00 FIE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for now programs in a cordance with 42 CFR 437.79(e) 0.00 0.00 7.00 7.01 CAS \$502 reduction.common to IME (ap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddle sully 1, 2011 then see instructions. 0.00 7.01 8.00 Adjustment (increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 2540 May 12. 0.00 8.00 1.00 The amount of increase in decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 2540 May 12. 0.00 0.00 8.00 1.00 The amount of increase in fee hospital was awarded FTE cap slots under \$5503 of the ACA. If the cost report straddles July 1, 2011, see instructi	2.00	Outlier payments for discharges. (see instructions)			118, 586	2.00
Managed Car's Simulated Payments	2. 01	Outlier reconciliation amount			0	2. 01
Bed days available divided by number of days in the cost reporting period (see instructions) 44.52 4.05 https://en.com/instructions/files/and/subsent/files/and/subsen	2.02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2. 02
Indirect Medical Education Adjustment	3.00	Managed Care Simulated Payments			0	3.00
FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending of or before 12/31/19/96, (see instructions) FIE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 431.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(v)(B)(2) If the 0.00 7.01 ACA 5 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(v)(B)(2) If the 0.00 7.01 ACA 5 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(v)(B)(2) If the 0.00 7.01 ACM distinct (increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(v), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA If the cost report stradide July 1, 2011, see instructions. 8.02 Index § 5500 of ACA. (see instructions) 8.03 Index § 5500 of ACA. (see instructions) 8.04 Instructions) 9.05 Index § 5500 of ACA. (see instructions) 9.06 FTE count for residents in dental and podiatric programs. 9.07 Index § 5500 of ACA. (see instructions) 9.08 Index § 5500 of ACA. (see instructions) 9.09 Instructions) 9.00 FTE count for residents in in initial years of the program of the current year from your records 9.00 Index § 5500 of ACA (see instructions) 9.00 Index § 5500 of	4.00	Bed days available divided by number of days in the cost repo	rting period (see instru	ıcti ons)	44. 52	4.00
or before 12/31/1996, (see instructions) 6. 00 FTC count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7. 00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 8. 00 Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under \$5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$5506 of ACA. (see instructions) 9. 02 Sun of lines \$ plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 9.00 instructions) 10. 06 FTE count for residents in dental and pod atric programs. 10. 07 FTE count for residents in dental and pod atric programs. 10. 08 FTE count for residents in dental and pod atric programs. 10. 09 Total allowable FTE count for the penult mate year if that year ended on or after September 30, 1997, concern year allowable FTE count for the penult mate year if that year ended on or after September 30, 1997, concern year allowable FTE count for the penult mate year if that year ended on or after September 30, 1997, concern year sidents in itial years of the program of the year of year year year year year year year year		Indirect Medical Education Adjustment	-			
FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413, 79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412, 105(f)(1)(iv)(B)(2) If the cost report straddies July 1, 2011 then see instructions. 7.00 7	5.00	FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending or	0.00	5.00
new programs in accordance with 42 CFR 413.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 8.00 Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26440 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.10 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.20 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 9.00 Sun of lines \$ plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see		or before 12/31/1996. (see instructions)				
7.00 IMMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 0.00 7.00 8.00 All yathemet (increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50099 (August 1, 2002). 0.00 8.00 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5500 of the ACA. (see instructions). 0.00 8.01 8.02 The amount of increase if the hospital was awarded FTE cap slots under § 5506 of ACA. (see instructions). 0.00 8.02 9.00 Sum of Lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see instructions). 0.00 1.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 1.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 1.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 1.00 10.00 FTE count for the prior year. 0.00 1.00 10.00 FTE count for the prior year. 0.00	6.00	FTE count for allopathic and osteopathic programs that meet t	he criteria for an add-d	on to the cap for	0.00	6.00
ACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the cost report straddles July 1, 2011 then see instructions.		new programs in accordance with 42 CFR 413.79(e)		·		
cost report straddles July 1, 2011 then see instructions. 8. 00 Al quisment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under § 5500 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) 9. 00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see instruction) 10. 00 FTE count for all opathic and osteopathic programs in the current year from your records 10. 00 Trecount for residents in dental and podiatric programs. 10. 00 Current year allowable FTE (see instructions) 10. 01 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997. 10. 01 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997. 10. 02 Sum of lines 12 through 14 divided by 3. 10. 03 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997. 10. 03 Just ment for residents in initial years of the program 10. 04 Adjustment for residents in initial years of the program 10. 05 Just year resident to bed ratio (line 18 divided by line 4). 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10.	7.00	MMA Section 422 reduction amount to the IME cap as specified	under 42 CFR §412.105(f)	(1) (i v) (B) (1)	0. 00	7.00
Adjustment (Increase or decrease) to the FTE count for all lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b). 413.79(c)(2)(iv). 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	7. 01	ACA § 5503 reduction amount to the IME cap as specified under	42 CFR §412. 105(f)(1)(i	v)(B)(2) If the	0.00	7. 01
Adjustment (Increase or decrease) to the FTE count for all lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b). 413.79(c)(2)(iv). 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		cost report straddles July 1, 2011 then see instructions.	. , , , ,	, , , , ,		
1998), and 67 FR 5006 (August 1, 2002).	8.00	Adjustment (increase or decrease) to the FTE count for allopa	thic and osteopathic pro	grams for	0. 00	8.00
8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradiles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see Instructions) 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see Instructions) 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 10.00 FTE count for residents in dental and podiatric programs. 10.00 Current year allowable FTE (see instructions) 10.00 Current year allowable FTE count for the proll timate year if that year ended on or after September 30, 1997, otherwise enter zero. 10.00 Adjustment for residents in initial years of the program or hospital closure 10.00 Adjustment for residents in initial years of the program or hospital closure 10.00 Adjustment for residents displaced by program or hospital closure 10.00 Adjustment for residents in initial years of the program or hospital closure 10.00 Adjustment for residents in initial years of the program or hospital closure 10.00 Adjustment for residents in initial years of the program or hospital closure 10.00 Adjustment for resident to bed ratio (line 18 divided by line 4). 10.00 One Prior year resident to bed ratio (see instructions) 10.00 Prior year resident to bed ratio (see instructions) 10.00 One Prior year resident alloyablic interestications or program or hospital closure 10.00 Prior year resident obed ratio (see instructions) 10.00 One Prior year resident obed ratio (see instructions) 10.00 One Prior year resident obed ratio (see instructions) 10.00 One Prior year resident obed ratio (see instructions) 10.00 One Prior year resident obed ratio (see instructions) 10.00 One Prior year resident obed ratio (see instructions) 10.00 One Prior year resident obed ratio (see instructions) 10.00 One Prior year seed that the year in the Add-on for § 422 of the MMA 10.00 On		affiliated programs in accordance with 42 CFR 413.75(b), 413.	79(c)(2)(iv), 64 FR 2634	lÕ (May 12,		
report straddles July 1, 2011, see instructions.		1998), and 67 FR 50069 (August 1, 2002).		. •		
B. 02	8. 01	The amount of increase if the hospital was awarded FTE cap sl	ots under § 5503 of the	ACA. If the cost	0. 00	8. 01
under \$ 5506 of ACA. (see instructions)		report straddles July 1, 2011, see instructions.				
Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 FTE count for residents in dental and podiatric programs. 0.00 12.00 13.00 Total allowable FTE count for the prior year. 0.00 12.00 14.00 10.01 10.01 10.01 10.00 10.00 12.00 14.00 10.00 10.00 14.00 10.00 10.00 14.00 10.00 10.00 14.00 10.00 10.00 14.00 10.00 10.00 14.00 10.00 10.00 14.00 10.0	8.02	The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teachi	ng hospi tal	0. 00	8. 02
instructions) 1.0. 00 FTE count for allopathic and osteopathic programs in the current year from your records 1.0. 00 FTE count for residents in dental and podiatric programs. 1.0. 00 Current year allowable FTE (see instructions) 1.0. 00 Total allowable FTE count for the prior year. 1.0. 01 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, 0. 00 13.00 1.0. 00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, 0. 00 14.00 1.0. 00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, 0. 00 14.00 1.0. 00 Adj ustment for residents in initial years of the program 1.0. 00 Adj ustment for residents displaced by program or hospital closure 1.0. 00 Adj ustment for residents displaced by program or hospital closure 1.0. 00 Adj usted rolling average FTE count 1.0. 00 Adj usted rolling average FTE count 1.0. 00 Prior year resident to bed ratio (line 18 divided by line 4). 1.0. 00 Prior year resident to bed ratio (see instructions) 1.0. 00 Prior year resident to bed ratio (see instructions) 1.0. 00 Prior year resident to managed Care (see instructions) 1.0 00 IME payment adjustment (see instructions) 1.0 00 IME payment adjustment - Managed Care (see instructions) 1.0 00 IME FTE Resident Count Over Cap (see instructions) 1.0 00 IME FTE Resident Count Over Cap (see instructions) 1.0 00 IME FTE Resident Count over Cap (see instructions) 1.0 00 IME FTE Resident Count over Cap (see instructions) 1.0 00 IME add-on adjustment amount (see instructions) 1.0 0 Procentage of SSI recipient patient days (see instructions) 1.0 0 Procentage of Medicaid patient days (see instructions) 2.0 0 Total IME payment . Managed Care (see instructions)		under § 5506 of ACA. (see instructions)				
Instructions	9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lir	es (8, 8,01 and 8,02)	see	0.00	9.00
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 11.00 12.00 12.00 12.00 13.00 10.01 12.00 13.00 10.01 12.00 13.00 10.01 12.00 13.00 10.01 10.00 1		instructions)				
12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00	10.00	FTE count for allopathic and osteopathic programs in the curr	ent year from your recor	ds ds	0. 00	10.00
13.00 Total allowable FTE count for the prior year' 0.00 13.00 14.00 15.00 15.00 16.00	11.00	FTE count for residents in dental and podiatric programs.			0. 00	11.00
14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 18.00 19.00 1	12.00	Current year allowable FTE (see instructions)			0.00	12.00
14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 18.00 19.00 1	13.00	Total allowable FTE count for the prior year.			0.00	13.00
Otherwise enter zero. Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 18.00 Adjusted rolling average FTE count 0.00 18.00 19.00		·	ar ended on or after Sep	tember 30, 1997,	0.00	14.00
16.00			·			
16.00	15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
17.00					0.00	16.00
18.00		, ,	sure			
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00						
20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 0.000000 22.00 IME payment adjustment (see instructions) 0 22.01 IME payment adjustment - Managed Care (see instructions) 0 22.01 IME payment adjustment - Managed Care (see instructions) 0 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA).			
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0 22.00 1ME payment adjustment - Managed Care (see instructions) 0 22.01 1 Imidirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(C). 0.00 1 Imidirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.000 24.00 1 Imidirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.000 25.00 1 Imidirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.000 26.00 1 Imidirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.000 25.00 1 Imidirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.000 26.00 1 Imidirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.000 0.000 26.00 1 Imidirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.000 0.0		i i	, ,			
22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see		, , , , , , , , , , , , , , , , , , ,				
22. 01 IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f) (1) (iv) (C). 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 21. 01 SIL 03. 00 31. 00 Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions) 9. 89 33. 00						•
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 25.00 instructions) 28.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.28.00 IME add-on adjustment amount (see instructions) 0.28.00 IME add-on adjustment amount - Managed Care (see instructions) 0.28.00 IME add-on adjustment amount - Managed Care (see instructions) 0.28.00 INTO INTO INTO INTO INTO INTO INTO INTO		, , ,				
Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 1 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 IME payments adjustment factor. (see instructions) 1 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 1 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 20.00 Sum of lines 30 and 31 21.00 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 9.89 33.00	22.01		2 of the MMA		Ü	22.01
(f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 9.89 33.00	23 00			FR 412 105	0.00	23 00
24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 9. 89 33. 00	25.00		ient cap stots under 42 (71 K 412. 105	0.00	25.00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Sum of lines 30 and 31 25.06 32.00 33.00 Allowable disproportionate share percentage (see instructions) 9.89 33.00	24 00				0.00	24 00
instructions		. ,	Lower of line 22 or line	24 (600		
26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 00 29. 01 Disproportionate Share Adjustment 0 29. 01 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.05 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 21. 01 31. 00 32. 00 Sum of lines 30 and 31 25. 06 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 9. 89 33. 00	25.00		Tower of Title 23 of Title	: 24 (366	0.00	25.00
27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 9.89 33.00	26 00				0.000000	26 00
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 9.89 33.00		, , , , , , , , , , , , , , , , , , , ,				•
28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 9. 89 33. 00		, , , , , , , , , , , , , , , , , , , ,				
29.00 Total IME payment (sum of lines 22 and 28) 0 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.05 31.00 Percentage of Medicaid patient days (see instructions) 21.01 31.00 32.00 Sum of lines 30 and 31 25.06 32.00 33.00 Allowable disproportionate share percentage (see instructions) 9.89 33.00			1			•
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 30. 01 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 4. 05 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 4. 05 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 4. 05 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 4. 05 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 5. 06 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 6. 07 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01 and 28.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01) 9. 08 Operation in the payment - Managed Care (sum of lines 22.01) 9. 08 Operat)		_	
Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 9.89 33.00			11)		_	
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.05 30.00 31.00 Percentage of Medicaid patient days (see instructions) 21.01 31.00 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 9.89 33.00	29. UT		'1)		0	29.01
31.00 Percentage of Medicaid patient days (see instructions) 21.01 31.00 32.00 Sum of lines 30 and 31 25.06 32.00 33.00 Allowable disproportionate share percentage (see instructions) 9.89 33.00	20.00			+!>		20.25
32.00 Sum of lines 30 and 31 25.06 32.00 Allowable disproportionate share percentage (see instructions) 9.89 33.00			eatient days (see instruc	ctions)		
33.00 Allowable disproportionate share percentage (see instructions) 9.89 33.00						
34.00 Disproportionate share adjustment (see instructions) 203,743 34.00			5)			
	34. 00	וטן sproportionate share adjustment (see instructions)		ļ	203, 743	34.00

ALCUI	Financial Systems MAJOR HOSPI ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0097	Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/23/2019 3:1	pared
		Title XVIII	Hospital	PPS On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)			8, 272, 872, 447	
5. 01 5. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter	or zoro on this line) (se	0. 000092412 ee 625, 325		35. C
3. 02	instructions)	er zero on this inne) (se	025, 325	1, 100, 021	35.0
5. 03		ount (see instructions)	467, 709	298, 943	35.0
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0		766, 652		36. C
0. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges on Worksheet S-3, Part I excluding		igh 46) 0		 40. c
0. 00	652, 682, 683, 684 and 685 (see instructions)	di schai ges Toi MS-Ditos	0		40.0
1. 00		683, 684 an 685. (see	0		41.0
4 04	instructions)	DD0 /50 /00 /00 /0			
1. 01	Total ESRD Medicare covered and paid discharges excluding MS- lan 685. (see instructions)	-DRGS 652, 682, 683, 684	0		41.0
2. 00	Divide line 41 by line 40 (if less than 10%, you do not quali	ify for adjustment)	0. 00		42.0
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68		0		43. (
4 00	instructions)	h., line 44 divided by 7	0.000000		
4. 00	Ratio of average length of stay to one week (line 43 divided days)	by Tine 41 divided by 7	0. 000000		44.0
5. 00	Average weekly cost for dialysis treatments (see instructions	s)	0.00		45. (
6. 00	Total additional payment (line 45 times line 44 times line 41	1. 01)	0		46.
7.00	Subtotal (see instructions)		9, 329, 328		47.
8. 00	Hospital specific payments (to be completed by SCH and MDH, sonly. (see instructions)	small rural hospitals	0		48.
	only. (See That detrois)			Amount	
				1. 00	
9.00	Total payment for inpatient operating costs (see instructions			9, 329, 328	•
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar Exception payment for inpatient program capital (Wkst. L, Pt.			671, 847 0	50. 51.
2. 00	Direct graduate medical education payment (from Wkst. E-4, li			0	52.
3. 00	Nursing and Allied Health Managed Care payment	,		0	53.
4. 00	Special add-on payments for new technologies			0	54.
4. 01	Islet isolation add-on payment	(0)		0	54.
5. 00 6. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line & Cost of physicians' services in a teaching hospital (see intr	•		0	55. 56.
7. 00	Routine service other pass through costs (from Wkst. D, Pt. I		through 35).	Ö	57.
8. 00	Ancillary service other pass through costs from Wkst. D, Pt.		3 ,	0	58.
9. 00	Total (sum of amounts on lines 49 through 58)			10, 001, 175	•
0.00	Primary payer payments	- 1: (0)		14, 030	
1.00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	s rine 60)		9, 987, 145 1, 094, 444	•
3. 00	1			13, 400	
	Allowable bad debts (see instructions)			102, 434	
5. 00	, , , , , , , , , , , , , , , , , , , ,			66, 582	
6.00	,	tructions)		12, 036	
7. 00 8. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	annlicable to MS_DPGs (s	eaa instructions)	8, 945, 883 0	67. 68.
5. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	69.
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	•	,	0	70.
9. 00 0. 00	Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see	instructions)	0	70.
0. 00 0. 50				0	70.
0. 00 0. 50 0. 87	Demonstration payment adjustment amount before sequestration			0	70.
0. 00 0. 50 0. 87 0. 88	SCH or MDH volume decrease adjustment (contractor use only)	tructions)			
0. 00 0. 50 0. 87 0. 88 0. 89	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	tructions)		O	
0. 00 0. 50 0. 87 0. 88	SCH or MDH volume decrease adjustment (contractor use only)	tructions)		0	70.
0. 00 0. 50 0. 87 0. 88 0. 89 0. 90	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	tructions)			70. 70. 70. 70.
0. 00 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)	tructions)		0	70. 70. 70. 70.

Health Financial Systems	MAJOR HOSPITAL		In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CCN: 15-0097	Peri od: From 01/01/2018 To 12/31/2018		epared: 7 pm
	Ti tl e	e XVIII	Hospi tal	PPS	
·	· ·	FF'	Y (yyyy)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year the corresponding federal year for the period	od prior to 10/1)		2018	38, 841	70. 96
70.97 Low volume adjustment for federal fiscal year the corresponding federal year for the period			2019	161, 651	70. 97
70.98 Low Volume Payment-3	-			0	70. 98
70.99 HAC adjustment amount (see instructions)				0	70. 99
71.00 Amount due provider (line 67 minus lines 68	plus/minus lines 69 & 70)			9, 201, 086	71.00
71.01 Sequestration adjustment (see instructions)				184, 022	71. 01
71.02 Demonstration payment adjustment amount afto	er sequestration			0	
72.00 Interim payments				9, 066, 352	
73.00 Tentative settlement (for contractor use onl 74.00 Balance due provider/program (line 71 minus	3,			0 -49, 288	70.00
73) 75.00 Protested amounts (nonallowable cost report CMS Pub. 15-2, chapter 1, §115.2	items) in accordance with			154, 845	75. 00
TO BE COMPLETED BY CONTRACTOR (lines 90 thro	ough 04)				
90.00 Operating outlier amount from Wkst. E, Pt. / plus 2.04 (see instructions)				0	90.00
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00 Operating outlier reconciliation adjustment	amount (see instructions)			0	
93.00 Capital outlier reconciliation adjustment and				o o	
94.00 The rate used to calculate the time value of				0.00	94.00
95.00 Time value of money for operating expenses				0	95.00
96.00 Time value of money for capital related expe	enses (see instructions)			0	96.00
			Prior to 10/1 1.00	0n/After 10/1 2.00	
HSP Bonus Payment Amount					
100.00 HSP bonus amount (see instructions)			0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101.00
102.00 HVBP adjustment amount for HSP bonus paymen	t (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00 HRR adjustment factor (see instructions)			0. 0000		103.00
104.00 HRR adjustment amount for HSP bonus payment			0	0	104.00
Rural Community Hospital Demonstration Proje					
200.00 Is this the first year of the current 5-year		the 21st			200.00
Century Cures Act? Enter "Y" for yes or "N" Cost Reimbursement	TOT NO.				
201.00 Medicare inpatient service costs (from Wkst.	D 1 D+ II line (0)				201.00
202.00 Medicare discharges (see instructions)	D-1, Ft. II, IIIIe 49)				202.00
203.00 Case-mix adjustment factor (see instructions)	=)				203.00
Computation of Demonstration Target Amount I period)		of the curr	ent 5-year demons	stration	1203.00
204. 00 Medi care target amount					204.00
205.00 Case-mix adjusted target amount (line 203 ti	mes line 204)				205.00
206.00 Medicare inpatient routine cost cap (line 20					206.00
A l'andre de la Maria de Brata A de la Companya de					1

207.00

208.00

209.00 210. 00 211. 00

212. 00 213. 00

218. 00

211.00 Total adjustment to Medicare IPPS payments (see instructions)

212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

209.00 Adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

(line 212 minus line 213) (see instructions)

213.00 Low-volume adjustment (see instructions)

210.00 Reserved for future use

Adjustment to Medicare Part A Inpatient Reimbursement

207.00 Program reimbursement under the §410A Demonstration (see instructions)

208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)

218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2018 Part A Exhi bi t 4 To 12/31/2018 Date/Ti me Prepared: 5/23/2019 3: 17 nm Provider CCN: 15-0097

					10		5/23/2019 3:1	
		W (0 E D) A			XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
1.00	Inno.	0	1. 00	2. 00	3. 00	4. 00	5. 00	1.00
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	0	0	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	6, 258, 317	0	6, 258, 317		6, 258, 317	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 982, 030	0		1, 982, 030	1, 982, 030	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1.03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		O	0	1. 04
2. 00	October 1 Outlier payments for discharges (see instructions)	2. 00	118, 586	0	108, 553	10, 033	118, 586	2.00
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
3. 00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0	0	0	0	3.00
	reconciliation			0			0	4.00
4. 00	Managed care simulated payments	3. 00	0	0	0	U	0	4.00
	Indirect Medical Education Adj							
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
	instructions) Indirect Medical Education Adj	uctmont for the	a Add on for Sa	action 122 of	the MMA			-
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000		0. 000000		7.00
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8. 01
9. 00	instructions) Total IME payment (sum of	29. 00	О	0	О	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed	29. 01	0	0	0	0	0	9. 01
9. 01	care (sum of lines 6.01 and 8.01)		O	0	U	J	0	9.01
10.00	Disproportionate Share Adjustm		0.0000	0.0000	0.0000	0.0000		10.00
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0989	0. 0989	0. 0989	0. 0989		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	203, 743	0	154, 737	49, 006	203, 743	11.00
11. 01	Uncompensated care payments	36. 00	766, 652	0	467, 709	298, 943	766, 652	11. 01
12. 00	Additional payment for high pe Total ESRD additional payment (see instructions)	rcentage of ESI 46.00	RD beneficiary 0	di scharges 0	0	0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	9, 329, 328	0	6, 989, 316	2, 340, 012	9, 329, 328	
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)		0	0	0	0	0	14.00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	9, 329, 328	0	6, 989, 316	2, 340, 012	9, 329, 328	15.00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	671, 847	0	510, 329	161, 518	671, 847	16. 00
17. 00	Special add-on payments for	54. 00	0	0	0	0	0	17. 00
17. 01	new technologies Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	0	17. 02

Heal th	Financial Systems		MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider CO		Period: From 01/01/2018 To 12/31/2018		pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		l i ne	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1. 00	2. 00	3.00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0 0	0	18.00
19. 00	SUBTOTAL			0	7, 499, 64	2, 501, 530	10, 001, 175	19 00
17.00	SOBTOTINE	W/S L, line	(Amounts from L)	0	7, 477, 04	2, 301, 330	10, 001, 173	17.00
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	671, 066	0	509, 80	161, 264	671, 066	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0	0	20. 01
	Capital DRG outlier payments	2. 00	781	0	52	254	781	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21.01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0.0000		22.00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23.00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0.0000	0. 0000	0. 000	0. 0000		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	671, 847	0	510, 32	9 161, 518	671, 847	26. 00
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
		0	1. 00	2. 00	3.00	4. 00	5. 00	
	(transfer amount to Wkst. E,	70. 96			0. 00517 38, 84		38, 841	27. 00 28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				161, 651	161, 651	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Health Financial SystemsMAJOR HOSEHOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0097 Peri od: Worksheet E From 01/01/2018 Part A Exhi bit 5 To 12/31/2018 Date/Time Prepared:

				11	0 12/31/2018	5/23/2019 3:1	
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt.	Amt. from	Period to	Period on	Total (cols.	
		A, line	Wkst. E, Pt.	10/01	after 10/01	2 and 3)	
			A)				
		0	1. 00	2. 00	3. 00	4. 00	
1. 00	DRG amounts other than outlier payments	1. 00					1.00
1. 01	DRG amounts other than outlier payments for	1. 01	6, 258, 317	6, 258, 317		6, 258, 317	1. 01
4 00	discharges occurring prior to October 1	4 00	4 000 000		4 000 000	4 000 000	4 00
1. 02	DRG amounts other than outlier payments for	1. 02	1, 982, 030		1, 982, 030	1, 982, 030	1. 02
1. 03	discharges occurring on or after October 1 DRG for Federal specific operating payment	1. 03	_	0		0	1. 03
1.03	for Model 4 BPCI occurring prior to October	1. 03	0	U		U	1.03
	1						
1. 04	DRG for Federal specific operating payment	1. 04	0		o	0	1.04
	for Model 4 BPCI occurring on or after						
	October 1						
2.00	Outlier payments for discharges (see	2. 00	118, 586	108, 553	10, 033	118, 586	2.00
	instructions)						
2. 01	Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
	BPCI	0.04					
3.00	Operating outlier reconciliation	2. 01	0	0	0	0	3.00
4. 00	Managed care simulated payments Indirect Medical Education Adjustment	3. 00	0	0	0	0	4. 00
5. 00	Amount from Worksheet E, Part A, Line 21	21. 00	0. 000000	0. 000000	0. 000000		5. 00
5.00	(see instructions)	21.00	0.00000	0.000000	0.000000		5.00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see		Ö	0	o	0	6. 01
	instructions)						
	Indirect Medical Education Adjustment for the	e Add-on for Se	ection 422 of	the MMA			
7.00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7.00
	instructions)						
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	8.00
8. 01	IME payment adjustment add on for managed	28. 01	0	0	0	0	8. 01
0 00	care (see instructions)	20.00	_	0	0	0	9. 00
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0	0	0	0	9.00
7. 01	lines 6.01 and 8.01)	27.01	0	U	ď	U	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33. 00	0. 0989	0. 0989	0. 0989		10.00
	(see instructions)						
11. 00	Disproportionate share adjustment (see	34. 00	203, 743	154, 737	49, 006	203, 743	11.00
	instructions)						
11. 01	Uncompensated care payments	36. 00	766, 652	467, 709	298, 943	766, 652	11. 01
10.00	Additional payment for high percentage of ESI			0	٥	0	10.00
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	9, 329, 328	6, 989, 316	2, 340, 012	9, 329, 328	13. 00
14. 00	Hospital specific payments (completed by SCH		7, 327, 320	0, 707, 310	2, 340, 012	0	14.00
00	and MDH, small rural hospitals only.) (see	10.00		ŭ	Ĭ	ŭ	
	instructions)						
15.00	Total payment for inpatient operating costs	49. 00	9, 329, 328	6, 989, 316	2, 340, 012	9, 329, 328	15.00
	(see instructions)						
16.00	Payment for inpatient program capital (from	50. 00	671, 847	510, 329	161, 518	671, 847	16.00
4	Wkst. L, Pt. I, if applicable)		_				
17.00	Special add-on payments for new technologies	54. 00	0	0	0	0	
17. 01	Net organ acquisition cost	40.00	_	_			17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00		Ü	O	0	17. 02
18. 00	Capital outlier reconciliation adjustment	93. 00	_	0	0	0	18. 00
10.00	amount (see instructions)	73.00		U	١	ا	10.00
19. 00	SUBTOTAL			7, 499, 645	2, 501, 530	10, 001, 175	19, 00
	1 · · · · · · · · · · · · · · · · · · ·		1	., .,,,,,,,,	_, 55., 560	. 2, 30 ., . 70	

1.00

Ν

0

70. 99

2.00

3.00

(Amt. to Wkst. E, Pt.

4. 00

0 32.00

100.00

instructions)

instructions)

Wkst. E, Pt. A.

32.00 HAC Reduction Program adjustment (see

100.00 Transfer HAC Reduction Program adjustment to

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SET	TLEMENT Provi der CCN: 15-0	097

			12/01/2010	5/23/2019 3:1	7 pm
		Title XVIII	Hospi tal	PPS	
	DADT D. MEDICAL AND OTHER HEALTH CERVILORS			1. 00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			5, 651	1.00
1. 00 2. 00	Medical and other services reimbursed under OPPS (see instruc	etions)		17, 504, 414	2.00
3. 00	OPPS payments			12, 071, 809	
4. 00	Outlier payment (see instructions)			55, 270	
4. 01	Outlier reconciliation amount (see instructions)			0	1
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	5.00
6.00	Line 2 times line 5			0	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8. 00	Transitional corridor payment (see instructions)			0	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			5, 651	11.00
	Reasonable charges				1
12. 00	Ancillary service charges			19, 680	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)	,		19, 680	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for			0	
16. 00	Amounts that would have been realized from patients liable fo		n a chargebasis	0	16.00
47.00	had such payment been made in accordance with 42 CFR §413.13(e)		0.00000	47.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000 19, 680	1
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	lv if line 18 evceeds li	no 11) (soo	14, 029	1
17.00	instructions)	if y 11 Title 10 exceeds 11	116 11) (366	14, 027	19.00
20. 00	Excess of reasonable cost over customary charges (complete on	lvifline 11 exceeds li	ne 18) (see	0	20.00
	instructions)	,	, (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	
21.00	Lesser of cost or charges (see instructions)			5, 651	21.00
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			12, 127, 079	24.00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			222	25.00
26. 00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin	•	uctions)	333 2, 337, 950	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			9, 794, 447	1
27.00	instructions)	p. 46 1.16 54 51 11.1165 22	ana 20] (000	.,,,,,,,,	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
	Subtotal (sum of lines 27 through 29)			9, 794, 447	
	Primary payer payments			2, 646	
32.00	Subtotal (line 30 minus line 31)	CEC)		9, 791, 801	32.00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. I-5, line 11)	CES)		0	33.00
	Allowable bad debts (see instructions)			514, 768	
	Adjusted reimbursable bad debts (see instructions)			334, 599	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		361, 813	
	Subtotal (see instructions)			10, 126, 400	37.00
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39.50
	Demonstration payment adjustment amount before sequestration		4:>	0	
39. 98 39. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	icea devices (see instruc	trons)	0	
	Subtotal (see instructions)			10, 126, 400	1
40. 01	Sequestration adjustment (see instructions)			202, 528	
	Demonstration payment adjustment amount after sequestration			0	
	Interim payments			9, 900, 798	41.00
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			23, 074	43.00
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR				00.00
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	1
	Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)			_	94.00
					-

Peri od: Worksheet E-1 From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared: 5/23/2019 3:17 pm Provider CCN: 15-0097

					5/23/2019 3:1	7 pm
		Title	XVIII	Hospi tal	PPS	
		I npati en	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		8, 879, 898		9, 596, 272	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER	07/16/2018	98, 100	07/16/2018	47, 600	3. 01
3. 02	ADDUST MENTO TO TROVIDER	12/31/2018	88, 354		256, 926	3. 02
3. 03		127 017 2010	00,001	127 017 2010	0	3. 03
3. 04			0			3. 04
3. 05			0		0	3.05
3. 03	Provider to Program		0		0	3.03
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	TABOUT MIENTO TO TROURAM		0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		186, 454		304, 526	3. 99
	3. 50-3. 98)		·			
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		9, 066, 352		9, 900, 798	4. 00
	appropriate) TO BE COMPLETED BY CONTRACTOR					
F 00			T			E 00
5. 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. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		n		23, 074	6. 01
6. 02	SETTLEMENT TO PROGRAM		49, 288		23,074	6. 02
7. 00	Total Medicare program liability (see instructions)		9, 017, 064		9, 923, 872	7. 00
7.00	Trotal modification program frability (See Tristidet10113)		7, 017, 004	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
			 O	1. 00	2.00	
8. 00	Name of Contractor				2.00	8. 00
5. 50		!		ļ	1 1	3.30

Heal th	Financial Systems MAJOR HOSE	PI TAL	In Lie	u of Form CMS	-2552-10
CALCUL					1 epared: 17 pm
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	t. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32.00
		, ,			'

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: Worksheet E-3 From 01/01/2018 Part VII To 12/31/2018 Date/Time Prepared:

DART VII - CALCULATION OF RETINDIPSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				Γο 12/31/2018	Date/Time Pre 5/23/2019 3:1	
PART VII - CALCILIATION OF RELIABURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			Title XIX			
PART VI - CALCULATION OF REIMBURSCHAIT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 1.0					2. 00	
Inpati ent hospital /SIF/AN services			S FOR TITLES V OR XI	X SERVICES		
Medical and other services						
3.00 Organ acquisition (certified transplant centers only)		' '		757, 899	_	
Subtotal (sum of lines 1, 2 and 3) 757,899 0 4.00					0	
1,000		1 9 1		757 000		
0.00		1		757, 899	U	
Subtotal (Line 4 Less sum of lines 5 and 6)				٧	0	
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges (sum of lines 8 through 11) Reasonable Charges (sum of lines 11) Reasonable Charges (sum of lines 11) Reasonable Charges (sum of lines 12) Reasonable C		1		757 899	-	
Reasonable Charges 8.00 8.00 Ancillary service charges 6.77, 950 8.00 9.00 Ancillary service charges 1,652,118 0 9.00 10.00 Incentive from target amount computation 0 11.00 11.00 Incentive from target amount computation 0 11.00 11.00 Incentive from target amount computation 2,330,068 0.12.00 Incentive from target amount computation 12.00 Incentive from target amount computation 0 11.00 Incentive from target amount computation 12.00 Incentive from target amount computation 12.00 Incentive from target amount computation 12.00 Incentive from target amount computation 13.00 Incentive from target amount computation Incent	7.00			131,077	J	7.00
Routine service charges						
9.00 Ancillary service charges 1,652,118 0 9.00	8. 00	9		677, 950		8. 00
11.00 Incentive from target amount computation 2,330,068 0 11.00 12.00 1	9.00	1			0	9. 00
12.00 Total reasonable charges (sum of lines 8 through 11) 2, 330, 068 0 12.00	10.00	Organ acquisition charges, net of revenue		O		10.00
CUSTOMARY CHARGES 0	11. 00	Incentive from target amount computation		0		11.00
13.00 Amount actually collected from patients	12.00			2, 330, 068	0	12.00
basis						
14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	13. 00		vices on a charge	0	0	13.00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16.00 Total customary charges (see instructions) 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1.572, 169 0 17.00 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 16 exceeds 11.572, 169 0 17.00 line 4) (see instructions) 19.00 Interns and Residents (see instructions) 19.00 Interns and Residents (see instructions) 19.00 Cost of physicians' services in a teaching hospital (see instructions) 10.00 Cost of physicians' services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of physicians' services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of physicians' services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 5 or line	14 00				0	14 00
15.00	14.00			il 4	U	14.00
16. 00 Total customary charges (see instructions) 2, 330, 068 0 16. 00	15 00		K 3413. 13(e)	0.000000	0 000000	15 00
17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1,572,169 0 17.00		1				
			line 16 exceeds		-	
16) (see instructions)		, ,		, , , , , ,		
19, 00 Interns and Residents (see instructions) 0 0 19, 00 20.	18.00	Excess of reasonable cost over customary charges (complete only if	line 4 exceeds line	0	0	18.00
20. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 20. 00 21. 00 21. 00 22. 00 23. 00 24. 00 25. 0		1 ' ` '				
21.00				0	-	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			ons)	757.000	-	
22.00 Other than outlier payments 0 0 22.00	21.00		Lated for DDC provis		0	21.00
23. 00	22 00		reted for PPS provid		0	22.00
24. 00 Program capital payments 0 24. 00 25. 00 Capital exception payments (see instructions) 0 25. 00 26. 00 Routine and Ancillary service other pass through costs 0 0 26. 00 27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 757, 899 0 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 0 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 757, 899 0 31. 00 32. 00 Deductible S 0 0 32. 00 33. 00 Allowable bad debts (see instructions) 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 34. 00 35. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 757, 899 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 <td></td> <td>, ,</td> <td></td> <td>-</td> <td>-</td> <td></td>		, ,		-	-	
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 30. 00 Allowable bad debts (see instructions) 31. 00 Utilization review 32. 00 Julilization review 33. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (sum of line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Hitler im payments 42. 00 Bal ance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 25. 00 26. 00 27. 00 28. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 0				0	o .	
26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31. 00 Deductibles 30. 00 Jac. 00 31. 00 32. 00 Deductibles 30. 00 Allowable bad debts (see instructions) 31. 00 Julilization review 32. 00 Julilization review 33. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 36. 00 Subtotal (line 36 ± line 37) 37. 00 Joc. 00 Jo		1 9		o		
28.00 Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 30.00 Coinsurance 31.00 Coinsurance 32.00 Juli lization review 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Hoterim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 28.00 757, 899 0 30.00 757, 899 0 40.00 43.00		1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		0	0	26.00
29.00 Titles V or XIX (sum of lines 21 and 27) 757,899 0 29.00	27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) T57, 899 O 31.00				0	0	28. 00
30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 0 0 0 32. 00 33. 00 Coi nsurance 30. 01 Illowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 30. 00 757, 899 0 0 31. 00 0 32. 00 0 0 32. 00 0 0 33. 00 0 0 34. 00 0 35. 00 0 0 35. 00 0 0 37. 00 0 43. 00	29. 00			757, 899	0	29. 00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 30.00 Coi nsurance 31.00 Allowable bad debts (see instructions) 32.00 Utilization review 33.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 34.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,				.1		
32.00 Deductibles 0 0 32.00 33.00 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 757,899 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 757,899 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 OTOTAL amount payable to the provider (sum of lines 38 and 39) 757,899 0 40.00 41.00 Interim payments 1,112,325 0 41.00 42.00 Bal ance due provider/program (line 40 minus line 41) -354,426 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				757.000	-	1
33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 757,899 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 757,899 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 757,899 0 40.00 41.00 Interim payments 1,112,325 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -354,426 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				757, 899	-	
34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 757,899 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 757,899 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 0 757,899 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 757,899 0 40.00 41.00 Interim payments 1,112,325 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -354,426 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				0	-	
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 35.00 35.00 35.00 36.00 757,899 0 36.00 757,899 0 38.00 39.00 11.11,12,325 0 41.00 42.00 43.00				0	-	
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 36.00 757,899 0 36.00 757,899 0 38.00 757,899 0 49.00 1,112,325 0 41.00 42.00 43.00					O	
37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 37.00 757, 899 0 38.00 757, 899 1, 112, 325 0 41.00 42.00 43.00				757, 899	0	
38.00 Subtotal (line 36 ± line 37) 757,899 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 757,899 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 757,899 0 40.00 41.00 Interim payments 1,112,325 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -354,426 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				0	0	
40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 40.00 41.00 41.00 42.00 43.00				757, 899	0	38. 00
41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 1, 112, 325 0 41.00 42.00 42.00 0 43.00	39.00	Direct graduate medical education payments (from Wkst. E-4)		0		
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 42.00 43.00		Total amount payable to the provider (sum of lines 38 and 39)			-	
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00					-	
		, , , , , , , , , , , , , , , , , , , ,		-354, 426	-	
cnapter i, giis.z	43. 00	1 '	rith CMS Pub 15-2,	0	0	43.00
		Chiapter 1, 3110.2		ı		I

Heal th	Financial Systems MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
	E SHEET (If you are nonproprietary and do not maintain	Provi der C	CN: 15-0097 Pe	eri od:	Worksheet G	
	ype accounting records, complete the General Fund column		F1 T0	om 01/01/2018 12/31/2018	Date/Time Pre	nared:
onl y)				12/31/2010	5/23/2019 3: 1	
		General Fund	Speci fi c	Endowment	Plant Fund	
		1 00	Purpose Fund	Fund	4.00	
	CURRENT ASSETS	1.00	2.00	3. 00	4. 00	
1. 00	Cash on hand in banks	6, 999, 408	O	0	0	1.00
2. 00	Temporary investments	0,777,100	Ö	Ö	0	
3. 00	Notes receivable	0	o	Ö	0	
4.00	Accounts recei vable	37, 649, 456	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-24, 760, 689	0	0	0	6.00
7.00	Inventory	2, 539, 827	0	0	0	
8. 00	Prepai d expenses	0	0	0	0	8. 00
9.00	Other current assets	13, 177, 128	1	0	0	
10.00	Due from other funds	0 25 405 120	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	35, 605, 130	ıj U	U	U	11.00
12. 00	Land	2, 900, 662	0	0	0	12.00
13. 00	Land improvements	11, 427, 519		0	0	13.00
14. 00	Accumul ated depreciation	-3, 445, 608	1	o	0	14.00
15.00	Bui I di ngs	117, 007, 689		0	0	15.00
16.00	Accumulated depreciation	-14, 163, 475	1	0	0	16.00
17.00	Leasehold improvements	268, 012	0	0	0	17.00
18.00	Accumulated depreciation	-240, 042	0	0	0	18.00
19.00	Fi xed equi pment	5, 678, 599	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22. 00	Accumul ated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	52, 666, 922		0	0	23. 00
24.00	Accumulated depreciation	-29, 953, 204	0	0	0	24.00
25. 00	Minor equipment depreciable	0	0	0	0	25.00
26. 00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27.00
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable	0	0	0	0	28. 00 29. 00
30.00	Total fixed assets (sum of lines 12-29)	142, 147, 074	-	0	0	30.00
30.00	OTHER ASSETS	142, 147, 074	1 9	<u> </u>		30.00
31. 00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	O	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	176, 163, 654	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	176, 163, 654		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	353, 915, 858	0	0	0	36.00
	CURRENT LI ABI LI TI ES		1 _1	_1		
37.00	Accounts payable	4, 567, 040	1	0	0	37.00
38.00	Salaries, wages, and fees payable	9, 662, 430	0	0	0	
39.00	Payroll taxes payable	0	0	U	0	39.00
40.00	Notes and Loans payable (short term)	0	0	0		
41. 00 42. 00	Deferred income Accelerated payments		l o	U	0	41.00
43. 00	Due to other funds		0	0	0	
44. 00	Other current liabilities	5, 476, 661		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	19, 706, 131		Ö	0	
	LONG TERM LIABILITIES	, , , , ,		- 1		
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured Loans	0	0	0	0	48.00
49.00	Other long term liabilities	98, 769, 070	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	98, 769, 070		0	0	
51.00	Total liabilities (sum of lines 45 and 50)	118, 475, 201	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52. 00	General fund balance	235, 440, 657	1			52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55. 00 56. 00
57.00	Plant fund balance - invested in plant			۷	0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
55. 00	replacement, and expansion				O	55.55
59.00	Total fund balances (sum of lines 52 thru 58)	235, 440, 657	o	o	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	353, 915, 858	1	o	0	
	59)					

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0097

Worksheet G-1 From 01/01/2018 12/31/2018 Date/Time Prepared:

5/23/2019 3:17 pm General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 3. 00 4.00 2.00 1.00 Fund balances at beginning of period 217, 955, 530 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 17, 485, 127 2.00 2.00 3 00 Total (sum of line 1 and line 2) 235, 440, 657 ol 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 5.00 0 0 0 0 0 5.00 0 6.00 0 6.00 7. 00 0 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 235, 440, 657 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 000000 13.00 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 235, 440, 657 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 2.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 0 3.00 3.00 Total (sum of line 1 and line 2) 0 4.00 Additions (credit adjustments) (specify) 4.00 5.00 5.00 6.00 0 6.00 0 7.00 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 10.00 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 0 13.00 14.00 0 14.00 15.00 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 0 18.00 Fund balance at end of period per balance 0 0 19.00 sheet (line 11 minus line 18)

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0097

Description			T	o 12/31/2018	Date/Time Pre 5/23/2019 3:1	
PART I - PATIENT REVENUES Seneral Inpatient Routine Services		Cost Center Description	I npati ent	Outpatient		/ piii
PART I - PAILENT REVENUES		300 t 301 to 1 2000 1 p t 1 0 1				
Seneral Inpatient Routine Services 14, 282, 487 14, 282, 487 1.0		PART I - PATIENT REVENUES	1.00	2.00	0.00	
Description						
SUBPROVIDER IFF	1 00		14 282 487		14 282 487	1 00
SUPPROVIDER - IRF 0			1 1, 202, 107		11,202,107	
SUPPROVIDER					0	
5.00 Swing bed SNF 0 0 0 0 0 0 0 0 0			1			
6.00 Swing Ded NF			_			
3.00 SKILLEN BURSING FACILITY		1 3	1			
8.00 NURSING FACILITY 9.00 14, 282, 487 14, 282, 487 10, 00 14, 282, 487 10, 00 10 10 10 10 10 10			٦		O	
9.00 OTHER LONG TERM CARE 10.00 Intensive Care Type Inpatient Hospital Services 11.00 Intensive Care Type Inpatient Hospital Services 12.00 COROMARY CARE UNIT 12.00 SURGICAL INTENSIVE CARE UNIT 13.00 SURGICAL INTENSIVE CARE UNIT 15.00 Total intensive care type inpatient hospital services (sum of lines 4, 657, 111						
10.00						
Intensive Care Type Inpatient Hospital Services			1/1 292 //97		1/1 202 /07	
11. 00 INTENSIVE CARE UNIT	10.00		14, 202, 407		14, 202, 407	10.00
12.00 CORONARY CARE UNIT	11 00		/ 657 111		1 657 111	11 00
13. 00 BURN INTENSIVE CARE UNIT			4,037,111		4,037,111	
14. 00 SURGICAL INTENSIVE CARE (SPECIFY) 1,4 00 15. 00 1.0						
15. 00 OTHER SPECIAL CARE (SPECIFY) 16. 00 10. 00 10. 01						
Total intensive care type inpatient hospital services (sum of lines 1.15						
11-15 1			1 457 111		A 4E7 111	
17. 00	10.00	, , , , , , , , , , , , , , , , , , , ,	4,037,111		4, 637, 111	10.00
18. 00	17 00		10 020 500		10 020 500	17 00
19.00						
20. 00 MHP PEDI ATRI CS 0 3, 486, 046 20, 00 MHP OBGYN 0 2, 347, 530 2, 347, 530 20, 01 20. 01 MHP PEM 0 9, 832, 210 9, 832, 210 20. 02 CD FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 22, 805, 339 22, 805, 339 22, 00 23, 00 24, 00 00 0 0 0 24, 00 00 0 0 0 25, 00 00 0 0 24, 00 00 0 25, 00 00 0 26, 00 00 0 27, 00 0059174LIST 2, 261, 566 997, 381 3, 258, 947 27, 00 27, 00 0059174LIST 2, 261, 566 997, 381 3, 258, 947 27, 01 27, 02 07 07 07 07 07 07 07						
20. 01 MHP OBGYN						
20. 02 21. 00 FEDERALLY QUALIFIED HEALTH CENTER			1			
21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 21. 00			_			
22. 00 HOME HEALTH AGENCY			1	9, 832, 210		
23. 00				0		
24. 00 CMHC AMBULATORY SURGICAL CENTER (D.P.) 24. 00 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 26. 00 100 27. 00 100 100 27. 00 100 100 27. 00 10				2, 805, 339		
25. 00				0	0	
26. 00 HOSPICE						
27. 00 HOSPITALIST 27. 01 OTHER NONREIMBURSABLE 27. 02 PROFESSI ONAL FEES 28. 00 Foresting expenses (sum of lines 17-27) (transfer column 3 to Wkst. 81, 151, 821 and 151, 821						
27. 01 OTHER NONREIMBURSABLE						
27. 02 PROFESSIONAL FEES 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 81, 151, 821 307, 173, 441 388, 325, 262 28. 00 29. 00 Ogerating expenses (per Wkst. A, column 3, line 200) 30. 00 ADD (SPECIFY) 29. 00 Ogerating expenses (per Wkst. A, column 3, line 200) 31. 00 Ogerating expenses (per Wkst. A, column 3, line 200) 32. 00 Ogerating expenses (per Wkst. A, column 3, line 200) 33. 00 Ogerating expenses (per Wkst. A, column 3, line 200) 34. 00 Ogerating expenses (per Wkst. A, column 3, line 200) 35. 00 Ogerating expenses (per Wkst. A, column 3, line 200) 36. 00 Ogerating expenses (per Wkst. A, column 3, line 200) 37. 00 Ogerating expenses (per Wkst. A, column 3, line 200) 38. 00 Ogerating expenses (sum of lines 30-35) 38. 00 Ogerating expenses (sum of lines 30-35) 39. 00 Ogerating expenses (sum of lines 37-41) Total deductions (sum of lines 29 and 36 minus line 42) (transfer lines 42) (transfer lines 136, 277, 335 line 27. 02 28. 00 Ogerating expenses (per Wkst. A, column 3 to Wkst. 81, 151, 821 og 307, 173, 441 og 388, 325, 262 og 388, 325, 262 og 307, 173, 441 og 307, 173, 44						
28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 81, 151, 821 307, 173, 441 388, 325, 262 6-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) ADD (SPECIFY) O 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) DEDUCT (SPECIFY) O Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 81, 151, 821 307, 173, 441 388, 325, 262 28.00 81, 151, 821 307, 173, 441 388, 325, 262 29.00 30, 00 31.00 32.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 37.00 38.00 39.00 40.00 41.00 42.00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 136, 277, 335 43.00			· · · · · · ·	·	· ·	
G-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) 30.00 31.00 32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 136, 277, 335 29.00 30.00 31.00 0 31.00 0 32.00 33.00 34.00 35.00 0 36.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
PART II - OPERATING EXPENSES 29.00	28. 00		81, 151, 821	307, 173, 441	388, 325, 262	28.00
29. 00 30. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (per Wkst. A, column 3, line 200) 136, 277, 335 29. 00 30. 00 31. 00 32. 00 32. 00 33. 00 34. 00 0 35. 00 0 36. 00 37. 00 38. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
30.00 ADD (SPECIFY) 30.00 31.00 32.00 32.00 33.00				404 077 005		
31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 0 31. 00 32. 00 33. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 136, 277, 335						
32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 0 32.00 33.00 33.00 34.00 35.00 0 37.00 37.00 0 38.00 0 0 0 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer		ADD (SPECIFY)	•			
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 0 33.00 34.00 0 35.00 0 36.00 0 37.00 0 38.00 0 0 40.00 0 41.00 42.00 136,277,335			1			
34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 0 34.00 0 35.00 0 36.00 0 37.00 0 38.00 0 0 0 40.00 0 41.00 42.00 136, 277, 335						
35.00 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 0 35.00 36.00 37.00 37.00 38.00 0 0 0 40.00 41.00 0 42.00 136, 277, 335			1			
36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 36.00 37.00 38.00 0 38.00 0 40.00 41.00 0 41.00 42.00 136, 277, 335			_			
37. 00 DEDUCT (SPECIFY) 0 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 136, 277, 335 43. 00			0			
38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 136, 277, 335 43.00						
39.00		DEDUCT (SPECIFY)				
40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 136, 277, 335 43.00			1			
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 136, 277, 335 43.00						
42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 136, 277, 335 42.00			1			
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 136, 277, 335 43.00			0			
				0		
to Wkst. G-3, line 4)	43. 00		er	136, 277, 335		43.00
		to WKSt. G-3, Tine 4)				

	Financial Systems MAJOR H MENT OF REVENUES AND EXPENSES	HOSPITAL Provider CCN: 15-0097	Period:	u of Form CMS-2 Worksheet G-3	
SIAIL	ILIVI OI KEVENOES AND EXPENSES	FIOVIDE CON. 15-0097	From 01/01/2018	WOLKSHEET G-3	
			To 12/31/2018		
				5/23/2019 3:1	/ pm
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 28)		388, 325, 262	1.00
2. 00	Less contractual allowances and discounts on patients' ac			258, 608, 908	2.00
3. 00	Net patient revenues (line 1 minus line 2)			129, 716, 354	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, I	ine 43)		136, 277, 335	4.00
5.00	Net income from service to patients (line 3 minus line 4)	·		-6, 560, 981	5.00
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			-2, 333, 067	7. 00
8. 00	Revenues from telephone and other miscellaneous communica	ition services		0	8. 00
9. 00	Revenue from television and radio service			0	9.00
10.00	Purchase discounts			0	10.00
11.00				0	11.00
12.00				0	12.00
13. 00 14. 00	1			0	13. 00 14. 00
15. 00	Revenue from rental of living quarters			0	15.00
16. 00	Revenue from sale of medical and surgical supplies to oth	per than nationts		0	16.00
	Revenue from sale of drugs to other than patients	iei than patrents		0	17.00
	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00				0	20.00
21. 00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER OPERATING INCOME			5, 927, 329	24.00
24. 01				891, 572	24. 01
24. 02				28, 919, 303	
25. 00	Total other income (sum of lines 6-24)			33, 405, 137	
26. 00				26, 844, 156	
	OTHER EXPENSE			9, 359, 029	
	Total other expenses (sum of line 27 and subscripts)	10)		9, 359, 029	
29. 00	Net income (or loss) for the period (line 26 minus line 2	(8)	l	17, 485, 127	29.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

0

-7, 108

0

1, 750, 395

0

0

1, 750, 395

23.50

24.00

Tel emedi ci ne

24.00 Total (sum of lines 1-23)

23.50

DEST ALLOCATION - HAA GRIFFAL SERVICE COST Provider COL 15-097	Heal th	Financial Systems		MAJOR HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
No. Expurses Plant Related Costs Plant Approximation Proceedings Plant Proceedings Proceedings Plant Proceedings Procedings Procedings Proceedings			E COST		Provi der C		Peri od: From 01/01/2018	Worksheet H-1 Part I Date/Time Pre	epared:
Capital Related Costs Fixtures Fixtures Equipment Copration & Maintenance Costs Costs Fixtures Equipment Copration & Maintenance Costs									7 pm
First Number Firs				Capital Rela	ated Costs		Agency I		
CREATENT SERVICE COST CENTERS			for Cost Allocation (from Wkst.			Operation 8	k n		
Capital Related - Bidg. 8 0 0 0 0 0 0 0 0 0		CENEDAL SEDVICE COST CENTEDS		1. 00	2.00	3. 00	4. 00	4A. 00	
Capital Related - Movable Equipment of Related - Movable Equ	1.00		0	0				0	1.00
2.00 Plant Operation & Maintenance 0 0 0 0 0 3.00	2. 00	Capital Related - Movable	0		0			0	2.00
Admin Strative and General 682,881 0 0 0 682,881 5.00		Plant Operation & Maintenance	0	О	0		- 1	О	
HAR RELIMBURSABLE SERVICES			0 682 581	-1	-			682 581	
7.00 Physical Therapy 319,575 0 0 0 319,575 7.00 8.00 Coupational Therapy 44,249 0 0 0 0 42,249 80 9.00 Speech Pathology 786 0 0 0 0 340,000 9.00 Speech Pathology 786 0 0 0 0 36,001 11.00 Modical Social Services 3,601 0 0 0 0 3,601 12.00 Supplies (see instructions) 36,606 0 0 0 0 3,601 13.00 Dirugs 0 0 0 0 0 0 3,601 13.00 Dirugs 0 0 0 0 0 0 0 15.00 Home Heal th Aid e 62,770 10 0 0 0 0 0 15.00 Home Billystalls SERVICES 0 0 0 0 0 0 16.00 Replicatory Therapy 0 0 0 0 0 0 0 17.00 Private Buty Nursing 0 0 0 0 0 0 0 0 18.00 Clinic Control of the Con		HHA REIMBURSABLE SERVICES		-					
8.00 Occupational Therapy				- 1					
10.00 Medical Social Services 3.601 0.00 0 0.0		Occupational Therapy	44, 249	0		•			
12.00 Supplies (see instructions) 36,606 0 0 0 0 36,606 12.00 14.00 DUE				0	-			l .	1
13.00 Drugs		1		0	0		-		1
HAN NONEE IMBURSABLE SERVICES			1	0	0			1	
15.00	14.00		0	0	0		0 0	0	14.00
17.00 Pri vate Duty Nursing 0 0 0 0 0 0 17.00 19.00 Heal th Promotion Activities 0 0 0 0 0 0 0 18.00 19.00 Heal th Promotion Activities 0 0 0 0 0 0 0 19.00 19.00 Water Program 0 0 0 0 0 0 0 20.00 19.00 Home Deli Vered Meals Program 0 0 0 0 0 0 0 20.00 19.00 Home Deli Vered Meals Program 0 0 0 0 0 0 0 20.00 19.00 Home Deli Vered Meals Program 0 0 0 0 0 0 0 20.00 19.00 Home Deli Vered Meals Program 0 0 0 0 0 0 0 20.00 19.00 All Others (specify) 0 0 0 0 0 0 0 22.00 23.00 All Others (specify) 0 0 0 0 0 0 0 22.00 24.00 Total (sum of Lines 1-23) 1.750,395 0 0 0 0 0 0 23.50 24.00 Total (sum of Lines 1-23) 1.750,395 0 0 0 0 0 0 23.50 24.00 Total (sum of Lines 1-23) 1.750,395 0 0 0 0 0 0 23.50 25.00 Capital Related - Bidg. & Fixtures 2.00 6.00 26.00 Capital Related - Movable Equi pment 2.00 6.00 27.00 Capital Related - Movable Equi pment 2.00 6.00 6.00 28.00 Capital Related - Movable Equi pment 3.00 4.00 6.00 6.00 29.00 Capital Related - Movable 682,581 6.00 6	15. 00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
18.00 Clinic			0	0	-				1
20. 00 Day Care Program		Clinic	0	Ö	Ö		-	1	18. 00
21.00			0	0	-				1
23.00 All Others (specify)	21. 00	Home Delivered Meals Program	o o	Ö	0		0 0	0	21.00
23.50 Telemedicine			0	0	-		-	· -	
Administrativ e & General 4A + 5) 5.00 6.	23. 50	Tel emedi ci ne	Ö	Ö	0		0 0	0	23. 50
Capital Related - Bidg. &	24. 00	Total (sum of lines 1-23)		Total (cols.	0		0 0	1, 750, 395	24.00
CENERAL SERVICE COST CENTERS 1.00 Fixtures 2.00 Capital Related - Bidg. & Fixtures 2.00 Capital Related - Movable Equipment 3.00 Plant Operation & Maintenance 4.00 Transportation 4.00 Transporta				4A + 5)					-
Fixtures		GENERAL SERVICE COST CENTERS	5.00	8.00					
Capital Related - Movable Equipment Capital Related - Movable Equipment Capital Related - Movable Equipment Capital Related - Movable Capital Related	1. 00								1.00
3.00	2. 00	Capital Related - Movable							2.00
4.00	3. 00								3.00
HHA REIMBURSABLE SERVICES	4.00	Transportati on	(00.504						4.00
6. 00 Skilled Nursing Care 383, 684 983, 911 7. 00 Physical Therapy 204, 283 523, 858 8. 00 Occupational Therapy 28, 285 72, 534 9. 00 Speech Pathology 502 1, 288 10. 00 Medical Social Services 2, 302 5, 903 11. 00 Home Health Aide 40, 125 102, 895 12. 00 Supplies (see instructions) 23, 400 60,006 13. 00 Drugs 0 0 14. 00 DME 0 0 HHA NONREIMBURSABLE SERVICES 15. 00 Respiratory Therapy 0 0 16. 00 Respiratory Therapy 0 0 17. 00 Private Duty Nursing 0 0 18. 00 Clinic 0 0 19. 00 Health Promotion Activities 0 0 20. 00 Day Care Program 0 0 21. 00 Home Delivered Meals Program 0 0 22. 00 Homemaker Service 0 0 23. 00 All Others (specify) 0 0 23. 50 Tel emedicine 0 0	5.00		682, 581						5.00
8. 00 Occupational Therapy 28, 285 72, 534 8. 00 9. 00 Speech Pathology 502 1, 288 9. 00 10. 00 Medical Social Services 2, 302 5, 903 10. 00 11. 00 Home Heal th Aide 40, 125 102, 895 11. 00 12. 00 Supplies (see instructions) 23, 400 60, 006 12. 00 13. 00 Drugs 0 0 13. 00 14. 00 MME 0 0 0 14. 00 HHA NONREI MBURSABLE SERVI CES 0 0 15. 00 16. 00 16. 00 Respiratory Therapy 0 0 16. 00 17. 00 Pri vate Duty Nursing 0 0 17. 00 18. 00 Cli nic 0 0 18. 00 19. 00 Heal th Promotion Activities 0 0 18. 00 20. 00 Day Care Program 0 0 20. 00 21. 00 Home Delivered Meals Program 0 0 21. 00 22. 00 Homemaker Service 0 0 22. 00 23. 00 All Others (specify) 0 0 23. 00 23. 50 Tel emedicine 0 0 0		Skilled Nursing Care							
10.00 Medical Social Services 2, 302 5, 903 11.00 Home Heal th Aide 40, 125 102, 895 12.00 Supplies (see instructions) 23, 400 60, 006 13.00 Drugs 0 0 14.00 DME 0 0 HHA NONREIMBURSABLE SERVICES 0 0 15.00 Respiratory Therapy 0 0 16.00 Respiratory Therapy 0 0 17.00 Private Duty Nursing 0 0 19.00 Heal th Promotion Activities 0 0 19.00 Day Care Program 0 0 20.00 Day Care Program 0 0 21.00 Home Delivered Meals Program 0 0 22.00 Home maker Service 0 0 23.00 All Others (specify) 0 0 23.50 Tel emedicine 0 0									
11.00 Home Heal th Ai de 40, 125 102, 895 12.00 12.00 13.00 12.00 13.00 14.00			1						1
13.00 Drugs DME DM									
14.00 DME 0 0 HHA NONREI MBURSABLE SERVI CES 15.00 Home Di al ysis A ide Servi ces 0 0 16.00 Respi ratory Therapy 0 0 17.00 Pri vate Duty Nursing 0 0 18.00 Cli ni c 0 0 19.00 Heal th Promotion Activities 0 0 20.00 Day Care Program 0 0 21.00 Home Del i vered Meal's Program 0 0 22.00 Homemaker Servi ce 0 0 23.00 All Others (specify) 0 0 23.50 Tel emedici ne 0 0		1	1						
15. 00 Home Dialysis Aide Services 0 0 15. 00 16. 00 Respiratory Therapy 0 0 16. 00 17. 00 Private Duty Nursing 0 0 17. 00 18. 00 Clinic 0 0 18. 00 19. 00 Heal th Promotion Activities 0 0 19. 00 20. 00 Day Care Program 0 0 20. 00 21. 00 Home Dialysis Aide Services 0 0 21. 00 40. 00 Heal th Promotion Activities 0 0 21. 00 21. 00 Home Dialysis Aide Services 0 0 0 22. 00 Home Dialysis Aide Services 0 0 0 23. 00 All Others (specify) 0 0 23. 00 23. 50 Tel emedicine 0 0 0		9		1					
16.00 Respiratory Therapy 0 0 16.00 17.00 Private Duty Nursing 0 0 17.00 18.00 Clinic 0 0 18.00 19.00 Heal th Promotion Activities 0 0 19.00 20.00 Day Care Program 0 0 20.00 21.00 Home Delivered Meals Program 0 0 21.00 22.00 Homemaker Service 0 0 22.00 23.00 All Others (specify) 0 0 23.00 23.50 Tel emedicine 0 0 23.50	15 00			O					15 00
18.00 Clinic 0 0 19.00 Health Promotion Activities 0 0 20.00 Day Care Program 0 0 21.00 Home Delivered Meals Program 0 0 22.00 Homemaker Service 0 0 23.00 All Others (specify) 0 0 23.50 Tel emedicine 0 0	16.00	Respi ratory Therapy	1	O					16.00
19.00 Health Promotion Activities 0 0 20.00 Day Care Program 0 0 21.00 Home Delivered Meals Program 0 0 22.00 Homemaker Service 0 0 23.00 All Others (specify) 0 0 23.50 Tel emedicine 0 0		, ,	0	- 1					
21.00 Home Delivered Meals Program 0 0 22.00 Homemaker Service 0 0 23.00 All Others (specify) 0 0 23.50 Tel emedicine 0 0	19.00	Health Promotion Activities	0	O					19.00
22. 00 Homemaker Service 0 0 23. 00 All Others (specify) 0 0 23. 50 Tel emedicine 0 0		, ,	0	- 1					
23. 50 Tel emedicine 0 0 23. 50	22.00	Homemaker Service	0	0					22. 00
				1, 750, 395					

	Financial Systems ALLOCATION - HHA STATISTICAL BA:	cic	MAJOR HO		CN: 15-0097	In_Lie Period:	w of Form CMS-2 Worksheet H-1	
COST A	ALLUCATION - MMA STATISTICAL DA.	31 3		HHA CCN:		From 01/01/2018	Part II Date/Time Pre 5/23/2019 3:1	pared:
						Home Health	PPS	7 рііі
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportation	Reconciliatio	Administrativ	
		Fixtures (SQUARE FEET)	Equi pment (DOLLAR VALUE)	Operation & Maintenance (SQUARE FEET)	n (MI LEAGE)	n	e & 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			0		3.00
4. 00	Transportation (see	0	0	ol c		0		4.00
	instructions)							
5. 00	Administrative and General	0	0) C)	0 -682, 581	1, 067, 814	5.00
	HHA REIMBURSABLE SERVICES		0		\	0	(00.227	/ 00
6. 00 7. 00	Skilled Nursing Care Physical Therapy	0	0	1	1	0 0	600, 227 319, 575	6. 00 7. 00
8. 00	Occupational Therapy		0			0 0	44, 249	1
9. 00	Speech Pathology	0	0		1		786	•
10.00	Medical Social Services	0	0	o c		o o	3, 601	1
11.00	Home Health Aide	0	0	o c		0 0	62, 770	11.00
12.00	Supplies (see instructions)	0	0) c		0 0	36, 606	12.00
13.00	Drugs	0	0	C	1	0	_	
14. 00	DME	0	0) C)	0 0	0	14.00
45.00	HHA NONREI MBURSABLE SERVI CES			J				45.00
15.00	Home Dialysis Aide Services	0	0			0 0	1	1
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0		1	0 0	0	16. 00 17. 00
18. 00	Clinic	0	0		1	0 0		18.00
	Health Promotion Activities		0					19.00
	Day Care Program		0					20.00
	Home Delivered Meals Program	0	0				0	21.00
22. 00	Homemaker Service	0	0	Ö		o o	l o	22.00
	All Others (specify)	0	0			0 0	Ö	23. 00
23. 50	Tel emedi ci ne	0	0	o c		0	0	23. 50
24.00	Total (sum of lines 1-23)	0	0) c		-682, 581	1, 067, 814	24.00
25. 00	Cost To Be Allocated (per	0	0) C)	0	682, 581	25. 00
	Wallahaak II 4 Dalak IX	1		1	1	1	1	ı

0.000000

0.000000

0.000000

0.000000

0. 639232 26. 00

Worksheet H-1, Part I)
26.00 Unit Cost Multiplier

Peri od: Worksheet H-2
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/23/2019 3:17 pm Provider CCN: 15-0097 HHA CCN: 15-7418 Home Health PPS

						Home Health Agency I	PPS	
			CAPI TAL			Agency		
			RELATED COSTS					
	Cost Center Description	HHA Trial	BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI V	OPERATION OF	
		Bal ance (1)		BENEFITS		E & GENERAL	PLANT	
		0	1. 00	DEPARTMENT 4. 00	4A	5. 00	7. 00	
1. 00	Administrative and General	0	197, 524	368, 080	565, 604		119, 743	1.00
2. 00	Skilled Nursing Care	983, 911	0	0	983, 911		0	2.00
3.00	Physi cal Therapy	523, 858	o	o	523, 858		0	3.00
4.00	Occupational Therapy	72, 534	0	0	72, 534	17, 149	0	4.00
5.00	Speech Pathology	1, 288	0	0	1, 288		0	5.00
6. 00	Medical Social Services	5, 903	0	0	5, 903		0	6.00
7. 00 8. 00	Home Health Aide	102, 895 60, 006	0	0	102, 895		0	7. 00 8. 00
9. 00	Supplies (see instructions) Drugs	00,000		0	60, 006	14, 167	0	9.00
10. 00	DME	0	l ol	ő	0	0	Ö	10.00
11. 00	Home Dialysis Aide Services	0	o	О	0	0	0	11.00
12.00	Respi ratory Therapy	0	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 16. 00	Health Promotion Activities Day Care Program			0	0	0	0	15. 00 16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18. 00	Homemaker Service	0	o	O	0	0	0	18.00
19. 00	All Others (specify)	0	o	0	0	0	0	19. 00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20.00	Total (sum of lines 1-19) (2)	1, 750, 395	197, 524	368, 080	2, 315, 999		119, 743	
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum				0. 000000			21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	Corullin 26, Title 1, Tourided to							
	6 decimal places.							
		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
	6 decimal places.	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	ADMI NI STRATI O	SERVICES &	
	6 decimal places.		HOUSEKEEPI NG 9.00	DI ETARY	CAFETERI A			
1.00	6 decimal places. Cost Center Description Administrative and General	LINEN SERVICE				ADMI NI STRATI 0 N 13. 00	SERVICES & SUPPLY 14.00	1.00
2. 00	6 decimal places. Cost Center Description Administrative and General Skilled Nursing Care	LI NEN SERVI CE 8. 00	9. 00 85, 587 0	10. 00	11. 00	ADMI NI STRATI 0 N 13. 00	SERVICES & SUPPLY 14.00 0	2. 00
2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	LI NEN SERVI CE 8. 00	9. 00 85, 587	10. 00	11.00	ADMI NI STRATI 0 N 13. 00	SERVI CES & SUPPLY 14. 00 0 0	2. 00 3. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	LI NEN SERVI CE 8. 00	9. 00 85, 587 0 0	10. 00	11. 00 0 0 0	ADMI NI STRATI 0 N 13. 00	SERVI CES & SUPPLY 14. 00 0 0 0 0 0	2.00 3.00 4.00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	LI NEN SERVI CE 8. 00	9. 00 85, 587 0	10. 00	11.00	ADMI NI STRATI 0 N 13. 00	SERVI CES & SUPPLY 14. 00 0 0	2.00 3.00 4.00 5.00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	LI NEN SERVI CE 8. 00	9. 00 85, 587 0 0 0	10. 00	11. 00 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0	2.00 3.00 4.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	LI NEN SERVI CE 8. 00	9. 00 85, 587 0 0 0 0	10. 00 0 0 0 0	11. 00 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	LI NEN SERVI CE 8. 00	9. 00 85, 587 0 0 0 0 0 0	10. 00 0 0 0 0 0	11. 00 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0	SERVI CES & SUPPLY 14.00 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	LI NEN SERVI CE 8. 00	9. 00 85, 587 0 0 0 0 0	10. 00 0 0 0 0 0 0 0	11. 00 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	LI NEN SERVI CE 8. 00	9. 00 85, 587 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0 0	11. 00 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0	SERVI CES & SUPPLY 14.00 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	LI NEN SERVI CE 8. 00	9. 00 85, 587 0 0 0 0 0 0	10. 00 0 0 0 0 0 0 0	11. 00 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	LI NEN SERVI CE 8. 00	9.00 85,587 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0 0	11. 00 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0	SERVI CES & SUPPLY 14.00 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
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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	LI NEN SERVI CE 8. 00	9. 00 85, 587 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0 0	11. 00 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 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 13. 00 14. 00 15. 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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	LI NEN SERVI CE 8. 00	9. 00 85, 587 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0	11. 00 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 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 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	LI NEN SERVI CE 8. 00	9. 00 85, 587 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0	11. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 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 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 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 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	LI NEN SERVI CE 8. 00	9. 00 85, 587 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0	11. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 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 13. 00 14. 00 15. 00 16. 00 17. 00 18. 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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	LI NEN SERVI CE 8. 00	9. 00 85, 587 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0	11. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 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 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 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 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	LI NEN SERVI CE 8. 00	9. 00 85, 587 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0	11. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14.00 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 14. 00 15. 00 16. 00 17. 00 18. 00 19. 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 19. 50	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	8. 00 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 85, 587 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0	11. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14.00 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 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	8. 00 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 85, 587 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0	11. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14.00 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 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 85, 587 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0	11. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14.00 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 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 85, 587 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0	11. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 74, 237 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14.00 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 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00

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

							3/23/2019 3. 1	/ pili
						Home Health Agency I	PPS	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		15. 00	16. 00	24. 00	25. 00	26. 00	27. 00	
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. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	15. 00 0 0 0 0 0 0 0 0 0 0 0 0	15, 873 0 0 0 0 0 0 0 0 0 0 0 0 0	994, 768 1, 216, 534 647, 712 89, 683 1, 593 7, 299 127, 222 74, 193 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		994, 768 1, 216, 534 647, 712 89, 683 1, 593 7, 299 127, 222 74, 193 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	559, 167 297, 714 41, 222 732 3, 355 58, 476 34, 102 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 19. 00 20. 00 21. 00
	Cost Center Description	Total HHA Costs	1		ı	1		
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 21. 00	Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	28. 00 1, 775, 701 945, 426 130, 905 2, 325 10, 654 185, 698 108, 295 0 0 0 0 0 0 0 0 3, 159, 004						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 17. 00 18. 00 19. 50 20. 00 21. 00

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

HHA CCN: 15-7418

						Home Health	PPS	
						Agency I		
		CAPI TAL						
		RELATED COSTS						
	Cost Center Description	BLDG & FIXT	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	
		(SQUARE FEET)	BENEFITS	n	E & GENERAL	PLANT	LINEN SERVICE	
			DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF	
			(GROSS				LAUNDRY)	
			SALARI ES)					
	,	1. 00	4. 00	5A	5. 00	7. 00	8. 00	
1.00	Administrative and General	6, 391	1, 428, 066	0		6, 391	0	1.00
2.00	Skilled Nursing Care	0	0	0	983, 911	0	0	2.00
3.00	Physi cal Therapy	0	0	0	523, 858	0	0	3.00
4.00	Occupational Therapy	0	0	0	72, 534	0	0	4.00
5.00	Speech Pathology	0	0	0	1, 288	0	0	5.00
6.00	Medical Social Services	l o	0	0	5, 903	0	0	6.00
7.00	Home Heal th Ai de	l o	0	0	102, 895	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	60, 006	0	0	8. 00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	l o	0	0	0	0	0	11.00
12.00	Respiratory Therapy	l o	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	l .	0	0	14.00
15. 00	Health Promotion Activities	0	0			0	0	15.00
16. 00	Day Care Program	0	0	0	0	0	0	16.00
17. 00	Home Delivered Meals Program	0	0	0	Ō	0	0	17. 00
18. 00	Homemaker Service	0	0	0	0	0	ő	18. 00
19. 00	All Others (specify)	١	0	0		0	o o	19.00
19. 50	Tel emedi ci ne	٥	0			n	o O	19. 50
20. 00	Total (sum of lines 1-19)	6, 391	1, 428, 066		2, 315, 999	6, 391	0	20.00
21. 00	Total cost to be allocated	197, 524	368, 080		547, 565	119, 743	0	21.00
22. 00	Unit cost multiplier	30. 906587	0. 257747		0. 236427	18. 736192	0. 000000	
22.00	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	22.00
	oost deliter beserretten	(SQUARE FEET)	(PATI ENT	(MANHOURS)	ADMI NI STRATI O	SERVICES &	(100% DRUGS	
		(000/1112 1221)	DAYS)	(N	SUPPLY	TO PATIENTS)	
			27.1.07		(MANHOURS)	(100%	10 17.112.110)	
					(SUPPLI ES)		
		9. 00	10. 00	11. 00	13.00	14. 00	15. 00	
1.00	Administrative and General	6, 391	0	0		0	0	1.00
2.00	Skilled Nursing Care	O	0	0	0	0	0	2.00
3.00	Physical Therapy	l o	0	0	0	0	0	3.00
4.00	Occupational Therapy	l o	0	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 Heal th Ai de	l o	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0		0	0	8. 00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	Ō	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0	Ō	0	0	11.00
12. 00	Respiratory Therapy	0	0	0	Ö	0	o o	12.00
13. 00	Private Duty Nursing		0	0		n	o	
	Clinic		0			0	0	
15. 00	Health Promotion Activities	0	0		0	0	0	
16. 00	Day Care Program		0			0	0	
17. 00	Home Delivered Meals Program		0				0	17.00
18.00	Homemaker Service		0		0		0	
19. 00	All Others (specify)		0		0		0	19.00
19. 00			0					
20. 00	Telemedicine Total (sum of lines 1-19)	4 201	0		40.430		0	20.00
20.00	Total cost to be allocated	6, 391 85, 587	0		40, 630 74, 237		0	
	Unit cost multiplier	13. 391801	0. 000000	0. 000000			-	
ZZ. UU	Tour Cost martipite	13.371001	0. 000000	ı 0.00000	1.02/14/	0.000000	0.000000	22.00

	Figure 1 at Contract		MA IOD HOODI	TA1			. C. F OHC .	2550 40
	Financial Systems TION OF GENERAL SERVICE COSTS T	TO HUA COST CENT	MAJOR HOSPI		CCN: 15-0097	Peri od:	u of Form CMS-2 Worksheet H-2	
BASI S	TION OF GENERAL SERVICE COSTS I	O HHA COST CEN	TERS STATISTICAL	HHA CCN:	15-7418	From 01/01/2018 To 12/31/2018	Part II	pared:
						Home Health	PPS	
						Agency I		
	Cost Center Description	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16, 00						
1. 00	Administrative and General	2, 805, 339						1. 00
2. 00	Skilled Nursing Care	2, 803, 339						2.00
3. 00	Physical Therapy	0						3.00
4. 00	Occupational Therapy	0						4.00
5. 00	Speech Pathology	0						5.00
6. 00	Medical Social Services	o						6.00
7.00	Home Health Aide	0						7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9. 00
10.00	DME	0						10.00
11. 00	Home Dialysis Aide Services	0						11.00
12.00	Respi ratory Therapy	0						12.00
13.00	Private Duty Nursing	0						13.00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17. 00	Home Delivered Meals Program	0						17.00
18. 00 19. 00	Homemaker Service	0						18. 00 19. 00
19. 00	All Others (specify) Telemedicine	0						19.00
20.00	Total (sum of lines 1-19)	2, 805, 339						20.00
21. 00	Total cost to be allocated	15, 873						21.00
	Unit cost multiplier	0. 005658						22.00

	Financial Systems	FC	MAJOR HO		ON 45 0007		u of Form CMS-2	
(PPOR I	TIONMENT OF PATIENT SERVICE COS	IS		HHA CCN:		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
				Title	e XVIII	Home Health	5/23/2019 3: 1 PPS	7 pm
						Agency I		
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line		Costs (from	1 + 2)		(col. 3 ÷	
		_	Part I)	Part II)			col . 4)	
	DART I COMPUTATION OF LEGGER	0	1.00	2.00	3.00	4.00	5. 00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF T	HE PROGRAM LIN	MITATION COST, O	R BENEFICIARY	
	Cost Per Visit Computation	1						
. 00	Skilled Nursing Care	2. 00			1, 775, 70		261. 17	1.0
. 00	Physi cal Therapy	3. 00		0	1,	· ·	246. 91	2.0
. 00	Occupational Therapy	4.00		0			104. 31	3.0
. 00	Speech Pathology	5.00		0	2, 32		105. 68	
. 00	Medical Social Services	6. 00	10, 654		10, 65		138. 36	5.0
. 00	Home Health Aide	7.00	185, 698		185, 69	1, 287	144. 29	6.0
. 00	Total (sum of lines 1-6)		3, 050, 709	0	3, 050, 70			7.0
					Program Visit	S		
					Pa	rt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
			(.,		to	Deducti bl es		
					Deductibles &			
					Coi nsurance	`		
		0	1. 00	2.00	3.00	4. 00	5. 00	
	Limitation Cost Computation							
. 00	Skilled Nursing Care		26900	0	-,			8.0
. 01	Skilled Nursing Care		99915	0				8.0
. 00	Physi cal Therapy		26900	0	2, 20			9.0
. 01	Physi cal Therapy		99915	0	2:	2		9.0
0. 00	Occupational Therapy		26900	0	65	4		10.0
0. 01	Occupational Therapy		99915	0)	0		10. C
1.00	Speech Pathology		26900	0	2.	2		11.0
1. 01	Speech Pathology		99915	0)	0		11.0
2.00	Medical Social Services		26900	0	5	7		12.0
2. 01	Medical Social Services		99915	0)	ol		12.0
3. 00	Home Heal th Ai de		26900	0	85	9		13.0
3. 01	Home Health Aide		99915	0		o		13.0
	Total (sum of lines 8-13)			0	7, 69	8		14.0
1. 00	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges	Ratio (col 3	11.0
	5551 5511151 B5551 P11 511	H-2 Part I,	Costs (from	Ancillary	Costs (cols.	(from HHA	÷ col . 4)	
		col. 28, line		Costs (from	1 + 2)	Records)	. (01. 4)	
		20, 11110	Part I)	Part II)	' ' 2)	Records)		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Comput							
	Cost of Medical Supplies	8.00		0			0. 000000	
5. 00	Cost of Drugs	9. 00	O Program Visits			0 0	0. 000000	16.0
			11 Ogram VISITS		Cost of Services			
			Par	t B	Services	Part B		
	Cost Center Description	Part A	Par	t B			Subject to	
	Cost Center Description		Par Not Subject		Servi ces Part A	Part B Not Subject to		
	Cost Center Description		Par Not Subject to	t B Subject to Deductibles &	Servi ces Part A	Not Subject to	Deductibles &	
	Cost Center Description		Par Not Subject	t B Subject to	Servi ces Part A	Not Subject		
	·	Part A 6.00	Par Not Subject to Deducti bles & Coinsurance 7.00	t B Subject to Deductibles & Coinsurance 8.00	Services Part A 9.00	Not Subject to Deductibles & Coinsurance	Deducti bl es & Coi nsurance	
	PART I - COMPUTATION OF LESSER	Part A 6.00	Par Not Subject to Deducti bles & Coinsurance 7.00	t B Subject to Deductibles & Coinsurance 8.00	Services Part A 9.00	Not Subject to Deductibles & Coinsurance	Deducti bl es & Coi nsurance	
	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation	Part A 6.00 OF AGGREGATE	Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00	Part A 9.00 HE PROGRAM LIM	Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, 0	Deducti bl es & Coi nsurance	
	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	Part A 6.00	Par Not Subject to Deducti bl es & Coi nsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF TO	Part A 9.00 HE PROGRAM LIM	Not Subject to Deducti bles & Coi nsurance 10.00 MI TATION COST, CO	Deducti bl es & Coi nsurance	
	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation	Part A 6.00 OF AGGREGATE	Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF TO	Part A 9.00 HE PROGRAM LIM	Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, 0	Deducti bl es & Coi nsurance	
00	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	Part A 6.00 OF AGGREGATE	Par Not Subject to Deducti bl es & Coi nsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF TO	Part A 9.00 HE PROGRAM LIM	Not Subject to Deducti bles & Coi nsurance 10.00 MI TATION COST, CO	Deducti bl es & Coi nsurance	2. (
00	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	Part A 6.00 OF AGGREGATE	Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 3,877 2,229 654 22	t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF TO	Part A 9.00 HE PROGRAM LIM	Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, CO 1,012,556 550,362	Deducti bl es & Coi nsurance	2. (3. (
. 00	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	Part A 6.00 OF AGGREGATE	Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 3,877 2,229 654 22	t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF TO	Part A 9.00 HE PROGRAM LIM	Not Subject to Deductibles & Coinsurance 10.00 II TATION COST, 0 1,012,556 550,362 68,219 2,325	Deducti bl es & Coi nsurance	2. 0 3. 0 4. 0
. 00	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	Part A 6.00 OF AGGREGATE	Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 3,877 2,229 654	Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF TO	Part A 9.00 HE PROGRAM LIM	Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, 0 0 1,012,556 550,362 0 68,219	Deductibles & Coinsurance 11.00 R BENEFICIARY	1. (2. (3. (4. (6. (6. (6. (6. (6. (6. (6. (6. (6. (6

APPUR I	IONMENT OF PATIENT SERVICE COS	TS		Provi der CO	CN: 15-0097	Peri od:	Worksheet H-3	3
				HHA CCN:	15-7418	From 01/01/2018 To 12/31/2018		epared
				Title	XVIII	Home Health Agency I	PPS	. , p
	Cost Center Description	6.00	7. 00	8. 00	9. 00	10.00	11. 00	
	Limitation Cost Computation	0.00	7.00	0.00	7.00	10.00	11100	
. 00	Skilled Nursing Care							7 8.0
. 01	Skilled Nursing Care							8.0
. 00	Physi cal Therapy							9. (
. 01	Physi cal Therapy							9. (
0. 00	Occupational Therapy							10.0
0. 01	Occupational Therapy							10.0
1. 00	Speech Pathology							11. (
1. 01	Speech Pathology							11.0
2. 00	Medical Social Services							12. (
2. 01	Medical Social Services							12.0
3.00	Home Health Aide							13.0
3. 01	Home Health Aide							13.0
4. 00	Total (sum of lines 8-13)							14. (
		Progi	am Covered Cha	irges	Cost of			
					Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	·		to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	Supplies and Drugs Cost Comput Cost of Medical Supplies	ations 0	28	0		0 0	(15.0
	cost of medical supplies		20		l	0		7 13.0
6. 00	Cost of Drugs		0	0		0	(16.0
6. 00	Cost of Drugs Cost Center Description	Total Program	0	0		0	(16.0
6. 00		Cost (sum of	0	0		0	(16.0
6. 00		Cost (sum of cols. 9-10)	0	0		0	C	16.0
	Cost Center Description	Cost (sum of cols. 9-10)		_				16.0
		Cost (sum of cols. 9-10)		_				16.0
	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation	Cost (sum of cols. 9-10) 12.00 OF AGGREGATE	PROGRAM COST, A	_				16.0
	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	Cost (sum of cols. 9-10) 12.00 OF AGGREGATE	PROGRAM COST, /	_				
. 00	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	Cost (sum of cols. 9-10) 12.00 OF AGGREGATE 1,012,556 550,362	PROGRAM COST, /	_				1. (
. 00	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	Cost (sum of col s. 9-10) 12.00 0F AGGREGATE 1,012,556 550,362 68,219	PROGRAM COST, /	_				1. (2. (3. (
. 00	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	Cost (sum of col s. 9-10) 12.00 OF AGGREGATE I 1,012,556 550,362 68,219 2,325	PROGRAM COST, /	_				1. (2. (3. (4. (
. 00 . 00 . 00 . 00	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	Cost (sum of cols. 9-10) 12.00 OF AGGREGATE 1 1,012,556 550,362 68,219 2,325 7,887	PROGRAM COST, /	_				1. (2. (3. (4. (5. (
. 00 . 00 . 00 . 00	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	Cost (sum of col s. 9-10) 12.00 OF AGGREGATE I 1,012,556 550,362 68,219 2,325	PROGRAM COST, /	_				1. (2. (3. (4. (5. (
. 00 . 00 . 00 . 00 . 00	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	Cost (sum of cols. 9-10) 12.00 OF AGGREGATE 1 1,012,556 550,362 68,219 2,325 7,887	PROGRAM COST, /	_				1. (2. (3. (4. (5. (6. (
. 00 . 00 . 00 . 00 . 00	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	Cost (sum of col s. 9-10) 12.00 0F AGGREGATE 1,012,556 550,362 68,219 2,325 7,887 123,945 1,765,294	PROGRAM COST, /	_				1.(2.(3.(4.(5.(6.(7.(
. 00 . 00 . 00 . 00 . 00 . 00	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	Cost (sum of col s. 9-10) 12.00 OF AGGREGATE 1,012,556 550,362 68,219 2,325 7,887 123,945	PROGRAM COST, /	_				1. ((2. ((3. ((4. ((5. ((6. ((
. 00	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	Cost (sum of col s. 9-10) 12.00 0F AGGREGATE 1,012,556 550,362 68,219 2,325 7,887 123,945 1,765,294	PROGRAM COST, /	_				1. (2. (3. (4. (5. (7. (
00 00 00 00 00	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care	Cost (sum of col s. 9-10) 12.00 0F AGGREGATE 1,012,556 550,362 68,219 2,325 7,887 123,945 1,765,294	PROGRAM COST, /	_				1. (2. (3. (4. (6. (6. (7. (6. (6. (7. (6. (6. (6. (6. (6. (6. (6. (6. (6. (6
00 00 00 00 00 00 00 00	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care	Cost (sum of col s. 9-10) 12.00 0F AGGREGATE 1,012,556 550,362 68,219 2,325 7,887 123,945 1,765,294	PROGRAM COST, /	_				1. 2. 3. 4. 5. 6. 7. 8. 8.
00 00 00 00 00 00 00 00 00	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy	Cost (sum of col s. 9-10) 12.00 0F AGGREGATE 1,012,556 550,362 68,219 2,325 7,887 123,945 1,765,294	PROGRAM COST, /	_				1. 2. 3. 4. 5. 6. 7. 8. 8. 9.
00 00 00 00 00 00 00 00 00 01 00 01	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy	Cost (sum of col s. 9-10) 12.00 0F AGGREGATE 1,012,556 550,362 68,219 2,325 7,887 123,945 1,765,294	PROGRAM COST, /	_				1. 2. 3. 4. 5. 6. 7. 8. 8. 9. 9.
00 00 00 00 00 00 00 00 01 00 01 00 01 00 01	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy	Cost (sum of col s. 9-10) 12.00 0F AGGREGATE 1,012,556 550,362 68,219 2,325 7,887 123,945 1,765,294	PROGRAM COST, /	_				1. 2. 3. 4. 5. 6. 7. 8. 8. 9. 9. 10.
00 00 00 00 00 00 00 00 01 00 01 00,00 01,00 0.00	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy	Cost (sum of col s. 9-10) 12.00 0F AGGREGATE 1,012,556 550,362 68,219 2,325 7,887 123,945 1,765,294	PROGRAM COST, /	_				1. 2. 3. 4. 5. 6. 7. 8. 8. 9. 9. 10. 10.
00 00 00 00 00 00 00 00 01 00 01 00 01 0.00 0.00	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology	Cost (sum of col s. 9-10) 12.00 0F AGGREGATE 1,012,556 550,362 68,219 2,325 7,887 123,945 1,765,294	PROGRAM COST, /	_				1. 2. 3. 4. 5. 6. 7. 8. 8. 9. 9. 10. 10. 11.
00 00 00 00 00 00 00 00 01 00 01 00 01 00 01 1.00	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology	Cost (sum of col s. 9-10) 12.00 0F AGGREGATE 1,012,556 550,362 68,219 2,325 7,887 123,945 1,765,294	PROGRAM COST, /	_				1. 2. 3. 4. 5. 6. 7. 8. 8. 9. 9. 10. 10. 11. 11.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 01 . 00 . 01 . 00 . 01 . 00 . 01 . 00	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services	Cost (sum of col s. 9-10) 12.00 0F AGGREGATE 1,012,556 550,362 68,219 2,325 7,887 123,945 1,765,294	PROGRAM COST, /	_				1 2 3 4 5 6 7 10 11 11 12
. 00 . 00 . 00 . 00 . 00 . 00 . 01 . 00 . 01 0. 00 0. 01 1. 00 0. 01 1. 00 2. 01	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services	Cost (sum of col s. 9-10) 12.00 0F AGGREGATE 1,012,556 550,362 68,219 2,325 7,887 123,945 1,765,294	PROGRAM COST, /	_				1 2 3 4 5 6 7 10 11 11 12 12 12
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 01 . 00 . 01 . 00 . 01 . 01	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services	Cost (sum of col s. 9-10) 12.00 0F AGGREGATE 1,012,556 550,362 68,219 2,325 7,887 123,945 1,765,294	PROGRAM COST, /	_				1 2 3 4 5 6 7 10 11 11 12

Heal th	Financial Systems		MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	ΓS		Provi der (CCN: 15-0097	Peri od:	Worksheet H-3	
				HHA CCN:	15-7418	From 01/01/2018 To 12/31/2018	Date/Time Pre	
							5/23/2019 3:1	7 pm
				Ti tl	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNI SHED I	BY SHARED HOSE	TAL DEPARTME	ENTS		
1.00	Physi cal Therapy	66.00	0. 458803	(D	0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0. 236784)	0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 291069	(0 col. 2, line 1	6. 00	5.00

	Financial Systems MAJOR F ATION OF HHA REIMBURSEMENT SETTLEMENT	HOSPITAL Provider C	°N: 15_0007	In Lie	u of Form CMS-2 Worksheet H-4	
ALCUL	ATION OF THE REIMBURSEMENT SETTLEMENT	HHA CCN:	15-7418	From 01/01/2018	Part I-II Date/Time Pre	pare
		Title	XVIII	Home Health	5/23/2019 3: 1 PPS	7 pm
				Agency I Par	t B	
			Part A	Not Subject to	Subject to Deductibles &	
				Deductibles & Coinsurance	Coi nsurance	
			1.00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR	CUSTOMARY CHARGI	ES			
00	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0 0	0	1.
00	Total charges			0 0		1
00	Customary Charges			0 0	0	1 ~
00	Amount actually collected from patients liable for paymen on a charge basis (from your records)	t for services		0 0	0	3.
00	Amount that would have been realized from patients liable for services on a charge basis had such payment been made with 42 CFR §413.13(b)			0 0	0	4
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 000000	0. 000000	5
00	Total customary charges (see instructions)			0 0	0	6
00	Excess of total customary charges over total reasonable conly if line 6 exceeds line 1)	ost (complete		0 0	0	7
00	Excess of reasonable cost over customary charges (complet 1 exceeds line 6)	e only if line		0 0	0	8
00	Primary payer amounts			0 0		9
				Part A Services 1.00	Part B Servi ces 2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	
	Total reasonable cost (see instructions)			0	_	
. 00	Total PPS Reimbursement - Full Episodes without Outliers			0		
. 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes			0	55, 478 13, 410	
. 00	Total PPS Reimbursement - PEP Episodes			0	8, 660	
. 00	Total PPS Outlier Reimbursement - Full Episodes with Outl	iers		0	7, 674	
. 00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	
. 00	Total Other Payments			0	0	17
. 00	DME Payments			0	0	
. 00	Oxygen Payments			0	0	
. 00	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude c	ol nouronoo)		0	_	
. 00 . 00	Subtotal (sum of lines 10 thru 20 minus line 21)	ornsurance)		0	0 1, 227, 964	
. 00	1			0	1, 227, 704	1
. 00	Subtotal (line 22 minus line 23)			0		
. 00	Coinsurance billed to program patients (from your records	5)			0	1
. 00	Net cost (line 24 minus line 25)			0	1, 227, 964	26
. 00	Reimbursable bad debts (from your records)					27
. 00	· ·)	_		28
. 00	Total costs - current cost reporting period (line 26 plus	Fline 27)		0		
. 00 . 50	MISC Pioneer ACO demonstration payment adjustment (see instruc	tions)		0		1
. 99	Demonstration payment adjustment amount before sequestrat			0	0	
. 00	Subtotal (see instructions)	- •		0	_	
. 01	Sequestration adjustment (see instructions)			0		
. 02	, , , , , , , , , , , , , , , , , , , ,	on		0		
2. 00	Interim payments (see instructions)			0		
3. 00	, , , , , , , , , , , , , , , , , , , ,	20 200		0	0	
1 00	Balance due provider/program (line 31 minus lines 31.01,	32 and 331		0	0	34
4. 00 5. 00			2 Dub 1E 2	0	0	

Health Financial Systems MAJOR HOST ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED MAJOR HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-0097

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/23/2019 3:17 pm PPS TO PROGRAM BENEFICIARIES HHA CCN: 15-7418

				Home Health Agency I	PPS	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	1, 203, 406 0	1. 00 2. 00
3. 00	services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3. 01				0	0	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3. 04 3. 05				0	0 0	3. 04 3. 05
3.00	Provider to Program			U _I	0	3.03
3. 50	Trovider to Trogram			ol	0	3.50
3. 51				Ö	o	3. 51
3.52				0	0	3.52
3. 53				0	0	3.53
3.54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)			0	1, 203, 406	4. 00
4.00	(transfer to Wkst. H-4, Part II, column as appropriate,			٥	1, 203, 406	4.00
	line 32)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
- 04	Program to Provider					- 04
5. 01				0	0	5. 01
5. 02 5. 03				0	0 0	5. 02 5. 03
3.03	Provider to Program			0	0	5.05
5. 50	Trovi doi: to trogi diii			o	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)			0	1, 203, 406	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
0.00	No. of Contraction	()	1. 00	2. 00	0.00
8. 00	Name of Contractor				l l	8. 00

Heal th	Financial Systems M.	AJOR HOSPITAL	Inlie	u of Form CMS-2	2552_10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0097	Peri od: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III	pared:
		Title XVIII	Hospi tal	PPS	
				1 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			671, 066	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2. 00	Capital DRG outlier payments			781	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments		1	0	
3. 00 4. 00	Total inpatient days divided by number of days in the Number of interns & residents (see instructions)	ne cost reporting period (see ins	structions)	27. 34 0. 00	
5. 00	Indirect medical education percentage (see instructi	ions)		0.00	
6. 00	Indirect medical education adjustment (multiply line)1. columns 1 and	0.00	1
	1.01) (see instructions)	,	.,	_	
7. 00	Percentage of SSI recipient patient days to Medicare 30) (see instructions)	e Part A patient days (Worksheet	E, part A line	0. 00	7.00
8.00	Percentage of Medicaid patient days to total days (s	see instructions)		0.00	
9. 00	Sum of lines 7 and 8			0. 00	
10.00	Allowable disproportionate share percentage (see ins				10.00
11.00	Disproportionate share adjustment (see instructions)			(71 047	
12. 00	Total prospective capital payments (see instructions	5)		671, 847	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instruct			0	
2.00	Program inpatient ancillary capital cost (see instru	,		0	
3. 00 4. 00	Total inpatient program capital cost (line 1 plus li	ine 2)		0	
4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line	4)		0	
3.00	The street program capital cost (Time 3 x Time	-7)		0	3.00
				1. 00	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs (see instructions)	ircumstances (see instructions)		0	
3. 00	Net program inpatient capital costs (line 1 minus li			0	
4. 00	Applicable exception percentage (see instructions)			0. 00	
5.00	Capital cost for comparison to payments (line 3 x li	ine 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstance			0.00	
7. 00	Adjustment to capital minimum payment level for extr	raordinary circumstances (line 2	x line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9. 00 10. 00	Current year capital payments (from Part I, line 12, Current year comparison of capital minimum payment I		loss lino O)	0	
11. 00	Carryover of accumulated capital minimum payment lev Worksheet L, Part III, line 14)			0	
12. 00	Net comparison of capital minimum payment level to d	capital payments (line 10 plus li	ne 11)	0	12.00
13. 00	Current year exception payment (if line 12 is positi			0	
14. 00	Carryover of accumulated capital minimum payment lev (if line 12 is negative, enter the amount on this li	vel over capital payment for the		0	1
15.00	Current year allowable operating and capital payment	t (see instructions)		0	15.00
	Current year operating and capital costs (see instru	uctions)		0	16.00
16. 00	Current year exception offset amount (see instruction			0	

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Peri od: Worksheet M-1 From 01/01/2018
	Component CCN: 15-8529	To 12/31/2018 Date/Time Prepared: 5/23/2019 3:17 pm

FACILITY HEALTH CARE STAFF COSTS							5/23/2019 3:	17 pm
FACILITY HEALTH CARE STAFF COSTS						RHC I		•
All location (col. 5 + col. 6) Col. 5 + col. 6 Col. 5 + col. 6 Col.			Adjustments	Net Expenses				
COL 5 COL 6 COL				for				
FACILITY HEALTH CARE STAFF COSTS				Allocation				
FACILITY HEALTH CARE STAFF COSTS				(col. 5 +				
FACILITY HEALTH CARE STAFF COSTS								
1.00			6. 00	7. 00				
2.00 Physician Assistant 95,695 95,695 3.00 4.00 Visiting Nurse 0 0 0 5.00 Other Nurse 0 0 0 6.00 Clinical Psychologist 0 0 0 7.00 Clinical Social Worker 0 0 0 8.00 Laboratory Technician 0 0 0 9.00 Unical Social Worker 0 0 0 1.00 Laboratory Technician 0 0 0 0 9.00 Laboratory Technician 0 0 0 0 1.00 Subtotal (sum of lines 1 through 9) 1,114,573 1,664,879 10 1.10 Physician Services Under Agreement 0 0 0 1.10 Physician Supervision Under Agreement 0 0 0 1.20 Physician Supervision Under Agreement 0 0 0 1.30 Other Costs Under Agreement 0 0 12.00 1.30 Other Costs Under Agreement 0 0 13.00 1.40 Subtotal (sum of lines 11 through 13) 0 0 14.00 1.50 Medical Supplies 0 419,744 <								
3.00								
4.00			·		1			
5.00		1	177, 858	266, 284				1
6.00			0	_				
7.00		1	0	261, 244				1
8. 00 Aboratory Technician 0 0 0 0 0 0 0 0 0		, ,	0	C				1
9, 00 Other Fac Lity Heal th Care Staff Costs 0 200, 576 1, 00 0 Subtotal (sum of lines 1 through 9) 1, 114, 573 1, 664, 819 10, 00 11, 00			0	C				
10. 00 Subtotal (sum of lines 1 through 9) 1,114,573 1,664,819 10. 00 11. 00 Physician Services Under Agreement 0 0 0 12. 00 Physician Supervision Under Agreement 0 0 0 13. 00 00 00 00 00 14. 00 00 01 00 15. 00 Medical Supplies 0 419,744 15. 00 16. 00 Transportation (Health Care Staff) 0 0 0 18. 00 Porfessional Liability Insurance 0 0 0 19. 00 00 00 00			0	C				
11.00 Physician Services Under Agreement 0 0 0 0 12.00 Physician Supervision Under Agreement 0 0 0 12.00 13.00 0 14.00 0 0 13.00 0 0 14.00 0 0 15.00 0 0 0 0 0 0 0 0 0			0					
12.00 Physician Supervision Under Agreement 0 0 0 0 13.00 14.00 14.00 15.00 14.00 15.00 14.00 15.00 16.00 17.00 16.00 17.00 16.00 17.00 17.00 17.00 18.00 17.00 18.0			1, 114, 573	1, 664, 819				
13.00 Other Costs Under Agreement 0 0 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 0 0 0 15.00 Medical Supplies 0 419,744 15.00 16.00 Transportation (Heal th Care Staff) 0 0 0 17.00 Depreciation-Medical Equipment 0 0 0 18.00 Professional Liability Insurance 0 0 0 19.00 Other Heal th Care Costs 0 0 19.00 Other Heal th Care Costs 0 0 20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 419,744 21.00 22.00 Total Cost of Heal th Care Services (sum of 1,114,573 2,084,563 10.00 Costs Of Heal th Care Services (sum of 1,114,573 2,084,563 10.00 Dental 0 0 23.00 24.00 Dental 0 0 0 25.00 Optometry 0 0 0 25.00 Optometry 0 0 0 25.00 Optometry 0 0 0 25.00 Ohrolic Care Management 0 0 0 25.00 All other nonreimbursable costs 0 0 26.00 All other nonreimbursable costs 0 0 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 29.00 Facility Costs -664,129 302,678 30.00 Administrative Costs 26,267 336,292 30.00 31.00 Total Facility Overhead (sum of lines 29 and -637,862 638,970 30.00 Administrative Costs 30.00 30.00 30.00 Administrative Costs 30.00 30.00 30.00 Total facility costs (sum of lines 29 and -637,862 638,970 30.00 Total facility costs (sum of lines 29 and -637,862 638,970 30.00 Total facility costs (sum of lines 24 476,711 2,723,533 32.00	11. 00	Physician Services Under Agreement	0	C)			
14.00 Subtotal (sum of lines 11 through 13) 0 0 0 0 0 1419,744 15.00			0	C)			
15.00 Medical Supplies	13.00		0	C)			
16. 00 Transportation (Heal th Care Staff) 0 0 0 17. 00 Depreciation-Medical Equipment 0 0 0 18. 00 18. 00 19. 00	14.00		0	_				
17. 00 Depreciation-Medical Equipment 0 0 0 18. 00 Professional Liability Insurance 0 0 0 18. 00 19. 00 19. 00 0 19. 00	15.00		0	419, 744				15.00
18. 00 Professional Liability Insurance 0 0 18. 00 19. 00 Other Heal th Care Costs 0 0 0 20. 00 Allowable GME Costs 20. 00 20. 00 21. 00 Subtotal (sum of lines 15 through 20) 0 419, 744 21. 00 22. 00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 20. 00 20. 00 23. 00 Pharmacy 0 0 23. 00 24. 00 Dental 0 0 24. 00 25. 00 Optometry 0 0 25. 01 25. 01 Tel eheal th 0 0 0 25. 02 Chronic Care Management 0 0 0 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Oxnall lowable GME costs 0 0 0 28. 00 Total Nonreimbursable costs (sum of lines 23 through 27) 0 0 0 Facility Costs -664, 129 30, 2678 336, 292 30. 00 30. 00 31. 00 Total Facility Overhead (sum of lines 29 and 30) -637, 862 638, 970	16.00	Transportation (Health Care Staff)	0	C				16. 00
19.00 Other Health Care Costs 0 0 0 0 20.00 20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 419,744 21.00 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	17.00	Depreciation-Medical Equipment	0	C				
20.00 21.00 Subtotal (sum of lines 15 through 20) 0 419,744 21.00 21.00 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 22.00 Costs Of Heal th Care Services (sum of lines 10, 14, and 21) Costs Of Heal th Care Services (sum of lines 10, 14, and 21) Costs Of Heal th Costs Of Lines 10, 14, and 21) 0 0 0 0 23.00 Pharmacy 0 0 0 0 24.00 Dental 0 0 0 0 25.00 Optometry 0 0 0 0 25.00 Optometry 0 0 0 0 25.00 Chronic Care Management 0 0 0 0 25.01 Teleheal th 0 0 0 0 25.01 Chronic Care Management 0 0 0 0 25.01 Chronic Care Management 0 0 0 0 25.01 Nonal Lowable GME costs 0 0 0 0 26.00 Nonal Lowable GME costs 0 0 0 0 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	18.00	Professional Liability Insurance	0	C				
21.00 Subtotal (sum of lines 15 through 20) 0 419,744 2,084,563 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 0 0 23.00 24.00 25.00 0 25.00 0 0 0 0 0 0 0 0 0	19.00	Other Health Care Costs	0	C				19. 00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy Dental Doptometry Dental Doptometry Doptom	20.00	Allowable GME Costs						20.00
Lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES	21.00		0	419, 744				21.00
COSTS OTHER THAN RHC/FQHC SERVICES Pharmacy	22.00		1, 114, 573	2, 084, 563				22. 00
23. 00 Pharmacy								
24. 00 Dental 0 0 0 0 24. 00 25. 00 Optometry 0 0 0 0 25. 01 Tel eheal th 0 0 0 0 25. 02 Chronic Care Management 0 0 0 0 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 0 0 0 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		COSTS OTHER THAN RHC/FQHC SERVICES						
25. 00 Optometry 0 0 0 0 25. 00 25. 01 Tel eheal th 0 0 0 0 25. 02 Chronic Care Management 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 22. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	C	1			
25. 01 Tel eheal th 0 0 0 25. 01 25. 02 Chronic Care Management 0 0 0 26. 00 All other nonreimbursable costs 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24.00	Dental	0	C	1			
25. 02 Chronic Care Management 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00	Optometry	0	C)			
26. 00		1	0	C)			
27. 00 Nonallowable GME costs 27. 00 28. 00	25. 02		0	C)			
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		All other nonreimbursable costs	0	C)			
through 27) FACILITY OVERHEAD 29. 00 Facility Costs 30. 00 Administrative Costs 31. 00 Total Facility Overhead (sum of lines 29 and 30) 32. 00 Total facility costs (sum of lines 22, 28 476, 711 2, 723, 533) 29. 00 Total facility costs (sum of lines 22, 28 476, 711 2, 723, 533) 32. 00 Total facility costs (sum of lines 22, 28 476, 711 2, 723, 533)		Nonallowable GME costs						
FACILITY OVERHEAD 29. 00 Facility Costs	28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C)			28. 00
29.00 Facility Costs								
30.00 Administrative Costs 26,267 336,292 30.00 31.00 Total Facility Costs (sum of lines 22, 28 476,711 2,723,533 32.00								
31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 476,711 2,723,533 32.00								
30) 32.00 Total facility costs (sum of lines 22, 28 476,711 2,723,533 32.00								
32.00 Total facility costs (sum of lines 22, 28 476,711 2,723,533 32.00	31.00	,	-637, 862	638, 970	1			31.00
		1 1						
and 31)	32. 00		476, 711	2, 723, 533				32.00
		and 31)			I			

Health Financial Systems	MAJOR HOSPITAL		In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der	CCN: 15-0097	Peri od: From 01/01/2018	Worksheet M-1
	Componer	t CCN: 15-8531	To 12/31/2018	Date/Time Prepared: 5/23/2019 3:17 pm
			RHC II	

			Component	CCN: 15-8531 T		Date/Time Pre 5/23/2019 3:1	
					RHC II		
		Compensation	Other Costs		Recl assi fi cat		
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1. 00	2. 00	3.00	4. 00	col . 4) 5.00	
	FACILITY HEALTH CARE STAFF COSTS					2.22	
1.00	Physi ci an	0	0	C	0	0	1.00
2.00	Physi ci an Assi stant	0	0	o c	0	0	2.00
3.00	Nurse Practitioner	100, 294	0	100, 294	0	100, 294	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	116, 957	0	116, 957	0	116, 957	5.00
6.00	Clinical Psychologist	0	0	C	0	0	6. 00
7.00	Clinical Social Worker	0	0	0	0	0	7. 00
8.00	Laboratory Techni ci an	0	0	0	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	204, 793	0	204, 793		204, 793	9. 00
10.00	Subtotal (sum of lines 1 through 9)	422, 044	0	422, 044	0	422, 044	10.00
11. 00	Physician Services Under Agreement	0	0	0	0	0	11.00
12. 00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15. 00	Medical Supplies	0	310, 302	310, 302	0	310, 302	15. 00
16. 00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17. 00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18. 00	Professional Liability Insurance	0	0	0	0	0	18. 00
19.00		0	0	1	0	0	19.00
20.00	Allowable GME Costs		040.000	040.000		040 000	20.00
21. 00	Subtotal (sum of lines 15 through 20)	400.044	310, 302			,	21.00
22. 00	Total Cost of Health Care Services (sum of	422, 044	310, 302	732, 346	0	732, 346	22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00		٥	0	0	0	0	23. 00
24. 00	Dental	0	0		-		24.00
25. 00	Optometry	0	0		0	0	25.00
25. 00	Tel eheal th	0	0		0	0	25. 00
25. 01	Chronic Care Management	0	0		0	0	25. 01
26. 00	All other nonreimbursable costs	0	0		0	0	26.00
27. 00	Nonallowable GME costs	O	0	1			27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28.00
20.00	through 27)	Ö		1		· ·	20.00
	FACILITY OVERHEAD			1			
29. 00	Facility Costs	0	718, 225	718, 225	0	718, 225	29. 00
30.00	Administrative Costs	198, 131	76, 504			· ·	•
31.00	Total Facility Overhead (sum of lines 29 and		794, 729			992, 860	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	620, 175	1, 105, 031	1, 725, 206	0	1, 725, 206	32.00
	and 31)						

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Period: Worksheet M-1 From 01/01/2018
	Component CCN: 15-8531	To 12/31/2018 Date/Time Prepared: 5/23/2019 3:17 pm

						5/23/2019 3:17 pm	n
					RHC II		
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	834, 497	834, 497			1.	. 00
2.00	Physician Assistant	0	C				. 00
3.00	Nurse Practitioner	0	100, 294			3.	. 00
4.00	Visiting Nurse	0	C)		4.	. 00
5.00	Other Nurse	0	116, 957				. 00
6.00	Clinical Psychologist	0	C)			. 00
7.00	Clinical Social Worker	0	C)			. 00
8.00	Laboratory Techni ci an	0	C)			. 00
9.00	Other Facility Health Care Staff Costs	0	204, 793				. 00
10.00	Subtotal (sum of lines 1 through 9)	834, 497	1, 256, 541				. 00
11. 00	Physician Services Under Agreement	0	C)			. 00
12.00	Physician Supervision Under Agreement	0	C)		l l	. 00
13.00	Other Costs Under Agreement	0	C			13.	. 00
14.00	Subtotal (sum of lines 11 through 13)	0	C			14.	. 00
15.00	Medical Supplies	0	310, 302			15.	. 00
16.00	Transportation (Health Care Staff)	0	C			16.	. 00
17.00	Depreciation-Medical Equipment	0	C			17.	. 00
18.00	Professional Liability Insurance	0	C			18.	. 00
19.00	Other Health Care Costs	0	C			19.	. 00
20.00	Allowable GME Costs					20.	. 00
21.00	Subtotal (sum of lines 15 through 20)	0	310, 302			21.	. 00
22.00	Total Cost of Health Care Services (sum of	834, 497	1, 566, 843			22.	. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	C				. 00
24.00	Dental	0	C)			. 00
25.00	Optometry	0	C)			. 00
25. 01	Tel eheal th	0	C)			. 01
25. 02	Chronic Care Management	0	C)			. 02
26.00	All other nonreimbursable costs	0	C)		26.	. 00
27. 00	Nonallowable GME costs						. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C)		28.	. 00
	through 27)						
	FACILITY OVERHEAD						
	Facility Costs	-714, 752		1			. 00
30.00	Administrative Costs	205, 080					. 00
31.00	Total Facility Overhead (sum of lines 29 and	-509, 672	483, 188	1		31.	. 00
	30)	201	0.050.55				
32. 00	Total facility costs (sum of lines 22, 28	324, 825	2, 050, 031			32.	. 00
	and 31)			I			

		Compensation	Other Costs		Recl assi fi cat		
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00			4 00	col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	FACILITY HEALTH CARE STAFF COSTS			1			1 00
1.00	Physi ci an	0	0	1	_	0	1.00
2.00	Physician Assistant	120 ((0	0	_	_	120 ((0	2.00
3.00	Nurse Practitioner	130, 669	0	130, 669	0	130, 669	3.00
4.00	Visiting Nurse	(42, 120	0	(42 120	0	0	4.00
5.00	Other Nurse	643, 130	0	643, 130	0	643, 130	
6.00	Clinical Psychologist	40 504	0	40 504	0	0	6.00
7.00	Clinical Social Worker	48, 594	0	48, 594	0	48, 594	7.00
8. 00	Laboratory Technician	1 007 005	0	1 00/ 005	0	0	8.00
9.00	Other Facility Health Care Staff Costs	1, 826, 985		1, 826, 985		1, 826, 985	9.00
10.00	Subtotal (sum of lines 1 through 9)	2, 649, 378	0	2, 649, 378	0	2, 649, 378	
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	(00.15)	(00.15)	0	0	14.00
15.00	Medical Supplies	0	688, 156	688, 156	0	688, 156	
16. 00 17. 00	Transportation (Health Care Staff)	0	0	0	0	0	16. 00 17. 00
18.00	Depreciation-Medical Equipment Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	U	U	0	0	0	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	688, 156	688, 156	0	688, 156	
21.00	Total Cost of Health Care Services (sum of	2, 649, 378	•				
22.00	lines 10, 14, and 21)	2,049,370	000, 130	3, 337, 334	0	3, 337, 334	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	40, 211	0	40, 211	0	40, 211	23. 00
24. 00	Dental	40, 211	0	40, 211	0	40, 211	24.00
25. 00	Optometry	0	0		0	0	25.00
25. 01	Tel eheal th	0	0		0	0	25. 00
25. 01	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0		26.00
27. 00	Nonallowable GME costs	0			0		27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	40, 211	0	40, 211	0	40, 211	
20.00	through 27)	40, 211		40, 211	0	40, 211	20.00
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	3, 350, 104	3, 350, 104	0	3, 350, 104	29. 00
30.00	Administrative Costs	599, 961	480, 399			1, 080, 360	
31. 00	Total Facility Overhead (sum of lines 29 and	·	3, 830, 503			4, 430, 464	
550	30)	3,,,,01	2,555,666	1, 155, 161		., .55, 101	
32. 00	Total facility costs (sum of lines 22, 28	3, 289, 550	4, 518, 659	7, 808, 209	0	7, 808, 209	32.00
	and 31)	-, -,,	.,,	, ,		, ,	
	,	•	•	•	,		•

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Period: Worksheet M-1 From 01/01/2018
	Component CCN: 15-8532	To 12/31/2018 Date/Time Prepared: 5/23/2019 3:17 pm

			Component	CCN: 15-8532	10	12/31/2018	5/23/2019 3	
						RHC III	3/23/2017 3	. 17 piii
		Adjustments	Net Expenses			100 111		
		naj astilionts	for					
			Allocation					
			(col. 5 +					
			col . 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	2, 383, 525	2, 383, 525					1.00
2.00	Physician Assistant	197, 929	197, 929					2.00
3.00	Nurse Practitioner	949, 042						3.00
4.00	Visiting Nurse	0	0	i				4.00
5.00	Other Nurse	0	643, 130					5.00
6.00	Clinical Psychologist	0	0	1				6.00
7.00	Clinical Social Worker	0	48, 594					7. 00
8. 00	Laboratory Techni ci an	0	0					8. 00
9.00	Other Facility Health Care Staff Costs	0	1, 826, 985					9.00
10.00	Subtotal (sum of lines 1 through 9)	3, 530, 496	6, 179, 874					10.00
11.00	Physician Services Under Agreement	0	0					11.00
12.00	Physician Supervision Under Agreement	0	0					12.00
13.00	Other Costs Under Agreement	0	0					13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0					14.00
15. 00	Medical Supplies	0	688, 156					15. 00
16.00	Transportation (Health Care Staff)	0	0	1				16, 00
17.00	Depreciation-Medical Equipment	0	0					17. 00
18. 00	Professional Liability Insurance	0	0					18.00
19.00	Other Health Care Costs	0	0					19.00
20.00	Allowable GME Costs							20.00
21.00	Subtotal (sum of lines 15 through 20)	0	688, 156					21.00
22.00	Total Cost of Health Care Services (sum of	3, 530, 496	6, 868, 030					22. 00
	lines 10, 14, and 21)	.,	., ,					
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	40, 211					23. 00
24.00	Dental	0	0					24.00
25.00	Optometry	0	0					25. 00
25. 01	Tel eheal th	0	0					25. 01
25.02	Chronic Care Management	0	0					25. 02
26.00	All other nonreimbursable costs	0	0					26.00
27.00	Nonallowable GME costs							27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	40, 211					28. 00
	through 27)							
	FACILITY OVERHEAD							
29. 00	Facility Costs	-3, 339, 009	11, 095					29. 00
30.00	Administrative Costs	885, 908	1, 966, 268					30.00
31.00	Total Facility Overhead (sum of lines 29 and	-2, 453, 101	1, 977, 363					31.00
	30)							
32.00	Total facility costs (sum of lines 22, 28	1, 077, 395	8, 885, 604					32.00
	and 31)							

Number of FTE Personnel Number of FTE Personnel Total Visits Productivity Minimum Greater of col. 2 or col. 4		Financial Systems	MAJOR HO				u of Form CMS-2	
Number of FTE Presented	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der 0			Worksheet M-2	
Number of FTE Personnel				Component				
Personnel						RHC I		
No Nurse Practitioner Nurse Nurs				Total Visits				
1.00 2.00 3.00 4.00 5.00			Personnel		Standard (1)			
VISITS AND PRODUCTIVITY Positions								
Positions			1. 00	2.00	3. 00	4. 00	5. 00	
1.00 Physician								
2. 00 Prysician Assistant			_					
3.00 Nurse Practitioner								1.00
4.00 Subtotal (sum of lines 1 through 3) 6.62 19,035 20,874 20,874 5.00 Visiting Nurse 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								2.00
5.00 Visiting Nurse			1					3.00
6.00 Clinical Psychologist 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					5	20, 874		
7.00 Clinical Social Worker								1
7. 01 Medical Nutrition Therapist (FQHC only)			1	l			_	
7. 02 Diabetes Self Management Training (FOHC 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	l			0	
only) 8.00 Total FTEs and Visits (sum of lines 4 6.62 19,035 20,874 8 through 7) 9.00 Physician Services Under Agreements 0 0 20,874 8 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 2,084,563 10,100 11,000			1	I			0	7. 01
8.00 Total FTEs and Visits (sum of lines 4 through 7) 9.00 Physician Services Under Agreements DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 20,874 8	7. 02		0.00	(0	7. 02
9.00 Physician Services Under Agreements 0 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 2,084,563 10 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 10 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 2,084,563 11 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 11 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 638,970 12 15.00 Parent provider overhead allocated to facility (see instructions) 1,534,695 15 16.00 Total overhead (sum of lines 14 and 15) 2,173,665 16 17.00 Allowable GME overhead (see instructions) 0 17 18.00 Enter the amount from line 16 2,173,665 16 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 2,173,665 16	8. 00	Total FTEs and Visits (sum of lines 4	6. 62	19, 035	5		20, 874	8. 00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18)	0 00			,			_	9.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18)	9.00	Priysi ci an servi ces under Agreements			/		U	9.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18)							1 00	
10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 2,084,563 12 2,084,563 12 1.000000 1.5000000 1.50000000 1.500000000 1.50000000000		DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASE	FD_RHC/FOHC_SE	RVLCES		1.00	
11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)							2, 084, 563	10.00
12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 2,084,563 1.2000000 1.5000000 1.534,665 2,173,665 1.50000000000000000000000000000000000								
13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1.0000000 1.0000000 1.00000000			·	,				1
14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 16.38, 970 14 2, 173, 665 16 2, 173, 665 17 2, 173, 665								
15.00 Parent provider overhead allocated to facility (see instructions) 1,534,695 15 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,534,695 15 2,173,665 16 2,173,665 17								
16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 2,173,665 16 2,173,665 17 2,173,665 18								
17. 00 Allowable GME overhead (see instructions) 18. 00 Enter the amount from line 16 19. 00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 0 17. 00 18. 00 19.			., (
18.00 Enter the amount from line 16 2,173,665 18 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 2,173,665 18	17. 00							1
19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 2,173,665 19								
	19.00		MC services (I	ine 13 x line	18)			
20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 4,258,228 20								

Heal th	Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provider C		Peri od:	Worksheet M-2		
			Component		From 01/01/2018 To 12/31/2018	Date/Time Pre 5/23/2019 3:1		
				_	RHC II			
		Number of FTE Personnel	Total Visits	Productivity Standard (1)		Greater of col. 2 or col. 4		
		1. 00	2.00	3.00	4.00	5, 00		
	VISITS AND PRODUCTIVITY	1.00	2.00	0.00	1. 00	0.00		
	Posi ti ons							
1.00	Physi ci an	2. 03	6, 470	4, 20	0 8, 526		1.00	
2.00	Physician Assistant	0.00	C	2, 10	0 0		2.00	
3.00	Nurse Practitioner	0.86					3.00	
4.00	Subtotal (sum of lines 1 through 3)	2. 89			10, 332	10, 332	4.00	
5.00	Visiting Nurse	0.00)		0	5.00	
6.00	Clinical Psychologist	0.00	l .			0	6. 00	
7. 00	Clinical Social Worker	0.00	l .)		0	7. 00	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .)		0	7. 01	
7. 02	Diabetes Self Management Training (FQHC only)	0.00	C			0	7. 02	
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	2. 89	8, 499			10, 332	8. 00	
9. 00	Physician Services Under Agreements					0	9.00	
			-					
						1. 00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SE	RVI CES				
	Total costs of health care services (from Wk					1, 566, 843	10.00	
	Total nonreimbursable costs (from Wkst. M-1,	· ·	,			0 1, 566, 843	11. 00 12. 00	
12.00	12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11)							
	13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)							
14.00								
15.00								
16. 00	Total overhead (sum of lines 14 and 15)					1, 568, 790		
17.00	Allowable GME overhead (see instructions)					0	17.00	
	Enter the amount from line 16			40)		1, 568, 790		
	Overhead applicable to hospital-based RHC/FC					1, 568, 790		
20.00	Total allowable cost of hospital-based RHC/F	runc services (Sum of Lines I	o and 19)		3, 135, 633	₁ 20.00	

Heal th	Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC :	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2018 To 12/31/2018		
					RHC III		
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
		1.00	0.00		1 x col . 3)	col. 4	
	MICLIES AND PROPUCTIVITY	1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						-
1 00	Posi ti ons	0.40	20.70/	1 4 20	0 25 (50	Γ	1 00
1. 00 2. 00	Physi ci an Physi ci an Assi stant	8. 49 1. 53					1.00 2.00
3. 00	Nurse Practitioner	7. 47				•	3.00
4. 00	Subtotal (sum of lines 1 through 3)	17. 49			54, 558	•	4.00
5. 00	Visiting Nurse	0.00		1	54, 556	0	
6. 00	Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	0.00				Ö	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				o o	7.01
7. 02	Di abetes Self Management Training (FQHC	0.00				0	7. 02
	only)						
8.00	Total FTEs and Visits (sum of lines 4	17. 49	59, 811			59, 811	8. 00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVI CES			
10.00	Total costs of health care services (from Wk					6, 868, 030	
11. 00	,					40, 211	1
12.00	Cost of all services (excluding overhead) (s					6, 908, 241	
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 994179	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		1, 977, 363	
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			5, 384, 687	
16.00	Total overhead (sum of lines 14 and 15)					7, 362, 050	
17. 00 18. 00	Allowable GME overhead (see instructions) Enter the amount from line 16					7 242 050	17. 00 18. 00
	Overhead applicable to hospital-based RHC/FC	NC convices (1	ino 12 v lino	10\		7, 362, 050 7, 319, 196	
	Total allowable cost of hospital-based RHC/F					14, 187, 226	
20.00	Tiotal allowable cost of hospital-based RHC/F	unc services (Sum ULLITIES I	o anu 19)		14, 107, 220	₁ 20.00

Heal th	Financial Systems MAJOR HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0097	Peri od:	Worksheet M-3	
SERVI C	ES	Component CCN: 15-8529	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/23/2019 3:1	
		Title XVIII	RHC I		
				1 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		4, 258, 228	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		446, 996	2.00
3. 00	Total allowable cost excluding vaccine (line 1 minus line 2)			3, 811, 232	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	Line ()		20, 874	
5. 00 6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	Title 9)		0 20, 874	5. 00 6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			182. 58	
			Cal cul ati on		
			Pri or to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1)	Peri od 2)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	1.00	2. 00 83. 45	8.00
9. 00	Rate for Program covered visits (see instructions)	. o or your contractor)	182. 58		
7. 00	CALCULATION OF SETTLEMENT		102.00	102.00	7.00
10.00	Program covered visits excluding mental health services (from	contractor records)	0	84	10.00
11. 00	Program cost excluding costs for mental health services (line		0	15, 337	1
12.00	Program covered visits for mental health services (from contr	•	0	0	12.00
13. 00 14. 00	Program covered cost from mental health services (line 9 x li Limit adjustment for mental health services (see instructions		0	0	13.00
15. 00	Graduate Medical Education Pass Through Cost (see instructions	,	0	U	15.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	,	0	15, 337	
16. 01	Total program charges (see instructions)(from contractor's re	-		7, 866	
16. 02	02 Total program preventive charges (see instructions)(from provider's records)		0	16. 02	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		0	16.03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		12, 270	16. 04
16. 05	Total program cost (see instructions)		0	12, 270	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		1, 573	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			12, 270	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		0	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			12, 270	
23. 00	Allowable bad debts (see instructions)			0	23.00
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	23. 01 24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	
25. 50	1 , , , , , , , , , , , , , , , , , , ,	s)		0	
	Demonstration payment adjustment amount before sequestration			0	25. 99
26.00	Net reimbursable amount (see instructions)			12, 270	
26. 01				26. 01	
26. 02 27. 00	02 Demonstration payment adjustment amount after sequestration 00 Interim payments		0 11, 393		
28. 00	Tentative settlement (for contractor use only)			0	28.00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)			29. 00
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II	,	0	30.00
	chapter I, §115.2				I

Heal th	Financial Systems MAJOR HOSPI	TAI	Inlie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	Worksheet M-3	
SERVI (EES	Component CCN: 15-8531	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/23/2019 3:1	
		Title XVIII	RHC II	0, 20, 201, 011	, p
				4 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		3, 135, 633	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li			13, 471	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3, 122, 162	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	Lino (1)		10, 332 0	4. 00 5. 00
6.00	Total adjusted visits (line 4 plus line 5)	1111e <i>9)</i>		10, 332	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			302. 18	
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1) 1.00	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	82. 30	83. 45	8.00
9.00	Rate for Program covered visits (see instructions)		302. 18	302. 18	1
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		0	310	1
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr	•	0	93, 676 0	11. 00 12. 00
13. 00	Program covered cost from mental health services (line 9 x li		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions	· ·	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction	*			15.00
16. 00 16. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	93, 676	
16. 01	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov	•		44, 538 11, 770	1
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			24, 756	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		54, 756	16. 04
1/ 05	(Titles V and XIX see instructions.)			70 510	1/ 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	79, 512 0	16. 05 17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		475	1
	records)	•			
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		6, 459	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			79, 512	
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		259	
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			79, 771 0	22.00
23. 00	Adjusted reimbursable bad debts (see instructions)			0	1
24.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24. 00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25. 50	Prioneer ACO demonstration payment adjustment (see instruction			0	25. 50 25. 99
26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			79, 771	
26. 01			1, 595		
26. 02	6.02 Demonstration payment adjustment amount after sequestration		0		
27. 00	1			53, 067	1
28. 00 29. 00	,	02 27 and 28)		0 25, 109	
	Protested amounts (nonallowable cost report items) in accorda		,	0	1
	chapter I, §115.2		1		1

ealth Financial Systems MAJOR HOSPI		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0097	Peri od:	Worksheet M-3	
SERVI CES	Component CCN: 15-8532	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/23/2019 3:1	
·	Title XVIII	RHC III		
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		14, 187, 226	1.00
2.00 Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		626, 607	
.00 Total allowable cost excluding vaccine (line 1 minus line 2)		13, 560, 619		
Protal Visits (from Wkst. M-2, column 5, line 8) 1.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 0)		59, 811 0	4. 00 5. 00
5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9) 5.00 Total adjusted visits (line 4 plus line 5)		59. 811	6.00	
7.00 Adjusted cost per visit (line 3 divided by line 6)			226. 72	7. 00
		Cal cul ati on	of Limit (1)	
		Pri or to Jan.	On or After	
		1 (Rate	Jan. 1 (Rate	
		Peri od 1) 1.00	Peri od 2)	
8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20) 6 or your contractor)	82. 30	2. 00 83. 45	8.00
2.00 Rate for Program covered visits (see instructions)	. o or your contractor,	226. 72		l
CALCULATION OF SETTLEMENT				
0.00 Program covered visits excluding mental health services (from	-	0	14, 936	
1.00 Program cost excluding costs for mental health services (line		0	3, 386, 290	1
2.00 Program covered visits for mental health services (from contr 3.00 Program covered cost from mental health services (line 9 x li	,	0	0	12.00
3.00 Program covered cost from mental health services (line 9 x li 4.00 Limit adjustment for mental health services (see instructions		0	0	
5.00 Graduate Medical Education Pass Through Cost (see instruction	•		O	15.00
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	3, 386, 290	
6.01 Total program charges (see instructions)(from contractor's re			2, 362, 741	
6.02 Total program preventive charges (see instructions) (from prov			228, 670	
6.03 Total program preventive costs ((line 16.02/line 16.01) times 6.04 Total Program non-preventive costs ((line 16 minus lines 16.0	*		327, 732 2, 403, 086	
(Titles V and XIX see instructions.)	os and 18) trilles .80)		2, 403, 000	10.04
6.05 Total program cost (see instructions)		0	2, 730, 818	16. 05
7.00 Primary payer amounts			0	17.00
8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		54, 701	18.00
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		415, 727	19. 00
records) 20.00 Net Medicare cost excluding vaccines (see instructions)			2, 730, 818	20.00
21.00 Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		386, 639	
22.00 Total reimbursable Program cost (line 20 plus line 21)	,		3, 117, 457	
23.00 Allowable bad debts (see instructions)	j , , , ,		0	23.00
23.01 Adjusted reimbursable bad debts (see instructions)			0	23. 01
24.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		0	24.00
<pre>25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 25.50 Pioneer ACO demonstration payment adjustment (see instruction</pre>	ne)		0	
25. 99 Demonstration payment adjustment amount before sequestration	13)		0	
26.00 Net reimbursable amount (see instructions)			3, 117, 457	
26.01 Sequestration adjustment (see instructions)			62, 349	26. 01
26.02 Demonstration payment adjustment amount after sequestration			0	
27.00 Interim payments			1, 989, 986	
28.00 Tentative settlement (for contractor use only) 29.00 Balance due component/program (line 26 minus lines 26.01, 26.	02 27 and 28)		0 1, 065, 122	28. 00 29. 00
80.00 Protested amounts (nonallowable cost report items) in accorda	•		1,005,122	1
chapter I, §115.2		'	0	55.50

Health Financial Systems	MAJOR HOSPI	TAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-0097	Peri od: From 01/01/2018	Worksheet M-4
VACCINE COST		Component CCN: 15-8529	To 12/31/2018	Date/Time Prepared: 5/23/2019 3:17 pm
		Title XVIII	RHC I	

		Title XVIII	RHC I		
			Pneumococcal	l nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1, 664, 819	1, 664, 819	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	al health care staff time	0. 005868	0. 009030	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	9, 769	15, 033	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fi	rom your records)	121, 219	72, 801	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	130, 988	87, 834	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksho	eet M-1, col. 7, line 22)	2, 084, 563	2, 084, 563	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2, 173, 665	2, 173, 665	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 062837	0. 042135	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	136, 587	91, 587	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	267, 575	179, 421	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections		1, 403	2, 159	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10	0/line 11)	190. 72	83. 10	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	istered to Program	0	0	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (t	heir) administration	0	0	14.00
	(line 12 x line 13)				
15.00	Total cost of pneumococcal and influenza vaccine and its (the	ir) administration (sum		446, 996	15.00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,	, line 2)			
16.00	Total Program cost of pneumococcal and influenza vaccine and			0	16.00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	MAJOR HOSPI	TAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-0097	Peri od: From 01/01/2018	Worksheet M-4
VACCINE COST		Component CCN: 15-8531	To 12/31/2018	Date/Time Prepared: 5/23/2019 3:17 pm
		Ti +Lo YVIII	DHC II	

		Title XVIII	RHC II		
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1, 256, 541	1, 256, 541	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	al health care staff time	0. 000000	0. 001171	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lir	ne 1 x line 2)	0	1, 471	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr	rom your records)	0	5, 260	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	0	6, 731	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshe	eet M-1, col. 7, line 22)	1, 566, 843	1, 566, 843	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 568, 790	1, 568, 790	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tot	tal direct cost (line 5	0. 000000	0. 004296	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	0	6, 740	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	0	13, 471	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	0	156	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10	D/line 11)	0.00	86. 35	12.00
13.00		stered to Program	0	3	13.00
44.00	beneficiaries			050	44.00
14. 00	1 3	neir) administration	O O	259	14.00
15 00	(line 12 x line 13)			10 471	15 00
15. 00				13, 471	15.00
14 00	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,			250	16. 00
16. 00	Total Program cost of pneumococcal and influenza vaccine and i administration (sum of cols. 1 and 2, line 14) (transfer this			259	16.00
		amount to WKSt. W-3,			
	line 21)			ı	

Health Financial Systems	MAJOR HOSPI	I TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provi der CCN: 15-0097	From 01/01/2018	
		Component CCN: 15-8532		5/23/2019 3:17 pm
		Title XVIII	RHC III	

			3/23/2019 3.1	/ PIII
	Title XVIII	RHC III		
		Pneumococcal	I nfl uenza	
		1. 00	2. 00	
Health care staff cost (from Wkst. M-1, col. 7, line 10)		6, 179, 874	6, 179, 874	1.00
Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff tim	e 0. 001495	0. 004776	2.00
Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	9, 239	29, 515	3.00
Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	117, 966	146, 620	4.00
Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	127, 205	176, 135	5.00
Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22	6, 868, 030	6, 868, 030	6.00
Total overhead (from Wkst. M-2, line 19)		7, 319, 196	7, 319, 196	7.00
Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 018521	0. 025646	8.00
divided by line 6)				
Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	135, 559	187, 708	9.00
Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	262, 764	363, 843	10.00
lines 5 and 9)				
Total number of pneumococcal and influenza vaccine injections	(from your records)	1, 360	4, 343	11.00
Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	193. 21	83. 78	12.00
Number of pneumococcal and influenza vaccine injections admin	istered to Program	1, 045	2, 205	13.00
benefi ci ari es				
Program cost of pneumococcal and influenza vaccine and its (t	heir) administration	201, 904	184, 735	14.00
(line 12 x line 13)				
Total cost of pneumococcal and influenza vaccine and its (the	ir) administration (sum		626, 607	15.00
of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3	, line 2)			
Total Program cost of pneumococcal and influenza vaccine and	its (their)		386, 639	16.00
	amount to Wkst. M-3,			
line 21)				
	Ratio of pneumococcal and influenza vaccine staff time to tot Pneumococcal and influenza vaccine health care staff cost (li Medical supplies cost - pneumococcal and influenza vaccine (f Direct cost of pneumococcal and influenza vaccine (line 3 plu Total direct cost of the hospital-based RHC/FQHC (from Worksh Total overhead (from Wkst. M-2, line 19) Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6) Overhead cost - pneumococcal and influenza vaccine (line 7 x Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9) Total number of pneumococcal and influenza vaccine injections Cost per pneumococcal and influenza vaccine injection (line 1 Number of pneumococcal and influenza vaccine injections admin beneficiaries Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (the of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3 Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of pneumococcal and influenza vaccine staff time to total health care staff time Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) Medical supplies cost - pneumococcal and influenza vaccine (from your records) Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) Total overhead (from Wkst. M-2, line 19) Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) Total number of pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections administered to Program beneficiaries Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of pneumococcal and influenza vaccine and its (their)	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of pneumococcal and influenza vaccine staff time to total health care staff time Pneumococcal and influenza vaccine health care staff tost (line 1 x line 2) Medical supplies cost - pneumococcal and influenza vaccine (from your records) Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) Total number of pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections (from your records) Program cost of pneumococcal and influenza vaccine injections (their) administration (sum of line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 2)	Heal th care staff cost (from Wkst. M-1, col. 7, line 10) Real th care staff cost (from Wkst. M-1, col. 7, line 10) Retail of pneumococcal and influenza vaccine staff time to total heal th care staff time Real time to total heal th care staff time Real time to total heal th care staff time Real time to total heal th care staff time Real time to total heal th care staff time Real time to total heal th care staff time Real time to total heal th care staff time Real time to total heal th care staff time Real time to total heal th care staff time Real time to total heal th care staff time Real time to total heal th care staff time Real time to total heal th care staff time Real time to total time time to total time to total time to total time time to total time to total time time to total time time to total time to time to time time to total time to total time to total time to time time time to time time time to time time time to time to time time time to time time time time time to time time time to time time time time time time time time

Health Financial Systems	MAJOR HOSPITAL	-	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC. SERVICES RENDERED TO PROGRAM BENEFICIARIES		ovider CCN: 15-0097 Imponent CCN: 15-8529	From 01/01/2018	Worksheet M-5 Date/Time Prepared: 5/23/2019 3:17 pm

				5/23/2019 3: 1	7 pr
			RHC I		
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
00	Total interim payments paid to hospital-based RHC/FQHC			11, 393	1.
	Interim payments payable on individual bills, either submit			0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount				3
	revision of the interim rate for the cost reporting period.	Also show date of each			
ļ	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3
02				0	3
03				0	3
)4				0	3
)5	Dec. 1 Lea Le Decessor			0] 3
	Provider to Program				
0				0	3
1				0	3
2				0	3
53					3
54 99	Subtatal (sum of lines 2 01 2 40 minus sum of lines 2 E0 2	00)			
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3. Total interim payments (sum of lines 1, 2, and 3.99) (trans			- 1	
00	27)	Ter to worksheet M-3, Time		11, 393	'
-	TO BE COMPLETED BY CONTRACTOR				
	List separately each tentative settlement payment after des	k review. Also show date of			5
	each payment. If none, write "NONE" or enter a zero. (1)	K Teview. Also show date of			`
	Program to Provider				
01				0	5
02				ol	5
03				ol	5
1	Provider to Program		•		1
50				0	5
51				0	5
52				0	5
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	Ę
	Determined net settlement amount (balance due) based on the cost report. (1)				6
)1	SETTLEMENT TO PROVIDER			632	6
)2	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			12, 025	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
00 l	Name of Contractor				l 8

Health Financial Systems	MAJOR HOSPITA	L	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC. SERVICES RENDERED TO PROGRAM BENEFICIARIES		rovider CCN: 15-0097 omponent CCN: 15-8531	From 01/01/2018	Worksheet M-5 Date/Time Prepared: 5/23/2019 3:17 pm

				5/23/2019 3: 1.	7 pm
			RHC II		
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			53, 067	1. (
2. 00	Interim payments payable on individual bills, either submitt	ed or to be submitted to		l	2.0
	the contractor for services rendered in the cost reporting p	eriod. If none, write			
	"NONE" or enter a zero				
8. 00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.0
	revision of the interim rate for the cost reporting period.				
	payment. If none, write "NONE" or enter a zero. (1)	All do dilon date of each			
	Program to Provider				1
. 01	Trogram to Trovider			0	3.
. 02				0	3.
. 03					3.
. 04					3.
. 05					3.
. 05	Provider to Program			0	3.
EΟ	Provider to Program		1	0	,
. 50					3.
. 51				0	3.
. 52				0	3.
. 53				0	3.
. 54				0	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9			0	3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transf	fer to Worksheet M-3, line		53, 067	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR		.1		_
. 00	List separately each tentative settlement payment after desk	review. Also show date of			5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		T		
. 01				0	5.
. 02				0	
. 03				0	5.
	Provider to Program		_		
. 50				0	5.
51				0	
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.
00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.
01	SETTLEMENT TO PROVIDER			25, 109	6.
. 02	SETTLEMENT TO PROGRAM			0	6.
. 00	Total Medicare program liability (see instructions)			78, 176	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
	Name of Contractor				8. (

Health Financial Systems	MAJOR HOSPITAL		In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC SERVICES RENDERED TO PROGRAM BENEFICIARIES		ider CCN: 15-0097 onent CCN: 15-8532	Peri od: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/23/2019 3:17 pm

				5/23/2019 3:1	'7 рп
			RHC III		
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
00	Total interim payments paid to hospital-based RHC/FQHC			1, 989, 986	1.
.00	Interim payments payable on individual bills, either submit			0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3
02				0	3
03				0	3
04				0	3
)5				0	3
	Provider to Program				
50				0	3
51				0	3
2				0	3
53				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		1, 989, 986	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	k review. Also show date of	f		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	5
)2				0	5
)3				0	5
	Provider to Program				
50				0	5
51				0	5
52				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)				6
)1	SETTLEMENT TO PROVIDER			1, 065, 122	6
02	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			3, 055, 108	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	