payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1334 Period: From 01/01/2018 To 12/31/2018 Worksheet S Parts I-III Date/Time Prepared: 5/30/2019 11: 32 am

				10 12/01/2010	5/30/2019 1	
PART I - COST	REPORT STATUS			<u>'</u>		
Provi der	1. [X] El ectroni call y	•		Date: 5/30/20	19 Time:	11: 32 an
use only	2. [] Manually submit	ted cost report				
	3. [0] If this is an a 4. [F] Medicare Utiliz		ne provider re	esubmitted this c	ost report	
Contractor use only		7. Contractor No. Audit 8. [N] Initial	11. C /ider CCN 12. [PR Date: contractor's Vendo 0]If line 5, co number of tim	olumn 1 is 4:	

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 SCOTT MEMORIAL HOSPITAL (15-1334) 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

			Ti tle 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	284, 081	-13, 353	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	38, 015	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		64, 376		0	10.00
200.00	Total	0	322, 096	51, 023	0	0	200. 00

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

	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	11001	uei cc	:N: 15-1334	Period: From 01/01 To 12/31		Part I Date/Ti	eet S-2 ime Pre	epare
	1.00	2.00		3. 00			4. 00	5/30/20	019 11:	32 ar
	Hospital and Hospital Health Care Co			3.00			4.00			
	Street: 1451 NORTH GARDNER	P0 Box:								1.
00	City: SCOTTSBURG	State: IN	Zip Cod	de: 471	70- Cou	nty: SCOTT				2.
		Component Name	CCN	CBS			1 2	nt Syst		
			Number	Numb	ber Type	Certi fi ed		, 0, or		1
		1.00	0.00	-	20 4 00	F 00	V	XVIII		-
		1.00	2.00	3.0	00 4.00	5. 00	6. 00	7. 00	8.00	
	Hospital and Hospital-Based Componen Hospital	SCOTT MEMORIAL HOSPITA	L 151334	311	40 1	07/01/1966	6 N	0	0	١,
	моsprtar Subprovider - IPF	SCOTT MEMORIAL HUSPITA	L 151334	311	40	0//01/1966) IN	0	0	3
	Subprovider – IRF				ŀ					5
	Subprovider - (Other)			1	1			1		6
		SCOTT MEMORIAL SWING	15Z334	311	40	03/21/2013	3 N	0	l N	7
U		BEDS	132334	311	40	03/21/2013) N	"	14	'
0	Swing Beds - NF	B253								8
	Hospital -Based SNF									9
	Hospi tal -Based NF			1						10
	Hospi tal -Based OLTC									11
00	Hospi tal -Based HHA			1						12
00	Separately Certified ASC									13
	Hospi tal -Based Hospi ce			1						14
		SCOTTSBURG FAMILY	158523	311	40	08/09/2017	7 N	0	0	15
	·	PRACTI CE								
	Hospital-Based Health Clinic - FQHC									16
	Hospital-Based (CMHC) I									17
	Renal Dialysis									18
00	0ther						Ц.,			19
						From		To		-
20	Cost Deporting Posted (//					1.00		2.		20
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					01/01/2	2018	12/31	/ 2018	20
<i>J</i> U	Type of control (see this fluctions)					4				21
					1. 00	2.00)	3.	00	1
	Inpatient PPS Information				1.00	2.00		J. 1		
001 002 000 000	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to "for no for the portic er October 1. (see instrequires final uncomper port settlement? (see i "for no, for the portic er 1. Enter in column 2 e cost reporting perior ic reclassification frods for delineating state olumn 1, "Y" for yes or g period prior to October 1. (see instance of the portion of the october 1. (see instance of the portion of th	this for the "for no of the cructions) ensated can struction on of the contraction of the contractions) ensate contractions (and and/or 2 sus days,	for 1. cost re ns) yes ter o reas no er as or 5	N N	N N N		N	N	222
	if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente	method used in the prio	or cost or no. cate In-s caid Medi days elig un da	State i cai d gi bl e oai d ays	Out-of State Medicaid paid days		Medicai HMO day	ys Med	other di cai d days 6.00	
00	If this provider is an IPPS hospital		0	0		0		0		24.
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	umn 2, olumn 3, d days in column t unpaid days in								

	Financial Systems SCOTT TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	MEMORIAL HO	Provider CC	N: 15-1334	Peri od:	III LIE		Form CMS- sheet S-2	
						1/2018	Part Date 5/30	: I e/Time Pre 9/2019 11:	epared
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medic HMO d	ays	Other Medi cai d days	
. 00	If this provider is an IRF, enter the in-state	1.00	2. 00	3. 00	4. 00	5. 0	0 0	6. 00	25. (
J. 00	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0	J		ural S		of Geogr	
					1. (Date	2. 00	1
	Enter your standard geographic classification (not we cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban content the effective date of the geographic reclassification is a sole community hospital (SCH), enter the	r rural. age) status r "2" for r ication in	at the end ural. If ap column 2.	l of the cos	t	2	2		26. 27. 35.
3. 00	effect in the cost reporting period.	e number or	perrous so	n Status III		(1		35.
					Begi ni			ndi ng: 2. 00	\perp
. 00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for number		JU		2.00	36.
, 00	of periods in excess of one and enter subsequent dat		r of period	le MDH etatu		(37.
.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period. .01 Is this hospital a former MDH that is eligible for the MDH transitional payment in						`			37.
accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 8.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is						38.			
	greater than 1, subscript this line for the number of enter subsequent dates.	i perrous i	n excess or	one and					
					1. (Y/N 2.00	-
. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent	er in colum nts in	me N n			N N	39.
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octono in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y					N	40.
						1. 0	_		-
	Prospective Payment System (PPS)-Capital					1.0	0 2.	00 3.00	
	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc		·			N N	N		45. 46.
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	t. L, Pt. I	II and Wkst	. L-1, Pt.	I through				
. 00 . 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals					N N	- 1		47. 48.
. 00	Is this a hospital involved in training residents in or "N" for no.	approved G	ME programs	? Enter "Y	" for yes	N			56.
. 00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is ""N", complete Wkst. D, Parts III & IV and D-2, Pt. I	r yes or "N th of this Y", complet	" for no in cost report e Worksheet	n column 1. ing period?	f column 1 Enter "Y'				57.
	If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15–1, chapter 21, §2148? If yes,	bursement f complete W	or physicia kst. D-5.		s as	N			58.
	Are costs claimed on line 100 of Worksheet A? If ye	s, complete	WKST. U-2,	Pt. I. NAHE 413.8 Y/N	5 Worksh Line		Qual	 s-Through ification erion Code	۱
9. 00									
9. 00				1. 00	2. (00		3. 00	

Health Financial Systems SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1334 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/30/2019 11:32 am Y/N IME Direct GME IME Direct GME 1.00 2.00 3. 00 4.00 5.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA Ν 0 00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 3.00 1.00 2.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62. 00	00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00					
	your hospital received HRSA PCRE funding (see instructions)					
62.01	Enter the number of FTE residents that rotated from a Teaching Health Cen-	ter (THC) into	your hospital	0.00	62. 01	
	during in this cost reporting period of HRSA THC program. (see instruction	ns)				
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this co	ost reporting p	eriod? Enter	N	63.00	
	"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through (67. (see instru	ctions)			
		Unwei ghted	Unwei ghted	Ratio (col. 1/		
		FTEs	FTEs in	(col. 1 + col.		
		Nonprovi der	Hospi tal	2))		
		Si te	·			
		1. 00	2.00	3.00		
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost r	eporting		
	period that begins on or after July 1, 2009 and before June 30, 2010.					
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0. 00	0. 000000	64.00	
	in the base year period, the number of unweighted non-primary care					
	resident FTEs attributable to rotations occurring in all nonprovider					
	settings. Enter in column 2 the number of unweighted non-primary care					
	resident FTEs that trained in your hospital. Enter in column 3 the ratio					
	of (column 1 divided by (column 1 + column 2)). (see instructions)					
			•	. '		

Health Financial Systems SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provi	der CCN: 15-1334	Peri od: From 01/01/2018		
					To 12/31/2018	B Date/Time Pre 5/30/2019 11:	
		Program Name	Program Cod	FTEs Nonprovi de	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	,
		1 00	2.00	Si te	4.00	5.00	-
65. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	3. 00 0.	4.00 00 0.0	5.00 0 0.000000	65. 00
	,,,, (55051 451.55)			Unwei ghted FTEs Nonprovi de	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
				Si te 1.00	2.00	3. 00	
	Section 5504 of the ACA Current		n Nonprovider Se	etti ngsEffecti ve	for cost report	ing periods	
66. 00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar occurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings ry care resident 3 the ratio of	i.	00 0. C	0. 000000	66. 00
		Program Name	Program Cod	de Unweighted FTEs Nonprovide Site	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	•
17.00	.	1.00	2.00	3. 00	4.00	5.00	17.00
	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			U.	OO O. C	0.000000	87.00
					1. (00 2.00 3.00	
70.00	Inpatient Psychiatric Facility F Is this facility an Inpatient Ps		PF) or does it	contain an IPE su			70. 00
	Enter "Y" for yes or "N" for no If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	of the facility have an efore November 15, 20 alumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	n approved GME t 004? Enter "Y" lity train resi (D)? Enter "Y"	eaching program ir for yes or "N" for dents in a new tea for yes or "N" for	n the most no. (see aching no.	0	71.00
75. 00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re	habilitation Facility	/ (IRF), or does	it contain an IRF	- N		75. 00
76. 00	subprovider? Enter "Y" for yes If line 75 is yes: Column 1: Did recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	l the facility have ar ling on or before Nove train residents in a er "Y" for yes or "N"	ember 15, 2004? new teaching pr for no. Column	Enter "Y" for yes ogram in accordanc 3: If column 2 is	or "N" for ce with 42 Y,	0	76. 00

alth Financial Systems SCOTT MEMORIA DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	L HOSPITAL Provider CO	N: 15-1334	Peri od: From 01/01/2018 To 12/31/2018	u of Form CMS- Worksheet S-2 Part I Date/Time Pre 5/30/2019 11:	epared:
				1. 00	
Long Term Care Hospital PPS 1.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes	and "N" for			NI NI	00.00
I. 00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.			g period? Enter	N N	80. 00 81. 00
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 6.00 Did this facility establish a new Other subprovider (exclude the facility of the facility establish and the facility establish and the facility of th				N	85. 00 86. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 7.00 Is this hospital an extended neoplastic disease care hospital and control of the c	al classified ι	under section	ı	N	87. 00
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	XI X	
			1. 00	2. 00	
Title V and XIX Services		1 111/11 6		.,	
Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	ai services? Er	iter "Y" for	Y	Y	90.0
1.00 Is this hospital reimbursed for title V and/or XIX through t			Y	Y	91.0
full or in part? Enter "Y" for yes or "N" for no in the appl 2.00 Are title XIX NF patients occupying title XVIII SNF beds (du	ual certificati			Υ	92. 0
instructions) Enter "Y" for yes or "N" for no in the applica 3.00 Does this facility operate an ICF/IID facility for purposes		NIX2 Enter	N	N	93. 0
"Y" for yes or "N" for no in the applicable column.					
applicable column.			N	N	94.0
5.00 If line 94 is "Y", enter the reduction percentage in the app 5.00 Does title V or XIX reduce operating cost? Enter "Y" for year			0. 00 N	0.00 N	95. 0 96. 0
applicable column.					
7.00 f line 96 is "Y", enter the reduction percentage in the app 3.00 Does title V or XIX follow Medicare (title XVIII) for the in			0. 00 Y	0. 00 Y	97. 0
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in				70.0
B. 01 Does title V or XIX follow Medicare (title XVIII) for the real Co., Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.	eporting of chat tle V, and in	arges on Wkst column 2 for	. Y	Y	98. 0
B.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX.			Y	Y	98. 0
3.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for year				N	98. 0
for title V, and in column 2 for title XIX. 3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH			N	N	98. 0
outpatient services cost? Enter "Y" for yes or "N" for no ir in column 2 for title XIX.	n column 1 for	title V, and			
3.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in o				Y	98. 0
column 2 for title XIX. 3.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column			Y	Y	98. 0
column 2 for title XIX. Rural Providers					-
D5. 00 Does this hospital qualify as a CAH?			Υ		105. 0
06.00 If this facility qualifies as a CAH, has it elected the all-	inclusive meth	nod of paymer			106. 0
for outpatient services? (see instructions) 07.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.	n 1. (see insti	ructions) If	N		107. 0
reimbursed. If yes complete Wkst. D-2, Pt. II. 18.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	•	o .			108. 0
is a section still riology. Enter 1 for yes or in for his.	Physi cal	Occupationa	I Speech	Respi ratory	
200 201 5 11 1 1 1 1 1 1 1	1.00	2.00	3.00	4.00	100
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	Υ	N	N	N	109. 0

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.

1.00

N

110. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provide	er CCN: 15-1334	Peri od:	Worksheet S	S-2552- -2
301 7 7 2 7 10 7 10 1 1 1 2 1 1 1 3 1 1 2 3 1 1 2 2 1 1 1 3		From 01/01/20° To 12/31/20°	18 Part I	repared
		1.00		
11.00 If this facility qualifies as a CAH, did it participate in the Frontie Health Integration Project (FCHIP) demonstration for this cost reporti "Y" for yes or "N" for no in column 1. If the response to column 1 is integration prong of the FCHIP demo in which this CAH is participating Enter all that apply: "A" for Ambulance services; "B" for additional to for tele-health services.	ing period? Enter Y, enter the g in column 2.	1.00 N	2.00	111.
		1.	00 2.00 3.0	0
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for r is yes, enter the method used (A, B, or E only) in column 2. If column 3 either "93" percent for short term hospital or "98" percent for long psychiatric, rehabilitation and long term hospitals providers) based of Pub. 15-1, chapter 22, §2208.1.	n 2 is "E", enter g term care (incl on the definition	r in column udes n in CMS	N O	
16.00 s this facility classified as a referral center? Enter "Y" for yes or 17.00 s this facility legally-required to carry malpractice insurance? Enter no.			N N	116. 117.
18. 00 Is the malpractice insurance a claims-made or occurrence policy? Enter claim-made. Enter 2 if the policy is occurrence.	r 1 if the policy	/is	1	118.
jordi ili ilidadi. Elitor E vi vilo porvoj vo ocodi volico.	Premi ums	Losses	Insurance	
	1. 00	2.00	3. 00	
18.01 List amounts of malpractice premiums and paid losses:	113, 9	909	0	0 118.
		1. 00	2.00	
18.02 Are malpractice premiums and paid losses reported in a cost center off Administrative and General? If yes, submit supporting schedule listing and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)	provision in ACA, "Y" for yes or the Outpatient		N	118. 119. 120.
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable dev	vices charged to	Υ		121.
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §' Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", & the Worksheet A line number where these taxes are included.				122.
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and	"N" for no. If	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter the co	ertification date	9		126.
in column 1 and termination date, if applicable, in column 2. [7.00] If this is a Medicare certified heart transplant center, enter the cer in column 1 and termination date, if applicable, in column 2.	rtification date			127.
18.00 f this is a Medicare certified liver transplant center, enter the cer in column 1 and termination date, if applicable, in column 2.	rtification date			128.
9.00 If this is a Medicare certified lung transplant center, enter the certicolumn 1 and termination date, if applicable, in column 2.	tification date i	n		129
0.00 If this is a Medicare certified pancreas transplant center, enter the date in column 1 and termination date, if applicable, in column 2.				130
1.00 If this is a Medicare certified intestinal transplant center, enter the date in column 1 and termination date, if applicable, in column 2.				131.
2.00 f this is a Medicare certified islet transplant center, enter the cer in column 1 and termination date, if applicable, in column 2.				132.
3.00 If this is a Medicare certified other transplant center, enter the cer in column 1 and termination date, if applicable, in column 2. 4.00 If this is an organ procurement organization (0P0), enter the 0P0 numbers.				133.
and termination date, if applicable, in column 2. All Providers				
40.00 Are there any related organization or home office costs as defined in chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and h		Y	44H097	140.

SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1334 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 To 5/30/2019 11:32 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141.00 Name: LIFEPOINT HEALTH INC. Contractor's Name: PALMETTO GBA Contractor's Number: 10001 141. 00 142.00 Street: PO BOX 100307 PO Box: 142. 00 143.00 City: COLUMBIA State: Zip Code: 29202 143. 00 1.00

144.00 Are provider based physicians' costs included in Worksheet	A?			Y	144. 00
			1. 00	2.00	
145.00 If costs for renal services are claimed on Wkst. A, line 74	, are the costs	s for			145. 00
inpatient services only? Enter "Y" for yes or "N" for no in	column 1. If o	column 1 is			
no, does the dialysis facility include Medicare utilization	for this cost	reporting			
period? Enter "Y" for yes or "N" for no in column 2.					
146.00 Has the cost allocation methodology changed from the previously filed cost report?					146. 00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If					
yes, enter the approval date (mm/dd/yyyy) in column 2.					
				1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for	N	147. 00			
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					148. 00
149.00 Was there a change to the simplified cost finding method? E	N	149. 00			
	Part A	Part B	Title V	Title XIX	
	1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an					
or charges? Enter "Y" for yes or "N" for no for each compon	ent for Part A	and Part B. (S			4
155. 00 Hospi tal	Υ	Y	N	N	155. 00
156. 00 Subprovi der – TPF	N	N	N	N	156. 00
157. 00 Subprovi der - IRF	N	N	N	N	157. 00
158. 00 SUBPROVI DER					158. 00
159. 00 SNF	N	N	N	N	159. 00
160.00 HOME HEALTH AGENCY	N	N	N	N	160. 00
161. 00 CMHC		N	N	N	161. 00
				1.00	
Mul ti campus					

Multicampus 165. 00 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 2.00 5.00 0 1.00 3.00 4.00 166.00 If line 165 is yes, for each 0. 00 166. 00 campus enter the name in column 0, county in column 1, state in

column 5 (see instructions)							
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00 Is this provider a meaningful user	under §1886(n)? En	ter "Y" for yes or "N'	' for no).		Y	167. 00
168.00 If this provider is a CAH (line 10	05 is "Y") and is a me	eaningful user (line 1	167 is "	Y"), enter	the		168. 00
reasonable cost incurred for the H	HIT assets (see instru	uctions)					
168.01 If this provider is a CAH and is r	not a meaningful user,	, does this provider o	qual i fy	for a hards	shi p		168. 01
exception under §413.70(a)(6)(ii)?							
169.00 If this provider is a meaningful u	user (line 167 is "Y")) and is not a CAH (li	ne 105	is "N"), e	nter the	0. 0	169. 00
transition factor. (see instruction	ons)						

transition ractor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting	01/01/2018	03/31/2018	170. 00
period respectively (mm/dd/yyyy)			
	1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N	0	171. 00
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, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

column 2, zip code in column 3, CBSA in column 4, FTE/Campus in Health Financial Systems SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1334 Peri od: Worksheet S-2 From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/30/2019 11:32 am Date 1. 00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1. 00 2. 00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 12/31/2018 4.00 Υ Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 N 7 00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the N 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 N 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data Was the cost report prepared using $\overline{\text{the PS\&R Report onl y?}}$ 04/25/2019 04/25/2019 16.00 Υ 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for Ν N 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R 19.00 N N

Report data for corrections of other PS&R Report

information? If yes, see instructions.

OSPI I	Financial Systems SCOTT MEMORIA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1334	Peri od: From 01/01/2018 To 12/31/2018	w of Form Cl Worksheet Part II Date/Time 5/30/2019	S-2 Prepared
		Descri	pti on	Y/N	Y/N	11102 011
		(1. 00	3. 00	
0. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 0
	neport data for other: bescribe the other adjustments.	Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4. 00	
1. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. (
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	PT CHILDRENS H	OSPI TALS)		11.00	
	Capital Related Cost					
2. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22.
8. 00	Have changes occurred in the Medicare depreciation expense of reporting period? If yes, see instructions.	due to apprais	als made dur	ring the cost	N	23.
1. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	d into during	this cost re	eporting period?	N	24.
. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	Plf yes, see	N	25.
5. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	e cost reporti	ng period? I	f yes, see	N	26.
7. 00	instructions. Has the provider's capitalization policy changed during the	cost reportin	g period? If	yes, submit	N	27.
	Interest Expense					
. 00	Were new loans, mortgage agreements or letters of credit enperiod? If yes, see instructions.	tered into dur	ing the cost	reporting	N	28.
. 00	Did the provider have a funded depreciation account and/or between treated as a funded depreciation account? If yes, see instru	Reserve Fund)	N	29.		
. 00	Has existing debt been replaced prior to its scheduled maturilinstructions.	s, see	N	30.		
. 00	Has debt been recalled before scheduled maturity without iss instructions.	s, see	N	31.		
. 00	Purchased Services Have changes or new agreements occurred in patient care serv	vices furnishe	d through co	ontractual	N	32.
3. 00	arrangements with suppliers of services? If yes, see instruction of services? If yes, see instruction of sec. 2135.2 appliers	ctions.	-		IV.	33.
. 00	no, see instructions. Provider-Based Physicians	Trea per tarrir	g to competi	tive bruaring: 11		
. 00	Are services furnished at the provider facility under an arr	rangement with	provi der-ba	sed physicians?	Υ	34.
. 00			ts with the	provi der-based	N	35.
	physicians during the cost reporting period? If yes, see ins	structions.		Y/N	Date	
				1.00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report?			Y		36.
. 00	If line 36 is yes, has a home office cost statement been pro	epared by the	home office?	Y		37.
. 00	1			- N		38.
. 00				s, N		39.
. 00	see instructions. If line 36 is yes, did the provider render services to the linstructions.	home office?	If yes, see	N		40.
	-		00		00	
	Cost Report Preparer Contact Information	1.	00	2.	00	
. 00		CLINTON		BALLEW		41.
	respecti vel y.	LIFEPOINT HEAL	TH, INC.			42.
2. 00						- 11

Health Financial Systems	SCOTT MEMORIA	L HOSPITAL		In Lie	In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der C		Peri od:	Worksheet S-2	2	
				From 01/01/2018 To 12/31/2018	Part II Date/Time Pre	narod	
				10 12/31/2016	5/30/2019 11:		
		3.	. 00				
Cost Report Preparer Contact Information							
41.00 Enter the first name, last name and the title		REI MBURSEMENT	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						43. 00	
report preparer in columns 1 and 2, respecti	vel y.					1	

 Heal th Financial
 Systems
 SCOTT

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-1334

					To	12/31/2018	Date/Time Pre 5/30/2019 11:	
							I/P Days / 0/P	52 aiii
							Visits / Trips	
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Available	CAH Hours	Title V	
		1.00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		2.00	7, 665	70, 541. 00		1. 00
1.00	8 exclude Swing Bed, Observation Bed and	30.00		21	7,003	70, 341. 00		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	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			21	7, 665	70, 541. 00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		4	1, 460	2, 713. 00	0	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	43. 00					0	13. 00
14.00	Total (see instructions)			25	9, 125	73, 254. 00	0	14. 00
15. 00	CAH visits						0	15. 00
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
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	RURAL HEALTH CLINIC	88. 00					0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00				25				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32. 00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions)							33. 00
	LTCH non-covered days LTCH site neutral days and discharges							33. 00
33. UT	LIGHT SI LE HEULT AT MAYS AND UI SCHALGES				l l			J 33. UT

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

				''	0 12/31/2010	5/30/2019 11:	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	02 (111)
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component	II the XVIII	TI CI C XIX	Patients	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 203	372	2, 274		10.00	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)	0.05					
2.00	HMO and other (see instructions)	325	0				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4. 00 5. 00	HMO IRF Subprovider	0	U O	44.2			4. 00 5. 00
6. 00	Hospital Adults & Peds. Swing Bed SNF	416	0 11	462			6.00
7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	1, 619	383	26 2, 762			7.00
7.00	beds) (see instructions)	1,019	303	2, 702			7.00
8. 00	INTENSIVE CARE UNIT	71	30	145			8.00
9. 00	CORONARY CARE UNIT	, ,	55	110			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		98	104			13. 00
14.00	Total (see instructions)	1, 690	511	3, 011	0.00	148. 90	14. 00
15.00	CAH visits	O	o	0			15. 00
16.00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC	4 407					25. 00
26. 00	RURAL HEALTH CLINIC	1, 437	0	6, 067	0.00		26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	O O	0	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)		202	1 01/	0. 00	155. 50	27. 00
28. 00 29. 00	Observation Bed Days Ambulance Trips	0	303	1, 016			28. 00 29. 00
30.00	Employee discount days (see instruction)	٥		0			30.00
31. 00	Employee discount days (see l'istruction)			0			31.00
32. 00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 00	Total ancillary labor & delivery room		٩	0			32.00
JZ. UI	outpatient days (see instructions)			U			32.01
33. 00	LTCH non-covered days	o					33. 00
	LTCH site neutral days and discharges	0					33. 01

				j	To 12/31/2018	Date/Time Pre 5/30/2019 11:	
		Full Time Equivalents		Di sc	harges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13. 00	14.00	15. 00	
1. 00 2. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		С	411		807	1. 00 2. 00
3. 00 4. 00 5. 00 6. 00 7. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)			O ₂	0		3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 10 25. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0.00	C	41	169	807	14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00
26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00 0. 00 0. 00					26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and discharges			1			33. 00 33. 01

Heal th	Financial Systems	SCOTT MEMORI.	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 15-1334	Peri od:	Worksheet S-8	3
			Component	CCN: 15-8523	From 01/01/2018 To 12/31/2018		
					RHC I	Cost	02 dili
	·						
	01:				1.	00	
1. 00	Clinic Address and Identification Street				1465 NORTH GAR	DNED STDEET	1.00
1.00	Sti ee t		Ci	tv	State	ZIP Code	1.00
				00	2.00	3. 00	
2.00	City, State, ZIP Code, County		SCOTTSBURG		IN	47170	2. 00
						4 00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "D" for rurs	al or "II" for i	ırhan		1.00	3.00
3.00	THOSE THE BASED TUNES ONLY. DESIGNATION - EITE	ei k ioi iuia	91 01 0 101 0		nt Award	Date	3.00
					1. 00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4. 00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6. 00 7. 00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	U(d), PHS ACT)					6. 00 7. 00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9. 00
10.00			50000 5		1. 00	2.00	10.00
10. 00	Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operation	ns in column	N	C	10.00
	Tiour 5.)	Sur	nday	N	londay	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1) CLINIC		I	08: 30	17: 00	08: 30	11. 00
11.00	I CELINI C			06. 30	17.00	08. 30	11.00
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report.	d in CMS Pub. ´ umn 1. If yes,	100-04, chapter enter in colum	9, section nn 2 the	N N	C	12. 00 13. 00
				Prov	ider name	CCN number	
					1.00	2.00	
14. 00	RHC/FQHC name, CCN number	\/ (N	1 1/	20/11/1	VIV	T 1 1 10 11	14. 00
		Y/N 1.00	V 2. 00	3. 00	XI X 4. 00	Total Visits 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)		2.00	3.00	4. 00	3.00	15. 00
				unty			
0.00	0.1			00			0.00
2.00	City, State, ZIP Code, County	Tuocdov	SCOTT	esday	Thus	seday	2. 00
		Tuesday to	from	to	from	sday to	
		6.00	7. 00	8.00	9. 00	10.00	
	Facility hours of operations (1)						
11. 00	CLINIC	16: 30	08: 30	16: 30	08: 30	16: 30	11. 00

Health Financial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co		Peri od:	Worksheet S-8	
		Component		From 01/01/2018 To 12/31/2018		
				RHC I	Cost	
	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: 30	16: 30				11. 00

ハビロ	n Financial Systems SCOTT MEMORIAL HOSPITAL TAL UNCOMPENSATED AND INDIGENT CARE DATA Provider	CCN: 15-1334	Peri od:	wof Form CMS-2 Worksheet S-1				
J	TAL UNCOMPENSATED AND INDIGENT CARE DATA PROVIDER	CCN: 15-1334	From 01/01/2018		U			
			To 12/31/2018	Date/Time Pre 5/30/2019 11:				
				1. 00				
	Uncompensated and indigent care cost computation							
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by	line 202 colum	n 8)	0. 275022	1.			
	Medicaid (see instructions for each line)							
00	Net revenue from Medicaid			3, 613, 898				
00	Did you receive DSH or supplemental payments from Medicaid?	6 M!! -	-: -10	N	3			
00 00	If line 3 is yes, does line 2 include all DSH and/or supplemental payme If line 4 is no, then enter DSH and/or supplemental payments from Medic		ai d?	0	4 5			
00	Medical dicharges	.ai u		16, 591, 933				
00	Medicaid cost (line 1 times line 6)			4, 563, 147				
00	Difference between net revenue and costs for Medicaid program (line 7 m	inus sum of li	nes 2 and 5; if	949, 249	•			
	< zero then enter zero)			·				
	Children's Health Insurance Program (CHIP) (see instructions for each I	i ne)						
00	Net revenue from stand-alone CHIP			0				
. 00	g and a second s			0				
. 00	· · · · · · · · · · · · · · · · · · ·	minus lino 0:	if < zoro thon	0	11 12			
. 00	enter zero)	IIII IIUS TTTIE 7,	II < Zero then	0	'-			
	Other state or local government indigent care program (see instructions	for each line)					
. 00				0	13			
. 00	Charges for patients covered under state or local indigent care program	(Not included	in lines 6 or	0	14			
	10)			_				
. 00		<i>(</i> 1.1	45 ' ''	0				
. 00	00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 1 13; if < zero then enter zero)							
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and st instructions for each line)	ate/local indi	gent care program	ns (see				
. 00		arity care		0	17			
. 00	Government grants, appropriations or transfers for support of hospital	operati ons		0	18			
. 00	00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 949,249							
. 50	8, 12 and 16)				19.			
. 50		Uni nsured	Insured	Total (col. 1	19.			
. 50		pati ents	pati ents	+ col . 2)	19.			
. 50	8, 12 and 16)				19			
	8, 12 and 16) Uncompensated Care (see instructions for each line)	pati ents	pati ents 2.00	+ col . 2) 3.00				
	8, 12 and 16) Uncompensated Care (see instructions for each line)	pati ents	pati ents	+ col . 2) 3.00				
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions)	patients 1.00	pati ents 2.00	+ col . 2) 3.00	20			
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions)	patients 1.00	0 0 0	+ col · 2) 3.00	20 21			
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as	patients 1.00	2. 00 0 0	+ col · 2) 3.00	20 21			
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	patients 1.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	+ col · 2) 3.00 0	20 21 22			
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	patients 1.00	0 0 0	+ col · 2) 3.00 0	20 21 22			
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	patients 1.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	+ col · 2) 3.00 0	20 21 22			
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days to	patients 1.00 eeyond a Length	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	+ col. 2) 3.00 0 0 0	20 21 22 23			
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days beingosed on patients covered by Medicaid or other indigent care programs of line 24 is yes, enter the charges for patient days beyond the indigent care.	patients 1.00	patients 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 f stay limit	+ col. 2) 3.00 0 0 0 1.00	20 21 22 23			
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days to imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit	patients 1.00 eyond a length ent care progra	patients 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 f stay limit	+ col · 2) 3.00 0 0 0 0 0 0 N 0	20 21 22 23 24 25			
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indiges stay limit Total bad debt expense for the entire hospital complex (see instruction)	patients 1.00 eeyond a length ent care progra	patients 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 f stay limit	+ col. 2) 3.00 0 0 0 1.00 N 0 4,186,548	20 21 22 23 24 25 26			
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care programs If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see instruction	patients 1.00 eyond a length ent care progra	patients 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 f stay limit	+ col. 2) 3.00 0 0 0 1.00 N 0 4,186,548 428,396	20 21 22 23 24 25 26 27			
. 00 . 00 . 00 . 00 . 00 . 00 . 01	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care programs If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see instruction Medicare allowable bad debts for the entire hospital complex (see instructions)	patients 1.00 eyond a length ent care progra	patients 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 f stay limit	+ col. 2) 3.00 0 0 0 1.00 N 0 4,186,548 428,396 659,071	20 21 22 23 24 25 26 27 27			
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indige stay limit Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see in Medicare allowable bad debts for the entire hospital complex (see instruction)	patients 1.00 eyond a length ent care progra s) structions) uctions)	patients 2.00 0 0 0 0 0 0 of stay limit m's length of	+ col. 2) 3.00 0 0 0 1.00 N 4,186,548 428,396 659,071 3,527,477	20 21 22 23 24 25 26 27 27 27 28			
0. 00 . 00 2. 00 3. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days to imposed on patients covered by Medicaid or other indigent care program. If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see in Medicare allowable bad debt spense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see	patients 1.00 eyond a length ent care progra s) structions) uctions)	patients 2.00 0 0 0 0 0 0 of stay limit m's length of	+ col. 2) 3.00 0 0 0 1.00 N 0 4,186,548 428,396 659,071	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.			

Heal th	Financial Systems	SCOTT MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider Co	[Period: From 01/01/2018 Fo 12/31/2018	Worksheet A	pared:
	Cost Center Description	Sal ari es	0ther	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS		70/ 000	70, 00,	040 000	0.40, 000	4 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		726, 920 22, 241			940, 809 163, 189	1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	45, 449	1, 496, 269			1, 481, 393	4.00
5. 01	00550 INFORMATION TECH	165, 661	575, 578			741, 239	5. 01
5.02	00570 ADMI TTI NG	376, 938	206, 874			580, 722	5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	0	58, 719			58, 719	5. 03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	7// 207	401, 210	•		401, 210	5. 04
5. 05 7. 00	00590 OTHER ADMIN AND GENERAL 00700 OPERATION OF PLANT	766, 897 235, 019	2, 546, 185 719, 217			3, 036, 738 950, 898	5. 05 7. 00
9. 00	00900 HOUSEKEEPI NG	218, 900	155, 048			373, 948	9.00
10. 00	01000 DI ETARY	196, 219	186, 668			92, 939	
11. 00	01100 CAFETERI A	0	0		289, 450	289, 450	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	0) (168, 120	13. 00
14.00	01400 CENTRAL SERVI CE & SUPPLY 01500 PHARMACY	65, 616	178, 141			129, 660	14.00
15. 00 16. 00	01600 MEDI CAL RECORDS & LI BRARY	188, 927 485, 672	531, 866 132, 325			317, 648 612, 745	15. 00 16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	403, 072	132, 323	017, 77	5, 252	012, 743	10.00
30. 00	03000 ADULTS & PEDIATRICS	1, 535, 100	656, 752	2, 191, 852	-158, 205	2, 033, 647	30. 00
31. 00	03100 INTENSIVE CARE UNIT	371, 097	30, 724			410, 872	31. 00
43. 00	04300 NURSERY	0	0) (103, 731	103, 731	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	474, 619	1, 085, 214	1, 559, 83	-109, 432	1, 450, 401	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	474,019	1, 065, 214		39, 616	39, 616	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	729, 339	573, 890	1, 303, 229		1, 239, 843	54. 00
60.00	06000 LABORATORY	445, 810	605, 037	1, 050, 84	-154, 286	896, 561	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	75, 100			75, 100	63. 00
65. 00	06500 RESPIRATORY THERAPY	442, 789	120, 894			388, 634	•
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	57, 100 0	577, 042		2 -62, 034 21, 837	572, 108 21, 837	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	1	34, 735	34, 735	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0			165, 000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			114, 743	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		218, 054	218, 054	72.00
73. 00 75. 00	07300 DRUGS CHARGED TO PATIENTS 03610 SLEEP LAB	0 350	8, 869	9, 21	.02, .02	402, 762 0	73. 00 75. 00
76. 00	03020 CARDI AC REHAB	0	0, 007	, 21	0 7,217	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	74, 911	9, 680	84, 59 ⁻	9, 254	93, 845	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00 91. 00	08800 RURAL HEALTH CLINIC 09100 EMERGENCY	390, 063	165, 213	1		512, 292 1, 477, 353	88. 00 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	874, 426	565, 270	1, 439, 690	37, 657	1, 477, 333	92.00
,2.00	SPECIAL PURPOSE COST CENTERS			<u> </u>			72.00
113.00	11300 INTEREST EXPENSE		326, 309	326, 309		326, 309	
118. 00		8, 140, 902	12, 737, 255	20, 878, 15	7 38, 713	20, 916, 870	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0		ol ol	0	190. 00
	19001 MARKETING	0	89, 560			89, 560	
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 457	112				192. 00
192. 01	19201 SCOTT PHYSICIAN GROUP	0	0		o		192. 01
	07950 BUHSE CAMPUS	155, 874	67, 258			211, 145	
	07951 MEDI CAL SPECI ALTY	21, 292	125, 162	146, 45	-1, 861	144, 593	
	207952 MEDICAL OFFICE 307953 VA PROPERTY		0				194. 02 194. 03
	107954 ALREFAI CAMPUS	0	0				194. 03
	07955 ORTHO CAMPUS	237, 727	104, 535	342, 262	-24, 632	317, 630	
194. 06	07956 DR. CRAIG CLINIC	0	0		o o	0	194. 06
	07957 DR. OLABIGE CLINIC	0	412	412	-233		194. 07
	07958 URGENT CARE CLINIC	0	0				194. 08
	07959 DR. PACE 07960 SCOTTSBURG FAMILY PRACTICE (RHC)		6, 363 0	6, 36			194. 09 194. 10
200.00		8, 557, 252	13, 130, 657	21, 687, 90			
					,		'

 Health Financial
 Systems
 SCOTT MEN

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/30/2019 11:32 am Provider CCN: 15-1334

				5/30/2019 11:	
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation	1	
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS			-1	4
1.00	00100 CAP REL COSTS-BLDG & FIXT	-439, 754	501, 055		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	514, 094	677, 283	l .	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 481, 393	1	4. 00
5. 01	00550 I NFORMATI ON TECH	0	741, 239	1	5. 01
5. 02 5. 03	00570 ADMITTING	0	580, 722	1	5. 02
5. 03 5. 04	OO560 PURCHASING RECEIVING AND STORES OO580 CASHIERING/ACCOUNTS RECEIVABLE	0	58, 719 401, 210	l .	5. 03 5. 04
5. 05	00590 OTHER ADMIN AND GENERAL	-1, 194, 212	1, 842, 526		5. 05
7. 00	00700 OPERATION OF PLANT	-1, 194, 212	950, 898	l .	7. 00
9. 00	00900 HOUSEKEEPING	0	373, 948	1	9. 00
10. 00	01000 DI ETARY	0	92, 939	1	10.00
11. 00	01100 CAFETERI A	-96, 944	192, 506	l .	11. 00
13. 00	01300 NURSING ADMINISTRATION	- 70, 744	168, 120	l .	13. 00
	01400 CENTRAL SERVICE & SUPPLY	-9, 522	120, 138	l .	14. 00
	01500 PHARMACY	-7, 322	317, 648	1	15. 00
	01600 MEDICAL RECORDS & LIBRARY	-24	612, 721		16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	21	012,721		10.00
30. 00	03000 ADULTS & PEDI ATRI CS	-237, 194	1, 796, 453	3	30.00
	03100 INTENSIVE CARE UNIT	0	410, 872	l control of the cont	31.00
	04300 NURSERY	0	103, 731		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	-435, 114	1, 015, 287	<i>'</i>	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	39, 616		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-235	1, 239, 608	3	54.00
60.00	06000 LABORATORY	0	896, 561		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	75, 100)	63. 00
65. 00	06500 RESPI RATORY THERAPY	0	388, 634	1	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	572, 108	1	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	21, 837	1	67. 00
	06800 SPEECH PATHOLOGY	0	34, 735	1	68. 00
	06900 ELECTROCARDI OLOGY	0	165, 000	l .	69. 00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	114, 743	l .	71.00
	07200 DRUCS CHARGED TO PATIENTS	0	218, 054	l .	72. 00 73. 00
	07300 DRUGS CHARGED TO PATIENTS 03610 SLEEP LAB	0	402, 762 0		75.00
76. 00	03020 CARDI AC REHAB	0	0		76.00
	07697 CARDI AC REHABI LI TATI ON	0	93, 845	1	76. 00
70. 77	OUTPATIENT SERVICE COST CENTERS	0	73, 043	1	10.77
88. 00	08800 RURAL HEALTH CLINIC	0	512, 292		88. 00
	09100 EMERGENCY	-2, 791	1, 474, 562	1	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	_,	.,,		92. 00
	SPECIAL PURPOSE COST CENTERS	1			
113.00	11300 NTEREST EXPENSE	-326, 309	0		113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-2, 228, 005	18, 688, 865	i i	118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0)	190. 00
190. 01	19001 MARKETI NG	0	89, 560)	190. 01
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 569)	192. 00
	19201 SCOTT PHYSICIAN GROUP	0	0)	192. 01
	07950 BUHSE CAMPUS	0	211, 145	j	194. 00
	07951 MEDI CAL SPECI ALTY	0	144, 593	3	194. 01
	07952 MEDICAL OFFICE	0	0		194. 02
	07953 VA PROPERTY	0	0	1	194. 03
	07954 ALREFAI CAMPUS	0	0		194. 04
	07955 ORTHO CAMPUS	0	317, 630)	194. 05
	07956 DR. CRAIG CLINIC	0	0	7	194. 06
	07957 DR. OLABI GE CLI NI C	0	179	l .	194. 07
	07958 URGENT CARE CLINIC	0	0		194. 08
	07959 DR. PACE	0	6, 363		194. 09
	07960 SCOTTSBURG FAMILY PRACTICE (RHC)	2 222 225	10 450 004	1	194. 10
200.00	TOTAL (SUM OF LINES 118 through 199)	-2, 228, 005	19, 459, 904	4	200. 00

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/30/2019 11: 32 am

					5/30/2019	11:32 am
		Increases				
	Cost Center	Li ne #	Salary	0ther		
	2. 00	3. 00	4. 00	5. 00		
1 00	A - LEASES	1 00	ما	75 7/4		1 00
1.00	CAP REL COSTS BLDG & FIXT	1.00	0	75, 764		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	118, 327		2.00
3.00	CARDIAC REHABILITATION	76. 97	0	35		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00 10. 00
10.00		0.00	0	0		
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00	•	0.00	0	0		13. 00
14. 00		0.00	0	0		14. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	o	0		18. 00
19. 00		0.00	o	0		19. 00
20. 00		0.00	o	0		20. 00
21. 00		0.00	0	0		21. 00
21.00			— — ў			21.00
	B - DIRECTOR OF NURSING		<u> </u>	171, 120		
1.00	NURSING ADMINISTRATION	13.00	138, 464	10, 306		1.00
00	0		138, 464	10, 306		
	C - CORPORATE PAID BENEFITS		100/ 101/	.57 555		
1.00	OTHER ADMIN AND GENERAL	5. 05	0	38, 699		1.00
2. 00	NURSING ADMINISTRATION	13. 00	o	19, 350		2. 00
	0			58, 049		
	D - GENERAL LIABLILITY INSURA	NCE				
1.00		0.00	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22, 621		2. 00
				22, 621		
	E - CAFETERIA	<u>'</u>	<u>'</u>	• ,		
1.00	CAFETERI A	11.00	148, 335	141, 115		1. 00
	0 — — — — — —		148, 335	141, 115		
	F - NURSERY, L&D					
1.00	NURSERY	43.00	83, 383	20, 348		1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	14, 235	3, 474		2. 00
	0 — — — — — —		97, 618	23, 822		
	G - RESP THERAPY TO EKG					
1.00	ELECTROCARDI OLOGY	69.00	104, 811	28, 616		1. 00
	0		104, 811	28, 616		
	H - MED SUPPLIES, DRUGS, COGS					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	114, 743		1. 00
	PATI ENT					
2.00	CENTRAL SERVICE & SUPPLY	14. 00	0	101, 306		2. 00
3.00		0.00	0_	0		3. 00
	0		0	216, 049		
	I - COST TO CHARGE					
1. 00	INTENSIVE CARE UNIT	31. 00	2, 714	6, 337		1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52. 00	14, 676	7, 231		2. 00
3.00	LABORATORY	60.00	11, 772	4, 972		3. 00
4.00	ELECTROCARDI OLOGY	69. 00	17, 913	13, 660		4. 00
5.00	ENERGENOV.	0.00	0	0		5. 00
6. 00	EMERGENCY	<u>91.</u> 00	16, 323	22, 962		6. 00
	U PROBERTY TAY		63, 398	55, 162		_
4 00	J - PROPERTY TAX	4 00	ما	100 105		
1. 00	CAP REL COSTS-BLDG & FIXT		0	138, 125		1. 00
	L - IMPLANTS RECLASS		U _I	138, 125		
1 00		72.00	ما	210.054		1 00
1. 00	IMPL. DEV. CHARGED TO	72. 00	0	218, 054		1. 00
2.00	PATI ENTS	0.00		0		2. 00
2.00				218, 054		2.00
	M - DRUGS RECLASS		U	∠ 10, ∪∪4		
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	402, 762		1.00
2. 00	PROUS CHARGED TO PATTERITS	0.00	0	402, 762		2. 00
2.00				402, 762		2.00
	N - RECLASS SLEEP LAB COST TO) CARD REHAR	U	402, 702		
1.00	CARDI AC REHABI LI TATI ON	76. 97	350	8, 869		1.00
1.00	0		350	$\frac{8,869}{8,869}$		1.00
	1-	ı	555	0,007		1

Heal th	Financial Systems	SCOTT MEMORIAL HOSPITAL				In Lieu of Form CMS-2552-10		
RECLASS	SI FI CATI ONS			Provi der (CCN: 15-1334	Peri od: From 01/01/2018	Worksheet A-6	ò
						To 12/31/2018	Date/Time Pro 5/30/2019 11:	
		Increases		<u> </u>				
	Cost Center	Li ne #	Sal ary	0ther				

						3/30/2017 11.	. JZ aiii	
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	O - RECLASS ST COSTS FROM PT TO OT, ST							
1.00	OCCUPATI ONAL THERAPY	67.00	1	1			1. 00	
2.00	SPEECH PATHOLOGY	68.00	1	1			2. 00	
	0		2	2				
	P - PT TO ST							
1.00	SPEECH PATHOLOGY	68.00	34, 733	0			1.00	
2.00	OCCUPATI ONAL THERAPY	67.00	21, 835	0			2. 00	
	TOTALS		56, 568	0]	
500.00	Grand Total: Increases		609, 546	1, 517, 678			500.00	

RECLASSI FI CATIONS

Health Financial Systems SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1334 Peri od: Worksheet A-6 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/30/2019 11:32 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - LEASES 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 2, 276 10 1.00 0 ADMITTING 5.02 3,090 10 2.00 2.00 OTHER ADMIN AND GENERAL 5.05 0 5, 527 0 3.00 3.00 4.00 OPERATION OF PLANT 7.00 0 3, 338 0 4.00 DI ETARY 10.00 0 498 0 5.00 5.00 o 6.00 CENTRAL SERVICE & SUPPLY 14.00 2.881 0 6.00 0 PHARMACY 0 7.00 15.00 719 7.00 8.00 MEDICAL RECORDS & LIBRARY 16.00 0 5, 252 0 8.00 0 9.00 ADULTS & PEDIATRICS 30.00 8, 531 0 9.00 OPERATING ROOM 50 00 0 0 10 00 10 00 58 637 0 11.00 RADI OLOGY-DI AGNOSTI C 54.00 0 1, 396 11.00 12.00 LABORATORY 60.00 o 1, 396 0 12.00 13.00 RESPIRATORY THERAPY 65.00 0 15, 468 0 13.00 PHYSICAL THERAPY 0 0 1 792 14 00 66 00 14 00 0 16.00 RURAL HEALTH CLINIC 88.00 0 42, 984 16.00 17.00 EMERGENCY 91.00 o 1,628 0 17.00 194.00 18.00 BUHSE CAMPUS 0 11, 987 0 18.00 MEDICAL SPECIALTY 0 1, 861 194.01 0 19.00 19 00 20.00 ORTHO CAMPUS 194.05 0 24, 632 0 20.00 21.00 DR. OLABIGE CLINIC 194.07 233 0 21.00 ō 194, 126 DIRECTOR OF NURSING OTHER ADMIN AND GENERAL 10, 306 1.00 5.05 138, 464 0 1.00 138, 464 10, 306 - CORPORATE PAID BENEFITS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 58, 049 0 1.00 2.00 0.00 0 0 2.00 58, 049 D - GENERAL LIABLILITY INSURANCE 1.00 0.00 0 0 1.00 2.00 OTHER ADMIN AND GENERAL 5.05 o 22, 621 2.00 12 0 22, 621 - CAFETERIA 148, 335 141, 115 1.00 DI ETARY 10.00 0 1.00 148, 335 141<u>, 115</u> NURSERY, L&D 1.00 ADULTS & PEDIATRICS 30.00 97, 618 23, 822 0 1.00 2.00 0.00 0 2.00 97, 618 23, 822 G - RESP THERAPY TO EKG 1.00 RESPIRATORY THERAPY 65.00 104, 811 28, 616 0 1.00 104, 811 28, 616 H - MED SUPPLIES, DRUGS. RADI OLOGY-DI AGNOSTI C 1.00 54.00 30.417 0 1.00 2.00 LABORATORY 60.00 o 169, 634 0 2.00 3.00 RESPIRATORY THERAPY 65.00 15, 998 0 3.00 0 216, 049 - COST TO CHARGE 1.00 ADULTS & PEDIATRICS 30.00 23, 943 4, 291 0 1.00 OPERATING ROOM 13.306 31, 957 2 00 50 00 O 2 00 0 3.00 RADI OLOGY-DI AGNOSTI C 54.00 17, 913 13, 660 3.00 4.00 0.00 0 4.00 5.00 RESPIRATORY THERAPY 65.00 7,706 2, 450 0 5.00 PHYSICAL THERAPY 66. 00 6 00 530 2.804 0 6.00 63, 398 55, 162

138, 125

138, 125

212, 522

218.054

402, 426

402, 762

8, 869

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1.00

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14. 00

50.00

15.00

66.00

75. 00

66.00

0.00

- PROPERTY TAX

OPERATING ROOM

PHYSICAL THERAPY

PHYSI CAL THERAPY

PHARMACY

SLEEP LAB

OTHER ADMIN AND GENERAL

- IMPLANTS RECLASS

DRUGS RECLASS

CENTRAL SERVICE & SUPPLY

N - RECLASS SLEEP LAB COST TO CARD REHAB

O - RECLASS ST COSTS FROM PT TO OT,

1.00

1.00

2.00

1.00

2.00

1.00

1.00

2.00

Health Financial Systems SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-1334 Period: Worksheet A-6
From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/30/2019 11: 32 am

						12, 01, 2010	5/30/2019 11:	
		Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref	°.		
	6. 00	7.00	8. 00	9. 00	10. 00			
	P - PT TO ST							
1.00	PHYSI CAL THERAPY	66.00	56, 568	0		0		1. 00
2.00		0.00	0	0		0		2. 00
	TOTALS		56, 568	0				
500.00	Grand Total: Decreases		609, 546	1, 517, 678				500.00
2.00	TOTALS — — — —		0 56, 568	0 0 0 1, 517, 678		0 0		2.00

| Period: | Worksheet A-7 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared:

				To	12/31/2018	Date/Time Pre 5/30/2019 11:	
				Acqui si ti ons		3/30/2019 11.	32 alli
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances	r ur chases	Donation	Total	Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	840, 000	0	0	0	0	1.00
2.00	Land Improvements	444, 683	0	0	0	0	2. 00
3.00	Buildings and Fixtures	3, 056, 164	0	0	0	0	3. 00
4.00	Building Improvements	290, 433	21, 516	0	21, 516	0	4. 00
5.00	Fi xed Equi pment	1, 454, 071	54, 047	0	54, 047	0	5. 00
6.00	Movable Equipment	2, 624, 504	1, 132, 771	0	1, 132, 771	0	6. 00
7.00	HIT designated Assets	1, 345, 381	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	10, 055, 236	1, 208, 334	0	1, 208, 334	0	8. 00
9.00	Reconciling Items	11, 674	-102, 069	0	-102, 069	0	9. 00
10.00	Total (line 8 minus line 9)	10, 043, 562	1, 310, 403	0	1, 310, 403	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	840, 000	0				1. 00
2.00	Land Improvements	444, 683	0				2. 00
3.00	Buildings and Fixtures	3, 056, 164	0				3. 00
4.00	Building Improvements	311, 949	0				4. 00
5.00	Fixed Equipment	1, 508, 118	0				5. 00
6.00	Movable Equipment	3, 757, 275	0				6. 00
7.00	HIT designated Assets	1, 345, 381	0				7. 00
8.00	Subtotal (sum of lines 1-7)	11, 263, 570	0				8. 00
9.00	Reconciling Items	-90, 395	0				9. 00
10. 00	Total (line 8 minus line 9)	11, 353, 965	0				10.00

Health Financial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 15-1334	Peri od:	Worksheet A-7	
				From 01/01/2018		nonod.
				To 12/31/2018	Date/Time Pre 5/30/2019 11:	
			SUMMARY OF CAF	PITAL	10,00,201, 111	<u> </u>
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK			and 2			1
1.00 CAP REL COSTS-BLDG & FLXT	726, 920		0	0	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	22, 241		0	0 0	0	2. 00
3.00 Total (sum of lines 1-2)	749, 161		0	0 0	0	3. 00
	SUMMARY O	F CAPITAL				
	0.11	T 1 1 (1) (_			
Cost Center Description		Total (1) (su	ım			
	Capi tal -Relate					
	d Costs (see	through 14)				
	instructions) 14.00	15. 00	_			
PART II - RECONCILIATION OF AMOUNTS FROM WORK			and 2			
1.00 CAP REL COSTS-BLDG & FLXT	O COLUM	726, 92				1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	22, 24	1			2.00
3.00 Total (sum of lines 1-2)		749, 16	1			3.00
5. 55 15 tal (5am 51 11165 1 2)	١	1 747, 10	' '			0.00

Health Financial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part III Date/Time Pre	pared:	
	COME	 PUTATION OF RAT	TLOS	ALLOCATION OF	5/30/2019 11:	32 am	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance		
		Leases	for Ratio	instructions)			
			2)				
	1.00	2.00	3.00	4. 00	5. 00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00 CAP REL COSTS-BLDG & FLXT	0	0		0 1.000000	0	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0.000000		2.00	
3.00 Total (sum of lines 1-2)	0	U ON OF OTHER	CADLTAL	0 1.000000		3. 00	
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease		
		Capi tal -Relate					
		d Costs	through 7)				
DART III DECONOLILIATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10. 00		
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 CAP REL COSTS-BLDG & FIXT	ENTERS	0		0 287, 166	75, 764	1. 00	
2.00 CAP REL COSTS-BLDG & FIXT	0	0		0 536, 335		2. 00	
3.00 Total (sum of lines 1-2)	0	0		0 823, 501	194, 091	3. 00	
or or interest (same or interest in 2)	3	Sl	JMMARY OF CAPI		171,071	0.00	
Cost Center Description	Interest	Insurance (see			Total (2) (sum		
		instructions)	instructions	Capi tal -Rel ate			
				d Costs (see instructions)	through 14)		
	11.00	12.00	13. 00	14. 00	15. 00		
PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	10.00	11.00	10.00		
1.00 CAP REL COSTS-BLDG & FIXT	0	0	138, 12	5 0	501, 055	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	0	22, 621		0 0	677, 283	2.00	
3.00 Total (sum of lines 1-2)	0	22, 621	138, 12	5 0	1, 178, 338	3. 00	

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 15-1334 Peri od: Worksheet A-8 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					o 12/31/2018	Date/Time Prep 5/30/2019 11:3	
				Expense Classification on	Worksheet A	373072017 11.	32 aiii
				To/From Which the Amount is			
	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		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		O	NEE 30313 MVBEE EQ311	2.00	Ŭ	2.00
3.00	Investment income - other		0		0.00	0	3.00
	(chapter 2)						
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5. 00	Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by		0		0.00	0	6. 00
7.00	suppliers (chapter 8)		0		0.00		7 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
	21)						
8.00	Television and radio service		0		0.00	0	8. 00
	(chapter 21)						
9.00	Parking lot (chapter 21)	1	0		0.00	0	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-670, 864			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
	(chapter 23)						
12.00	Related organization	A-8-1	-314, 062			0	12.00
12.00	transactions (chapter 10)		0		0.00		12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	B B	-06 044	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee		- 70, 744	CALLIERIA	0.00	0	15. 00
	and others						
16. 00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than						
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
17.00	patients		O		0.00	Ŭ	17.00
18. 00	Sale of medical records and	В	-24	MEDICAL RECORDS & LIBRARY	16. 00	0	18.00
40.00	abstracts				0.00		40.00
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
	books, etc.)						
20.00	Vendi ng machi nes	В	-1, 129	OTHER ADMIN AND GENERAL	5. 05	0	20.00
21. 00	Income from imposition of		0		0.00	0	21. 00
	interest, finance or penalty						
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to		0		0.00		22.00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	Λ	 PHYSICAL THERAPY	66.00		24. 00
_ 1. 00	therapy costs in excess of		O		00.00		_ /. 50
	limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	(Chapter 21) Depreciation - CAP REL	A	-439 754	CAP REL COSTS-BLDG & FIXT	1.00	9	26. 00
_5.00	COSTS-BLDG & FLXT	, ,	.57, 754			[_3. 50
27. 00	Depreciation - CAP REL	A	528, 359	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
20.00	COSTS-MVBLE EQUIP		_	*** Coot Ct D	40.00		20.00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	67. 00	- 1	29. 00 30. 00
20.00	therapy costs in excess of		O				23. 50
	limitation (chapter 14)]					
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	^	SPEECH PATHOLOGY	68. 00		31. 00
51.00	pathology costs in excess of	N-0-2	0	OLEGII I ATTIOLOGI	00.00		J 1. UU
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
33 00	Depreciation and Interest MISC INCOME	В	10 101	OTHER ADMIN AND GENERAL	5. 05		33. 00
JS. UU	INI SC I NCOME	l D	- 10, 181	OTHER ADMIN AND GENERAL	5.05	ı ^U	JJ. UU

From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

					0 12/31/2018	5/30/2019 11:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
		D 1 (0 1 (0)			1 "		
	Cost Center Description			Cost Center		Wkst. A-7 Ref.	
	TANDLANA DROUGED TAY	1.00	2.00	3.00	4. 00	5. 00	00.01
33. 01	INDIANA PROVIDER TAX	A	-1, 202, 162	OTHER ADMIN AND GENERAL	5. 05		00.0.
33. 02	OTHER ADJUSTMENTS (SPECIFY)	A	0		0.00	0	33. 02
33. 03	(3) DEPRECIATION ON HITECH ASSETS		14 2/5	 CAP REL COSTS-MVBLE EQUIP	2.00		33. 03
		A	-14, 200	CAP REL CUSTS-MVBLE EQUIP		9	
33. 04	OTHER ADJUSTMENTS (SPECIFY) (3)		Ü		0.00	0	33. 04
34.00	PHYSICIAN RECRUITING	A	-20	OTHER ADMIN AND GENERAL	5. 05	0	34.00
34.01	CONTRI BUTI ONS	A	-390	OTHER ADMIN AND GENERAL	5. 05	0	34. 01
36.00	LOBBYING EXP IN ASSOC DUES	A	-2, 088	OTHER ADMIN AND GENERAL	5. 05	0	36. 00
37.00	LOST CHARGES	A	-11	CENTRAL SERVICE & SUPPLY	14.00	0	37. 00
37. 01	LOST CHARGES	A	-1, 444	ADULTS & PEDIATRICS	30.00	0	37. 01
37. 02	LOST CHARGES	A	-235	RADI OLOGY-DI AGNOSTI C	54.00	0	37. 02
37. 03	LOST CHARGES	A	-2, 791	EMERGENCY	91.00	0	37. 03
37.04	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	37. 04
	(3)						
37. 05	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	37. 05
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		-2, 228, 005				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

 ⁽¹⁾ bescription - an enapter references in this column pertain to chis
 (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.

OFFICE COSTS

From 01/01/2018 | Date/Time Prepared:

Li ne No.	Cost Center	Expense Items	Amount of	Amount				
			Allowable Cost	Included in	ĺ			
				Wks. A, column				
				5				
1. 00	2. 00	3. 00	4. 00	5. 00				
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED								
HOME OFFICE COSTS:								
113. 00	INTEREST EXPENSE	HOME OFFICE INTEREST	0	326, 309	1. 00			
5. 05	OTHER ADMIN AND GENERAL	MALPRACTICE INS EXPENSE	17, 591	113, 909	2. 00			
5. 05	OTHER ADMIN AND GENERAL	MANAGEMENT FEES	762, 638	612, 860	3. 00			
5. 05	OTHER ADMIN AND GENERAL	HOME OFFICE PAYROLL TAXES	-31, 702	0	4.00			
14. 00	CENTRAL SERVICE & SUPPLY	HPG COST	7, 169	16, 680	4. 01			
TOTALS (sum of lines 1-4).			755, 696	1, 069, 758	5. 00			
Transfer column 6, line 5 to					1			
Worksheet A-8, column 2,					1			
line 12.								
	1.00 A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS: 113.00 5.05 5.05 14.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	1. 00 2. 00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF HOME OFFICE COSTS: 113. 00 INTEREST EXPENSE 5. 05 OTHER ADMIN AND GENERAL 5. 05 OTHER ADMIN AND GENERAL 5. 05 OTHER ADMIN AND GENERAL 14. 00 CENTRAL SERVICE & SUPPLY TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	Line No. Cost Center Expense I tems 1.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED OR HOME OFFICE COSTS: 113.00 INTEREST EXPENSE 5.05 OTHER ADMIN AND GENERAL TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	Line No. Cost Center Expense I tems Amount of Allowable Cost 1.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR HOME OFFICE COSTS: 113.00 INTEREST EXPENSE 5.05 OTHER ADMIN AND GENERAL 6.05 OTHER ADMIN AND GENERAL 762,638 HOME OFFICE INTEREST 762,638 HOME OFFICE PAYROLL TAXES 762,638 HOME OFFICE PAYROLL TAXES 7631,702 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	Li ne No. Cost Center Expense I tems Amount of All owable Cost I cluded in Wks. A, column 5 1.00 2.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 113.00 INTEREST EXPENSE FOR SO OTHER ADMIN AND GENERAL MALPRACTICE INSEXPENSE FOR OTHER ADMIN AND GENERAL FOR SO OTHER ADMIN ADDRESS OF THE ADMIN AND GENERAL FOR SO OTHER ADMIN ADDRESS OT			

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

1103 110	nds not been posted to worksheet A, cordinas i and/or 2, the amount arrowable should be indicated in cordina 4 or 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

i ci ilibai	Schieffe drider tritle Aviii.		
6.00	В	0. 00 LI FEPOI NT HOSP 100. 00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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

Heal th	Financial Syste	ems		SCOTT MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	N RELATED ORGANIZAT	TIONS AND HOME	Provi der C	CN: 15-1334	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS						From 01/01/2018		
							To 12/31/2018	Date/Time Pre	
								5/30/2019 11:	32 am
	Net	Wkst. A-7 Ref							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUS	TMENTS REQUIRED AS	A RESULT OF TRA	ANSACTIONS W	TH RELATED C	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:							
1.00	-326, 309	1	1						1. 00
2.00	-96, 318	1	2						2. 00
3.00	149, 778		o						3. 00
4 00	-31 702								4 00

-314, 062 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

4. 01

5 00

1100 110 0	book postou to normanost //	cordinate i diagraf 27 the dimedite divender o chedita so that dated in cordinat i of this parti	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	3.		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6. 00	HOSP MANAGEMENT	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
9. 00 10. 00 100. 00		100.00

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

0

4.01

5.00

-9, 511

- 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 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 provi der.

							10 12/31/2018	5/30/2019 11:	epared: 32 am
	Wkst. A Line #	Cos	st Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
			I denti fi er	Remuneration	Component	Component	1102 711104111	ider Component	
								Hours	
	1. 00		2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	50.00	DR. A		544, 466	435, 114	109, 352	C	0	1. 00
2.00	30. 00	DR. B		235, 750	235, 750	0	C	0	2. 00
3.00	0.00			0	0	0	C	0	3. 00
4.00	0.00			0	0	0	C	0	4. 00
5.00	0. 00			0	0	0	C	0	5. 00
6.00	0.00			0	0	0	C	0	6. 00
7.00	0.00			0	0	0	C	0	
8. 00	0. 00	4		0	0	0	[C	0	
9. 00	0. 00			0	0	0	C	0	
10. 00	0. 00			0	0	0	C	0	
200.00				780, 216				0	
	Wkst. A Line #	Cos	st Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
			I denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
					Limit	Continuing	Share of col.	Insurance	
	1. 00		2. 00	8.00	9. 00	Education	12 13. 00	14.00	
1. 00		DR. A	2.00	8.00		12.00			1. 00
2. 00		DR. B					-		
3. 00	0.00				0	0			
4. 00	0.00					0			
5. 00	0.00				0	0			
6. 00	0.00			0	0	0			
7. 00	0. 00			0	0	0		ol o	1
8. 00	0.00			0	0	0			
9. 00	0. 00			0	0	0			
10. 00	0.00			l o	Ö	0	l c	ol o	1
200.00				l o	l o	0	l c	ol o	
	Wkst. A Line #	Cos	st Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
			Identi fi er	Component	Limit	Di sal I owance			
				Share of col.					
				14					
	1. 00		2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		DR. A		0	0	_			1. 00
2.00		DR. B		0		0	200,,00	1	2. 00
3.00	0. 00			0	0	0	C)	3. 00
4. 00	0. 00			0	0	0	C)	4. 00
5.00	0.00			0	0	_	0	2	5. 00
6.00	0.00			0	0	_		2	6. 00
7.00	0.00			0	0	_		2	7. 00
8.00	0.00			0	0	_			8. 00
9.00	0.00			0	-	_			9.00
10.00	0. 00	1			0	_	(70.0(4	1	10.00
200. 00	I	I		0	0	0	670, 864	1	200. 00

Health Financial Systems	SCOTT MEMORIAL F	HOSPI TAL		In Li∈	eu of Form CMS-2	2552-10
REASONABLE COST DETERMINATION FOR THE OUTSIDE SUPPLIERS	ERAPY SERVICES FURNISHED BY	Provi der	CCN: 15-1334	Peri od: From 01/01/2018 To 12/31/2018	Worksheet A-8 Parts I-VI Date/Time Pre 5/30/2019 11:	pared:
				Physical Therapy		

				Ph	ysical Therapy	5/30/2019 11: Cost	32 am_	
				,	ye. eae. ap y	1. 00		
	PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides	s) (see instruc	tions)			0		
2. 00 3. 00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis	netrueti one)	0	2. 00 3. 00				
4. 00	Number of unduplicated days in which therapy		0	4. 00				
F 00	nor therapist was on provider site (see instr		!				F 00	
5. 00 6. 00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera				therapy	0	5. 00 6. 00	
	assistant and on which supervisor and/or the					_		
7. 00	instructions) Standard travel expense rate					0. 00	7. 00	
8. 00	Optional travel expense rate per mile					0.00		
		Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees		
9. 00	Total hours worked	1. 00 1, 766. 00	2. 00 6, 318. 00	3. 00 910. 00	4. 00 2, 106. 00	5. 00 0. 00	9. 00	
10.00	AHSEA (see instructions)	84. 74	82. 61	27. 64	41. 45	0. 00	10. 00	
11. 00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	41. 31	41. 31	13. 82			11. 00	
	one-half of column 3, line 10)							
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12. 01 13. 00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0				12. 01 13. 00	
13. 01	Number of miles driven (offsite)	Ö	0				13. 01	
						1. 00		
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00		
14.00	Supervisors (column 1, line 9 times column 1,					149, 651		
15. 00 16. 00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					521, 930 25, 152		
17. 00	Subtotal allowance amount (sum of lines 14 am	,	ratory therapy	or lines 14-16	for all	696, 733		
18. 00	others) Aides (column 4, line 9 times column 4, line	10)				87, 294	18. 00	
19. 00	Trainees (column 5, line 9 times column 5, li	•				07, 274	19. 00	
20. 00	Total allowance amount (sum of lines 17-19 for					784, 027	20. 00	
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than							
	the amount from line 20. Otherwise complete							
21. 00	Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3,	and 2, line 9	0.00	21. 00				
22. 00	Weighted allowance excluding aides and traine		0					
23. 00	Total salary equivalency (see instructions)	NED SITE	784, 027	23. 00				
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE Standard Travel Allowance							
24. 00	Therapists (line 3 times column 2, line 11)					0		
25. 00 26. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	ll others)		0	25. 00 26. 00	
27. 00	Standard travel expense (line 7 times line 3				nd 4 for all	0		
28 00	others) Total standard travel allowance and standard	travel expense	at the provid	er site (sum of	lines 26 and	0	28. 00	
20.00	27)		at the provid	cr srte (sum or	TTTICS 20 drid	0	20.00	
20.00	Optional Travel Allowance and Optional Travel		d 2 Line 12)			0	20.00	
29. 00 30. 00	Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,		u z, iine iz)			0		
31. 00	Subtotal (line 29 for respiratory therapy or	sum of lines 2		,		0	31. 00	
32. 00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s 1 and 2, line	13 for respir	atory therapy o	r sum of	0	32. 00	
33. 00	Standard travel allowance and standard travel	l expense (line	28)			0	33. 00	
34.00	Optional travel allowance and standard travel					0	34.00	
35. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				FS OUTSLDE PRO	OVIDER SLITE	35. 00	
	Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)					0		
37. 00 38. 00	Subtotal (sum of lines 36 and 37)					0		
39. 00	Standard travel expense (line 7 times the sur		d 6)			0	39. 00	
40. 00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0		2 line 10)			0	40. 00	
41. 00	Assistants (column 3, line 12.01 times column		_,ic 10)			0		
42.00	Subtotal (sum of lines 40 and 41)		0 1: 40 64			0		
43. 00	Optional travel expense (line 8 times the sur Total Travel Allowance and Travel Expense - 0	m от согиmns 1-: Offsite Service	s, rine 13.01) s: Complete on	e of the follow	ina three line	0 es 44, 45,	43. 00	
	or 46, as appropriate.							
44. 00 45. 00	Standard travel allowance and standard travel Optional travel allowance and standard travel						44. 00 45. 00	
	Toper onal travel arrowance and Standard travel	- CAPCIISE (Sull)	or rines 57 dil	G 12 300 11131	1 40 (1 0113)	·		

Health Financial Systems SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY Provider CCN: 15-1334 Peri od: Worksheet A-8-3 From 01/01/2018 Parts I-VI OUTSIDE SUPPLIERS Date/Time Prepared: 5/30/2019 11: 32 am 12/31/2018 Physical Therapy Cost 1.00 46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions) 0 46.00 Therapi sts Assi stants Ai des Total 3.00 5.00 2.00 PART V - OVERTIME COMPUTATION Overtime hours worked during reporting 47.00 0.00 0.00 0.00 0.00 0.00 47.00 period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56) 48.00 Overtime rate (see instructions) 0.00 0.00 0.00 0.00 48.00 49.00 Total overtime (including base and overtime 0.00 0.00 0.00 0.00 49.00 allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT 50.00 0 00 0 00 0 00 50 00 Percentage of overtime hours by category 0 00 0 00 (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 51.00 Allocation of provider's standard work year 0.00 0.00 0.00 0.00 0.00 51.00 for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount 82.61 27.64 41. 45 0.00 52.00 (see instructions) 53.00 Overtime cost limitation (line 51 times line 0 0 0 53.00 52) 54.00 Maximum overtime cost (enter the lesser of 0 54.00 0 C 0 line 49 or line 53) 55.00 Portion of overtime already included in 0 \mathcal{C} 0 55.00 hourly computation at the AHSEA (multiply line 47 times line 52) Overtime allowance (line 54 minus line 55 -0 56, 00 0 0 0 56, 00 if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.) 1.00 Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT Salary equivalency amount (from line 23) 784, 027 57.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 58.00 58.00 0 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 59 00 59 00 0 60.00 Overtime allowance (from column 5, line 56) 0 60.00 61.00 Equipment cost (see instructions) 0 61.00 62.00 Supplies (see instructions) 62.00 0 784, 027 63.00 Total allowance (sum of lines 57-62) 63 00 Total cost of outside supplier services (from your records) 546, 414 64.00 64.00 65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) 65.00 LINE 33 CALCULATION 100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 0 100. 00 100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 0 100. 01 100.02 Line 33 = line 28 = sum of lines 26 and 27 0 100.02 LINE 34 CALCULATION

0 101, 00

0 101. 01

0 101.02

0 102. 00

0 102. 01

0 102.02

101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others

102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line

101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others

102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others

101.02 Line 34 = sum of lines 27 and 31

102.02 Line 35 = sum of lines 31 and 32

LINE 35 CALCULATION

13 for all others

Health Financial Systems		SCOTT MEMORIA	AL HOSPITAL	In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS			Provi der CC	F	eriod: rom 01/01/2018 o 12/31/2018	Worksheet B Part I Date/Time Pre	pared:
			CAPI TAL REI	ATED COSTS		5/30/2019 11:	32 am
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	I NFORMATI ON	
		for Cost			BENEFI TS	TECH	
		Allocation (from Wkst A			DEPARTMENT		
		col. 7)					
	T	0	1. 00	2. 00	4. 00	5. 01	
1 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT	E01 0EE	501, 055				1 00
1. 00 2. 00	00200 CAP REL COSTS-BLDG & FIXT	501, 055 677, 283		677, 283			1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 481, 393		077, 203			4. 00
5. 01	00550 I NFORMATION TECH	741, 239		4, 918		777, 894	5. 01
5.02	00570 ADMI TTI NG	580, 722				44, 091	5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	58, 719				50, 390	5. 03
5. 04 5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMIN AND GENERAL	401, 210 1, 842, 526				0	5. 04 5. 05
7. 00	00700 OPERATION OF PLANT	950, 898				12, 597	7. 00
9. 00	00900 HOUSEKEEPI NG	373, 948				3, 149	1
10.00	01000 DI ETARY	92, 939		13, 808	8, 334	12, 597	
11.00	01100 CAFETERI A	192, 506				0	11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CE & SUPPLY	168, 120 120, 138		0 0		0 151, 170	13. 00 14. 00
15. 00	01500 PHARMACY	317, 648		0	32, 881	22, 046	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	612, 721	6, 299	10, 665		37, 792	
	INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 796, 453 410, 872		115, 768 5, 220		116, 527 9, 448	30. 00 31. 00
43. 00	04300 NURSERY	103, 731	854	1, 446		9, 440	43. 00
	ANCILLARY SERVICE COST CENTERS			,			
50.00	05000 OPERATING ROOM	1, 015, 287		145, 126		50, 390	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	39, 616		4, 744		0	52.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	1, 239, 608 896, 561	27, 924 9, 800	47, 274 16, 592		0 28, 344	54. 00 60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	75, 100		0,372		20, 344	63.00
65.00	06500 RESPI RATORY THERAPY	388, 634		22, 120	57, 481	22, 046	1
66.00	06600 PHYSI CAL THERAPY	572, 108		21, 927		31, 494	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	21, 837	0 338	0 572		0	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY	34, 735 165, 000		0		0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	114, 743		ő	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	218, 054		0		0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	402, 762	_	3, 086		0	73. 00
75. 00 76. 00	03610 SLEEP LAB 03020 CARDI AC REHAB	0	0	0	0	0	75. 00 76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	93, 845	Ĭ	10, 182	13, 098	40, 942	
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	512, 292					88. 00
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	1, 474, 562	28, 432	48, 135	155, 026	47, 241	91. 00 92. 00
,2,00	SPECIAL PURPOSE COST CENTERS						72.00
	11300 INTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	18, 688, 865	364, 744	617, 506	1, 408, 931	680, 264	1118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 521	4, 268	O	0	190. 00
	19001 MARKETI NG	89, 560		0	0		190. 01
	19200 PHYSICIANS' PRIVATE OFFICES	1, 569		0	254		192. 00
	19201 SCOTT PHYSICIAN GROUP	0	_	0 025	0		192. 01
	07950 BUHSE CAMPUS 07951 MEDICAL SPECIALTY	211, 145 144, 593					194. 00 194. 01
	07952 MEDICAL OFFICE	0		0,071	0,700		194. 02
	07953 VA PROPERTY	0	37, 971	0	0		194. 03
	07954 ALREFAI CAMPUS	0	0	0	0		194. 04
	07955 ORTHO CAMPUS 07956 DR. CRAIG CLINIC	317, 630	7, 594	12, 857	41, 374		194. 05 194. 06
	07950 DR. CRAIG CLINIC	179	0	0	n		194. 06
	07958 URGENT CARE CLINIC	0	0	, o	o o		194. 08
	07959 DR. PACE	6, 363					194. 09
	07960 SCOTTSBURG FAMILY PRACTICE (RHC)	0	4, 120	6, 975	0	0	194. 10
200. 00 201. 00	1 1		n	0	n	n	200. 00 201. 00
202.00		19, 459, 904	501, 055			777, 894	202. 00
	-	·			·		

| Peri od: | Worksheet B | From 01/01/2018 | Part I | Date/Time Prepared: |

				10	12/31/2018	5/30/2019 11:	
	Cost Center Description	ADMI TTI NG	PURCHASI NG RECEI VI NG AND	CASHI ERI NG/ACC OUNTS	Subtotal	OTHER ADMIN AND GENERAL	JZ dili
		5. 02	5. 03	RECEI VABLE 5. 04	5A. 04	5. 05	
	GENERAL SERVICE COST CENTERS	3.02	3.03	3.04	JA. 04	3.03	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.01	00550 INFORMATION TECH						5. 01
5.02	00570 ADMI TTI NG	702, 604					5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	0	127, 515				5. 03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	402, 928			5. 04
5.05	00590 OTHER ADMIN AND GENERAL	0	0	0	2, 088, 519	2, 088, 519	5. 05
7. 00	00700 OPERATION OF PLANT	0	0	0	1, 026, 812	123, 452	7. 00
9.00	00900 HOUSEKEEPI NG	0	0	0	425, 174	51, 118	9.00
10.00	01000 DI ETARY	0	0	0	135, 834	16, 331	10.00
11.00	01100 CAFETERI A	0	0	0	241, 799	29, 071	11.00
13.00	01300 NURSING ADMINISTRATION	0	0	0	192, 218	23, 110	13.00
14. 00 15. 00	01400 CENTRAL SERVICE & SUPPLY 01500 PHARMACY	0	182	0	282, 728 372, 757	33, 992	14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	585	·	752, 588	44, 816 90, 482	16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U	565	<u> </u>	752, 566	70, 402	10.00
30. 00	03000 ADULTS & PEDIATRICS	117, 363	16, 481	15, 121	2, 492, 104	299, 612	30.00
31. 00	03100 I NTENSI VE CARE UNI T	10, 955	0		505, 809	60, 812	31.00
43. 00	04300 NURSERY	10, 092	0		131, 715	15, 836	43. 00
	ANCILLARY SERVICE COST CENTERS			,		.,	
50.00	05000 OPERATING ROOM	31, 126	16, 700	15, 207	1, 439, 844	173, 110	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 204	0	361	55, 759	6, 704	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	59, 070	5, 173	103, 875	1, 606, 741	193, 175	54. 00
60.00	06000 LABORATORY	115, 313	12, 074	80, 383	1, 238, 705	148, 927	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2, 226	9, 095		86, 988	10, 458	
65. 00	06500 RESPI RATORY THERAPY	48, 004	2, 917		568, 531	68, 353	65. 00
66. 00	06600 PHYSI CAL THERAPY	13, 935	1, 331		669, 042	80, 438	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 335	0		27, 532	3, 310	67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 171	0	378	43, 239	5, 199	68. 00
69. 00	06900 ELECTROCARDI OLOGY	11, 535	10.005	10, 765	208, 659	25, 087	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	99, 039	13, 895		240, 926	28, 966	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	14, 485	26, 404		262, 659	31, 579	72.00
75. 00	03610 SLEEP LAB	127, 195 0	0	46, 540 0	581, 406	69, 901 0	73. 00 75. 00
76. 00	03020 CARDI AC REHAB	0	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	o o	114	4, 448	168, 644	20, 276	76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	J		1, 110	100, 011	20, 270	70.77
88. 00	08800 RURAL HEALTH CLINIC	0	0	7, 754	595, 244	71, 565	88. 00
91.00	09100 EMERGENCY	36, 556	22, 409		1, 880, 554	226, 095	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	SPECIAL PURPOSE COST CENTERS				•		
	11300 I NTEREST EXPENSE						113. 00
118.00	, , , , , , , , , , , , , , , , , , , ,	702, 604	127, 360	402, 928	18, 322, 530	1, 951, 775	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			6, 789		190. 00
	1 19001 MARKETI NG	0	14	0	89, 574		190. 01
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	_	99, 453	· ·	192.00
	19201 SCOTT PHYSICIAN GROUP	0	0		251 054		192. 01
	07950 BUHSE CAMPUS 07951 MEDICAL SPECIALTY	0	_		251, 054 174, 004		194. 00 194. 01
	2 07952 MEDICAL OFFICE	0	141		63, 031	· ·	194. 01
	3 07953 VA PROPERTY	0	0	_	37, 971		194. 02
	107954 ALREFAI CAMPUS	o o	0	0	0,,,,,		194. 04
	07955 ORTHO CAMPUS	o o	0	0	379, 455		194. 05
	07956 DR. CRAIG CLINIC	ő	n	o o	0		194. 06
	7 07957 DR. OLABI GE CLI NI C	o	O	O	179		194. 07
	07958 URGENT CARE CLINIC	O	0	0	o	0	194. 08
	07959 DR. PACE	0	0	0	24, 769	2, 978	194. 09
	07960 SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	11, 095	1, 334	194. 10
200.00	1				0		200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	702, 604	127, 515	402, 928	19, 459, 904	2, 088, 519	J202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: | 5/30/2019 11: 32 am

						5/30/2019 11:	32 am
	Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	·	PLANT				ADMI NI STRATI ON	
		7. 00	9.00	10.00	11. 00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 INFORMATION TECH						5. 01
5. 02	00570 ADMITTING						5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5. 03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5. 05	00590 OTHER ADMIN AND GENERAL						5. 05
7.00	00700 OPERATION OF PLANT	1, 150, 264					7. 00
9.00	00900 HOUSEKEEPI NG	9, 981	486, 273				9. 00
10.00	01000 DI ETARY	21, 966	0	174, 131			10.00
11. 00	01100 CAFETERI A	23, 480	2, 765	0	297, 115		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	2, 850	l .	13. 00
14. 00	01400 CENTRAL SERVI CE & SUPPLY	0	Ō	0	5, 850		14. 00
15. 00	01500 PHARMACY	0	0	0	7, 426		1
			F F20	-			
16. 00	01600 MEDI CAL RECORDS & LI BRARY	16, 965	5, 529	0	25, 804	41, 328	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1				1	
30. 00	03000 ADULTS & PEDI ATRI CS	184, 165	124, 717	167, 781	67, 302		
31. 00	03100 I NTENSI VE CARE UNI T	8, 304	17, 202	6, 350	14, 820	9, 545	31.00
43.00	04300 NURSERY	2, 301	8, 601	0	3, 285	0	43.00
	ANCILLARY SERVICE COST CENTERS						Ī
50.00	05000 OPERATI NG ROOM	230, 867	86, 012	0	18, 699	29, 055	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	7, 547	25, 803	0	1, 139		52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	75, 204	31, 947	0	33, 159		54.00
60. 00	06000 LABORATORY	26, 394	34, 405	0	28, 721		60.00
	1			_	•		1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	215		63. 00
65. 00	06500 RESPI RATORY THERAPY	35, 189	17, 202	0	17, 384	l .	65. 00
66. 00	06600 PHYSI CAL THERAPY	34, 882	9, 830	0	16, 877	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	910	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	8, 601	0	5, 486	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	ő	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 909	6, 144	0	0	Ö	73.00
	03610 SLEEP LAB	4, 303	0, 144	0	0		1
75. 00	1	0	U	U	U	0	75. 00
76. 00	03020 CARDI AC REHAB	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	16, 198	11, 059	0	4, 251	5, 245	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	7, 312	0	0	43, 525	0	88. 00
91.00	09100 EMERGENCY	76, 575	94, 613	0	0	54, 335	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS	•					
113 00	11300 I NTEREST EXPENSE						113.00
118.00		783, 149	484, 430	174, 131	296, 793	218, 178	
110.00	NONREI MBURSABLE COST CENTERS	700,117	101, 100	171,101	270, 170	210, 170	110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 790	1, 843	0		0	190. 00
				- 1	າາາ	l .	190. 00
	19001 MARKETI NG	0		0	322		
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	19201 SCOTT PHYSI CI AN GROUP	0	0	0	0		192. 01
194.00	07950 BUHSE CAMPUS	12, 783	0	0	0	0	194. 00
194. 01	07951 MEDICAL SPECIALTY	25, 566	0	0	0	0	194. 01
194. 02	07952 MEDICAL OFFICE	169, 757	0	0	0	0	194. 02
194. 03	07953 VA PROPERTY	102, 263	ol	0	0	0	194. 03
	07954 ALREFAI CAMPUS	0	0	0	0	0	194. 04
	07955 ORTHO CAMPUS	20, 453	n	0	n		194. 05
	07956 DR. CRAIG CLINIC	20, 400		0	0		194. 05
				-	0		
	707957 DR. OLABIGE CLINIC	0	0	0	-		194. 07
	07958 URGENT CARE CLINIC	0	이	0	0		194. 08
	07959 DR. PACE	18, 407	0	0	0		194. 09
194. 10	07960 SCOTTSBURG FAMILY PRACTICE (RHC)	11, 096	0	0	0	0	194. 10
200.00							200. 00
201.00		0	ol	0	0	0	201.00
202.00		1, 150, 264	486, 273	174, 131	297, 115		
	, (.,, 201	.00, 2, 0	,	277,710	2.0,.70	,

| Period: | Worksheet B | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1334

					To	12/31/2018		
		Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	Subtotal	5/30/2019 11: Intern &	32 alli
		·	SERVICE &		RECORDS &		Residents Cost	
			SUPPLY		LI BRARY		& Post Stepdown	
							Adjustments	
			14.00	15. 00	16. 00	24. 00	25. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1. 00
2.00	1	CAP REL COSTS-BLDG & TTXT						2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		INFORMATION TECH						5. 01
5.02		ADMITTING						5. 02
5. 03 5. 04		PURCHASING RECEIVING AND STORES CASHIERING/ACCOUNTS RECEIVABLE						5. 03 5. 04
5. 05	1	OTHER ADMIN AND GENERAL						5. 05
7.00	00700	OPERATION OF PLANT						7. 00
9.00		HOUSEKEEPI NG						9. 00
10. 00 11. 00	1	DI ETARY CAFETERI A						10. 00 11. 00
13. 00		NURSI NG ADMI NI STRATI ON						13.00
14. 00		CENTRAL SERVICE & SUPPLY	322, 570					14. 00
15. 00		PHARMACY	460	430, 704				15. 00
16. 00		MEDICAL RECORDS & LIBRARY	1, 479	0	934, 175			16. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	41, 691	0	35, 058	3, 485, 855	0	30. 00
31. 00		INTENSIVE CARE UNIT	41, 691	0		625, 561	0	31.00
43. 00	1	NURSERY	o	Ö		164, 243	0	43. 00
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	42, 244	0		2, 055, 089	0	50.00
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	13, 087	0	836 240, 826	97, 788 2, 194, 139	0 0	52. 00 54. 00
60.00		LABORATORY	30, 542	0	186, 366	1, 694, 060	0	60.00
63. 00		BLOOD STORING, PROCESSING & TRANS.	23, 006	0	1, 314	121, 981	0	63. 00
65. 00	1	RESPI RATORY THERAPY	7, 378	0	33, 068	747, 105	0	65. 00
66.00		PHYSI CAL THERAPY	3, 368	0		849, 898	0	66.00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	1, 299 877	32, 141 50, 225	0	67. 00 68. 00
69. 00		ELECTROCARDI OLOGY		0	24, 959	272, 792	0	69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	35, 150	0		335, 760	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	66, 799	0	8, 615	369, 652	0	72. 00
73.00		DRUGS CHARGED TO PATIENTS	0	430, 704	107, 903	1, 200, 967	0	73.00
75. 00 76. 00		SLEEP LAB CARDI AC REHAB	0	0		0	0	75. 00 76. 00
76. 97	1	CARDI AC REHABI LI TATI ON	289	Ö	- 1	236, 274	Ö	76. 97
		TIENT SERVICE COST CENTERS						
88. 00	1	RURAL HEALTH CLINIC	0	0	·	735, 623	0	88. 00
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	56, 686	0	158, 104	2, 546, 962	0	91. 00 92. 00
72.00		AL PURPOSE COST CENTERS						72.00
113.00		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	322, 179	430, 704	934, 175	17, 816, 115	0	118. 00
100 00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	ol	16, 238	0	190. 00
		MARKETING	35	0		100, 700		190. 00
		PHYSICIANS' PRIVATE OFFICES	0	0		111, 410		192. 00
		SCOTT PHYSICIAN GROUP	0	0	0	0		192. 01
		BUHSE CAMPUS	0	0	0	294, 021		194. 00
		MEDICAL SPECIALTY MEDICAL OFFICE	356	0	0	220, 846 240, 366		194. 01 194. 02
	1	VA PROPERTY	0	0	0	144, 799		194. 02
		ALREFAI CAMPUS	O	0	0	0		194. 04
		ORTHO CAMPUS	0	0	0	445, 529		194. 05
		DR. CRAIG CLINIC DR. OLABIGE CLINIC	0	0	0	0		194. 06
		URGENT CARE CLINIC		0	0	201 0		194. 07 194. 08
		DR. PACE		0	Ö	46, 154		194. 09
		SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	23, 525		194. 10
200.00	1	Cross Foot Adjustments		2		0		200. 00
201. 00 202. 00	1	Negative Cost Centers TOTAL (sum lines 118 through 201)	0 322, 570	0 430, 704	0 934, 175	0 19, 459, 904		201. 00 202. 00
202.00	1	TOTAL (Suil TITIES TTO LITTUUGH 201)	322, 370	+30, 704	734, 1/3	17,407,704	٠	1202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 SCOTT MEMORIAL HOSPITAL

Provider CCN: 15-1334 | Peri od: | Worksheet B | From 01/01/2018 | Part I | Date/Time Prepared: |

			To 12/31/2018 Date/Time Pro 5/30/2019 11:	
	Cost Center Description	Total	373072017-11.	. 52 diii
	·	26.00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 01 5. 02	00550 I NFORMATI ON TECH 00570 ADMI TTI NG	+		5. 01 5. 02
5. 02	00560 PURCHASING RECEIVING AND STORES			5. 02
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 04
5. 05	00590 OTHER ADMIN AND GENERAL			5. 05
7.00	00700 OPERATION OF PLANT			7. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10. 00
11. 00	01100 CAFETERI A			11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14.00	01400 CENTRAL SERVI CE & SUPPLY			14. 00
15.00	01500 PHARMACY			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS			16. 00
30. 00	03000 ADULTS & PEDIATRICS	3, 485, 855		30.00
31. 00	03100 I NTENSI VE CARE UNI T	625, 561		31.00
43. 00	04300 NURSERY	164, 243		43. 00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	2, 055, 089		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	97, 788		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 194, 139		54.00
60.00	06000 LABORATORY	1, 694, 060		60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	121, 981		63. 00
65. 00	06500 RESPI RATORY THERAPY	747, 105		65. 00
66.00	06600 PHYSI CAL THERAPY	849, 898		66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	32, 141 50, 225		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	272, 792		69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	335, 760		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	369, 652		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 200, 967		73. 00
75.00	03610 SLEEP LAB	0		75. 00
76. 00	03020 CARDI AC REHAB	0		76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	236, 274		76. 97
	OUTPATIENT SERVICE COST CENTERS	705 (00		
88. 00	08800 RURAL HEALTH CLINIC	735, 623		88. 00
91. 00 92. 00	09100 EMERGENCY	2, 546, 962		91. 00 92. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS			92.00
113 00	11300 INTEREST EXPENSE			113. 00
118.00		17, 816, 115		118. 00
	NONREI MBURSABLE COST CENTERS	,		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16, 238		190. 00
	19001 MARKETI NG	100, 700		190. 01
	19200 PHYSICIANS' PRIVATE OFFICES	111, 410		192. 00
	19201 SCOTT PHYSICIAN GROUP	0		192. 01
	07950 BUHSE CAMPUS	294, 021		194. 00
	07951 MEDI CAL SPECI ALTY	220, 846		194. 01
	207952 MEDICAL OFFICE 307953 VA PROPERTY	240, 366		194. 02 194. 03
	107953 VA PROPERTY	144, 799 0		194. 03
	07955 ORTHO CAMPUS	445, 529		194. 05
	07956 DR. CRAIG CLINIC	0		194. 06
	7 07957 DR. OLABI GE CLI NI C	201		194. 07
	07958 URGENT CARE CLINIC	0		194. 08
	07959 DR. PACE	46, 154		194. 09
	07960 SCOTTSBURG FAMILY PRACTICE (RHC)	23, 525		194. 10
200.00	1 1	0		200.00
201.00		10 450 004		201. 00 202. 00
202.00	TOTAL (sum lines 118 through 201)	19, 459, 904		J2U2. UU

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1334

				To	12/31/2018	Date/Time Pre 5/30/2019 11:	
			CAPI TAL REI	LATED COSTS		3/30/2019 11.	JZ dili
	Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2. 00	2A	4. 00	
G	ENERAL SERVICE COST CENTERS		1.00	2.00	ZN	4.00	
	0100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 0	0200 CAP REL COSTS-MVBLE EQUIP						2. 00
	0400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0	0	4. 00
	0550 INFORMATION TECH	0	2, 905		7, 823	0	5. 01
	0570 ADMITTING 0560 PURCHASING RECEIVING AND STORES	0	4, 526	1	12, 189	0	5. 02 5. 03
	0580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	6, 835 638	1	18, 406 1, 718	0	5. 03
	0590 OTHER ADMIN AND GENERAL	133, 817	50, 732		270, 438	0	5. 05
	0700 OPERATION OF PLANT	0	8, 323	1	22, 414	0	7. 00
	0900 HOUSEKEEPI NG	0	3, 706	1	9, 980	0	9. 00
	1000 DI ETARY	0	8, 156	13, 808	21, 964	0	10. 00
	1100 CAFETERI A	0	8, 718	1	23, 477	0	11. 00
	1300 NURSI NG ADMI NI STRATI ON	0	0		0	0	13.00
	1400 CENTRAL SERVICE & SUPPLY 1500 PHARMACY	7, 169	0	0	7, 169	0	14. 00 15. 00
	1600 MEDICAL RECORDS & LIBRARY	0	6, 299	10, 665	16, 964	0	16. 00
	NPATIENT ROUTINE SERVICE COST CENTERS	J	0, 277	10,003	10, 704	0	10.00
	3000 ADULTS & PEDIATRICS	0	68, 381	115, 768	184, 149	0	30. 00
31.00 0	3100 INTENSIVE CARE UNIT	0	3, 083	5, 220	8, 303	0	31. 00
	4300 NURSERY	0	854	1, 446	2, 300	0	43. 00
	NCILLARY SERVICE COST CENTERS		05 721	145 107	220 047	0	F0 00
	5000 OPERATING ROOM 5200 DELIVERY ROOM & LABOR ROOM	0	85, 721 2, 802		230, 847 7, 546	0	50. 00 52. 00
	5400 RADI OLOGY-DI AGNOSTI C	0	27, 924	1	7, 340 75, 198	0	54. 00
	6000 LABORATORY	0	9, 800	1	26, 392	0	60.00
63.00 0	6300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	O	0	63. 00
	6500 RESPI RATORY THERAPY	0	13, 066	1	35, 186	0	65. 00
	6600 PHYSI CAL THERAPY	0	12, 952		34, 879	0	66. 00
	6700 OCCUPATIONAL THERAPY	0	0		0	0	67. 00
	6800 SPEECH PATHOLOGY 6900 ELECTROCARDI OLOGY	0	338	572 0	910 0	0	68. 00 69. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	Ö	o	ol	0	72. 00
	7300 DRUGS CHARGED TO PATIENTS	0	1, 823	3, 086	4, 909	0	73. 00
	3610 SLEEP LAB	0	0	0	O	0	75. 00
	3020 CARDI AC REHAB	0	0	0	0	0	76. 00
	7697 CARDI AC REHABI LI TATI ON	0	6, 015	10, 182	16, 197	0	76. 97
	UTPATIENT SERVICE COST CENTERS 8800 RURAL HEALTH CLINIC	0	2, 715	4, 596	7, 311	0	88. 00
	9100 EMERGENCY	0	28, 432	1	76, 567	0	91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART		20, 102	10, 100	0	Ü	92. 00
S	PECIAL PURPOSE COST CENTERS						
	1300 I NTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	140, 986	364, 744	617, 506	1, 123, 236	0	118. 00
	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		2, 521	4, 268	6, 789	0	190. 00
	9000 MARKETING	0	2, 321		0, 769		190. 00
	9200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	ol		192. 00
	9201 SCOTT PHYSICIAN GROUP	0	0	0	o		192. 01
194. 00 0	7950 BUHSE CAMPUS	0	4, 746	1	12, 781		194. 00
	7951 MEDI CAL SPECI ALTY	0	9, 493		25, 564		194. 01
	7952 MEDICAL OFFICE	0	63, 031		63, 031		194. 02
	7953 VA PROPERTY 7954 ALREFAI CAMPUS	0	37, 971 0	1	37, 971 0		194. 03 194. 04
	7954 ALREFAI CAMPUS 7955 ORTHO CAMPUS		7, 594	1	20, 451		194. 04
	7956 DR. CRAIG CLINIC		0	0	20, 131		194. 06
	7957 DR. OLABIGE CLINIC	0	0	O	o		194. 07
	7958 URGENT CARE CLINIC	0	0	0	О		194. 08
	7959 DR. PACE	0	6, 835	1	18, 406		194. 09
	7960 SCOTTSBURG FAMILY PRACTICE (RHC)	0	4, 120	6, 975	11, 095		194. 10
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers	-	0	o	0		200. 00 201. 00
201.00	TOTAL (sum lines 118 through 201)	140, 986	-		1, 319, 324		201.00
	, (22	, , , , ,	, 500	, 200	., 5.,, 52.1		

Provider CCN: 15-1334

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

				To	12/31/2018	Date/Time Pre 5/30/2019 11:	
	Cost Center Description	I NFORMATI ON	ADMI TTI NG		CASHI ERI NG/ACC	OTHER ADMIN	
		TECH		RECEIVING AND	OUNTS	AND GENERAL	
		5. 01	5. 02	STORES 5. 03	RECEI VABLE 5. 04	5. 05	
	GENERAL SERVICE COST CENTERS	0.01	0.02	0.00	0.01	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00550 INFORMATION TECH	7, 823					5. 01
5. 02	00570 ADMITTING	443	12, 632				5. 02
5. 03 5. 04	00560 PURCHASING RECEIVING AND STORES 00580 CASHIERING/ACCOUNTS RECEIVABLE	507	0	18, 913 0	1 710		5. 03 5. 04
5. 04 5. 05	00590 OTHER ADMIN AND GENERAL		0	0	1, 718 0	270, 438	5. 04
7. 00	00700 OPERATION OF PLANT	127	0	0	0	15, 985	7. 00
9. 00	00900 HOUSEKEEPI NG	32	0	Ö	o	6, 619	9. 00
10.00	01000 DI ETARY	127	0	0	o	2, 115	10.00
11. 00	01100 CAFETERI A	0	0	0	o	3, 764	11. 00
13.00	01300 NURSING ADMINISTRATION	0	0	0	0	2, 992	13. 00
14. 00	01400 CENTRAL SERVI CE & SUPPLY	1, 518	0	0	0	4, 402	14. 00
15. 00	01500 PHARMACY	222	0	27	0	5, 803	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	380	0	87	0	11, 716	16. 00
30. 00	03000 ADULTS & PEDIATRICS	1, 172	2, 109	2, 444	66	38, 800	30.00
31. 00	03100 I NTENSI VE CARE UNI T	95	197	· ·	5	7, 874	31.00
43. 00	04300 NURSERY	0	181	Ö	5	2, 051	43. 00
	ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			-,	,	
50.00	05000 OPERATING ROOM	507	559	2, 477	66	22, 415	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	58		2	868	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 062		419	25, 014	54.00
60.00	06000 LABORATORY	285	2, 072		349	19, 284	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	40		2	1, 354	63.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	222 317	863 250		62 66	8, 851 10, 416	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	317	24	177	2	429	67.00
68. 00	06800 SPEECH PATHOLOGY		21		2	673	68. 00
69. 00	06900 ELECTROCARDI OLOGY		207	l o	47	3, 248	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	1, 780	2, 061	58	3, 751	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	260	3, 916	16	4, 089	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	2, 292	0	202	9, 051	73. 00
75. 00	03610 SLEEP LAB	0	0	0	0	0	75. 00
76.00	03020 CARDI AC REHAB	0	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	412	0	17	19	2, 625	76. 97
88. 00	08800 RURAL HEALTH CLINIC	O	0	0	34	9, 267	88. 00
91. 00	09100 EMERGENCY	475	657		296	29, 276	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			, , , ,		,	92. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
118.00		6, 841	12, 632	18, 890	1, 718	252, 732	118. 00
400.04	NONREI MBURSABLE COST CENTERS			1 0	ما	10/	1400 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	106	190.00
	19001 MARKETI NG 19200 PHYSI CI ANS' PRI VATE OFFI CES	982	0	2	0		190. 01 192. 00
	1 19201 SCOTT PHYSICIAN GROUP	0	0	0	0		192. 00
	07950 BUHSE CAMPUS		0	ő	o		194. 00
	07951 MEDI CAL SPECI ALTY	Ö	0	21	ō		194. 01
	07952 MEDICAL OFFICE	0	0	0	О		194. 02
194. 03	3 07953 VA PROPERTY	0	0	0	o	591	194. 03
	07954 ALREFAI CAMPUS	0	0	0	0		194. 04
	5 07955 ORTHO CAMPUS	0	0	0	0		194. 05
	5 07956 DR. CRAIG CLINIC	0	0	0	0		194. 06
	7 07957 DR. OLABIGE CLINIC		0		0		194. 07 194. 08
	BO7958 URGENT CARE CLINIC DO7959 DR. PACE		0		0		194. 08
	07959 DR. FACE 07960 SCOTTSBURG FAMILY PRACTICE (RHC)		0		0		194. 09
200.00			O		٩	173	200. 00
201.00			0	o	o	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	7, 823	12, 632	18, 913	1, 718	270, 438	202. 00

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| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | 5/30/2019 | 11: 32 am

						5/30/2019 11:	32 am
	Cost Center Description	OPERATION OF	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		PLANT				ADMI NI STRATI ON	
		7.00	9. 00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00550 I NFORMATI ON TECH						5. 01
5.02	00570 ADMITTING						5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5. 05	00590 OTHER ADMIN AND GENERAL						5. 05
		00 50/					1
7. 00	00700 OPERATION OF PLANT	38, 526					7. 00
9.00	00900 HOUSEKEEPI NG	334	16, 965				9. 00
10. 00	01000 DI ETARY	736	0	24, 942			10.00
11. 00	01100 CAFETERI A	786	96	0	28, 123		11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	o	270	3, 262	13.00
14.00	01400 CENTRAL SERVI CE & SUPPLY	0	0	0	554	0	1
15. 00	01500 PHARMACY	0	Ô	0	703	78	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	568	193	0	2, 442	618	1
16.00		300	193	l o	2, 442	010	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	6, 168			6, 371	1, 099	1
31. 00	03100 I NTENSI VE CARE UNI T	278	600		1, 403	143	1
43.00	04300 NURSERY	77	300	0	311	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	7, 733	3, 001	0	1, 770	434	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	253	900	l o	108	0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 519	1, 115	o o	3, 139	Ō	1
60. 00	06000 LABORATORY	884	1, 113	Ö	2, 719	0	1
		004		0		0	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	-	0	0	20		
65. 00	06500 RESPI RATORY THERAPY	1, 179	600		1, 645	0	1
66. 00	06600 PHYSI CAL THERAPY	1, 168	343	0	1, 597	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	30	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	300	l o	519	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ô	0	0	Ö	
73. 00	07300 DRUGS CHARGED TO PATIENTS	164	214	0	0	0	
			214	0	0	l .	1
75. 00	03610 SLEEP LAB	0	0	0	0	0	
76. 00	03020 CARDI AC REHAB	0	0	0	0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	543	386	0	402	78	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	245	0	0	4, 120	0	88. 00
91.00	09100 EMERGENCY	2, 565	3, 301	0	0	812	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						1
113 00	11300 I NTEREST EXPENSE						113. 00
118. 00		26, 230	16, 901	24, 942	28, 093	2 262	118. 00
110.00		20, 230	10, 701	24, 742	20, 073	3, 202	1110.00
100.00	NONREI MBURSABLE COST CENTERS	227					100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	227	64	0	0	l	190. 00
	19001 MARKETI NG	0	0		30	i e	190. 01
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
192. 01	19201 SCOTT PHYSICIAN GROUP	0	0	0	0	0	192. 01
194.00	07950 BUHSE CAMPUS	428	0	0	0	0	194.00
194. 01	07951 MEDICAL SPECIALTY	856	0	0	0	0	194. 01
	07952 MEDICAL OFFICE	5, 686	o	Ö	0		194. 02
	07953 VA PROPERTY	3, 425	Ö	-	0		194. 03
			0		0		194. 04
	07954 ALREFAI CAMPUS	0	0	0	0	•	1
	07955 ORTHO CAMPUS	685	O	0	0	l	194. 05
	07956 DR. CRAIG CLINIC	0	0	0	0		194. 06
	7 07957 DR. OLABIGE CLINIC	0	0	0	0		194. 07
	07958 URGENT CARE CLINIC	0	0	0	0		194. 08
	07959 DR. PACE	617	0	0	0	0	194. 09
	07960 SCOTTSBURG FAMILY PRACTICE (RHC)	372	n	n	0	l .	194. 10
200.00			Ĭ		ŭ		200.00
201.00		0	0	n	Λ	n	201. 00
201.00		38, 526	16, 965	24, 942	28, 123		201.00
202. U	ITOTAL (Sum TITIES TTO LIMOUGH ZUT)	30, 320	10, 905	24, 942	20, 123	J 3, 202	1202.00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1334

			To	12/31/2018	Date/Time Pre 5/30/2019 11:	
Cost Center Description	CENTRAL SERVI CE & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown	32 aiii
	14.00	15. 00	16.00	24. 00	Adjustments 25.00	
GENERAL SERVICE COST CENTERS	14.00	13.00	10.00	24.00	25.00	
1. 00	13, 643 19 63	6, 852 0	33, 031			1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00 16. 00
30. 00 03000 ADULTS & PEDIATRICS	1, 763	0	1, 240	273, 765	0	30. 00
31. 00 03100 INTENSIVE CARE UNIT	0	0	96	19, 904	0	31. 00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	89	5, 314	0	43. 00
50. 00 05000 OPERATING ROOM	1, 787	0	1, 247	272, 843	0	50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	30	9, 765	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	554 1, 292	0	8, 510 6, 591	118, 297 62, 859	0	54. 00 60. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	973	0	46	3, 784	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	312	o	1, 169	50, 522	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	142	o	1, 254	50, 629	0	66. 00
67.00 06700 OCCUPATIONAL THERAPY	0	0	46	501	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	31	1, 667	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1 407	0	883	5, 204	0	69. 00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	1, 487 2, 825	0	1, 086 305	10, 223 11, 411	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 625	6, 852	3, 816	27, 500	0	73. 00
75. 00 03610 SLEEP LAB	o	0	0	0	0	75. 00
76. 00 03020 CARDI AC REHAB	O	О	0	0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	12	0	365	21, 056	0	76. 97
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	O	636	21, 613	0	88. 00
91. 00 09100 EMERGENCY	2, 398	0	5, 591	125, 262	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2,070	Ĭ	0,071	120, 202	0	92. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE	40 (07	, 050	22 224	4 000 440		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	13, 627	6, 852	33, 031	1, 092, 119	0	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	o	0	7, 186	0	190. 00
190. 01 19001 MARKETI NG	1	O	0	1, 427	0	190. 01
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	2, 530		192. 00
192. 01 19201 SCOTT PHYSI CI AN GROUP	0	0	0	0		192. 01
194. 00 07950 BUHSE CAMPUS 194. 01 07951 MEDI CAL SPECI ALTY	0 15	0	0	17, 117 29, 165		194. 00 194. 01
194. 02 07952 MEDICAL OFFICE	0	0	0	69, 698		194. 01
194. 03 07953 VA PROPERTY	l o	o	0	41, 987		194. 03
194.04 07954 ALREFAI CAMPUS	O	o	0	0		194. 04
194. 05 07955 ORTHO CAMPUS	0	0	0	27, 043		194. 05
194.06 07956 DR. CRAIG CLINIC	0	0	0	0		194. 06 194. 07
194. 07 07957 DR. OLABI GE CLINI C 194. 08 07958 URGENT CARE CLINI C	0	O O	0	3		194. 07 194. 08
194. 09 07959 DR. PACE	0	0	0	19, 409		194. 00
194. 10 07960 SCOTTSBURG FAMILY PRACTICE (RHC)		ő	Ö	11, 640		194. 10
200.00 Cross Foot Adjustments		ļ		0	0	200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	13, 643	6, 852	33, 031	1, 319, 324	0	202. 00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1334

			To 12/31/2018 Date/Time Pro 5/30/2019 11:	
	Cost Center Description	Total	37 307 2017 11.	32 dili
	p	26.00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 01	00550 I NFORMATI ON TECH			5. 01
5. 02	00570 ADMITTING			5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES			5. 03
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 04
5. 05	00590 OTHER ADMIN AND GENERAL			5. 05
7.00	00700 OPERATION OF PLANT			7. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY			9.00
11. 00	01100 CAFETERI A			11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14. 00	01400 CENTRAL SERVICE & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
	01600 MEDICAL RECORDS & LIBRARY			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			1
30.00	03000 ADULTS & PEDIATRICS	273, 765		30.00
31.00	03100 INTENSIVE CARE UNIT	19, 904		31. 00
43.00	04300 NURSERY	5, 314		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	272, 843		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9, 765		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	118, 297		54.00
60. 00	06000 LABORATORY	62, 859		60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	3, 784		63. 00
65. 00	06500 RESPI RATORY THERAPY	50, 522		65. 00
66.00	06600 PHYSI CAL THERAPY	50, 629		66. 00
67. 00	06700 OCCUPATIONAL THERAPY	501		67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY	1, 667		68. 00 69. 00
71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 204 10, 223		71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	11, 411		72. 00
	07300 DRUGS CHARGED TO PATIENTS	27, 500		73. 00
75. 00	03610 SLEEP LAB	0		75. 00
76. 00	03020 CARDI AC REHAB	o		76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	21, 056		76. 97
	OUTPATIENT SERVICE COST CENTERS			
88. 00	08800 RURAL HEALTH CLINIC	21, 613		88. 00
91.00	09100 EMERGENCY	125, 262		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
	SPECIAL PURPOSE COST CENTERS			4
	11300 I NTEREST EXPENSE	1 000 110		113. 00
118. 00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1, 092, 119		118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7 10/		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 186 1, 427		190. 00 190. 01
	19200 PHYSI CLANS' PRI VATE OFFI CES	2, 530		192. 00
	19201 SCOTT PHYSICIAN GROUP	2, 530		192. 00
	07950 BUHSE CAMPUS	17, 117		194. 00
	07951 MEDI CAL SPECI ALTY	29, 165		194. 01
	07952 MEDICAL OFFICE	69, 698		194. 02
	07953 VA PROPERTY	41, 987		194. 03
	07954 ALREFAI CAMPUS	0		194. 04
	07955 ORTHO CAMPUS	27, 043		194. 05
194. 06	07956 DR. CRAIG CLINIC	o		194. 06
	07957 DR. OLABIGE CLINIC	3		194. 07
	07958 URGENT CARE CLINIC	0		194. 08
	07959 DR. PACE	19, 409		194. 09
	07960 SCOTTSBURG FAMILY PRACTICE (RHC)	11, 640		194. 10
200.00		0		200. 00
201.00		0		201. 00
202.00	TOTAL (sum lines 118 through 201)	1, 319, 324		202. 00

Heal th	Fi nar	ncial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
		TION - STATISTICAL BASIS	OSCIT IIIZIIIOINI	Provi der C	CN: 15-1334	Peri od:	Worksheet B-1	
						From 01/01/2018 To 12/31/2018		
			CAPITAL REL	ATED COSTS			5/30/2019 11:	32 am
		Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	I NFORMATI ON	ADMITTING	
			(SQUARE FEET)	(SQUARE FEET)	BENEFITS DEPARTMENT	TECH (# OF	(I NPATI ENT CHARGES)	
					(GROSS	COMPUTERS)	0.11.11.02.07	
			1.00	2. 00	SALARI ES) 4. 00	5. 01	5. 02	
	GENER	AL SERVICE COST CENTERS	1.00	2.00	4.00	3.01	3.02	
1.00	1	CAP REL COSTS-BLDG & FIXT	131, 959					1. 00
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	0	105, 359 0		2		2. 00 4. 00
5. 01		INFORMATION TECH	765	-				5. 01
5.02		ADMITTING	1, 192	1, 192			12, 093, 898	
5. 03 5. 04		PURCHASING RECEIVING AND STORES CASHIERING/ACCOUNTS RECEIVABLE	1, 800 168	1, 800 168	1	0 16 0 0	0	
5. 05		OTHER ADMIN AND GENERAL	13, 361	13, 361	•	-	0	1
7. 00		OPERATION OF PLANT	2, 192	2, 192			0	
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	976 2, 148	976 2, 148			0	/ // 00
11. 00		CAFETERIA	2, 296	2, 296			0	
	1	NURSI NG ADMI NI STRATI ON	0	0	138, 46		0	
		CENTRAL SERVICE & SUPPLY PHARMACY	0	0	65, 61 188, 92		0	
		MEDICAL RECORDS & LIBRARY	1, 659	1, 659			0	
		I ENT ROUTINE SERVICE COST CENTERS]
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	18, 009 812				2, 020, 164 188, 564	
		NURSERY	225				173, 706	1
		LARY SERVICE COST CENTERS						l
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	22, 576 738				535, 773 55, 145	1
54. 00		RADI OLOGY-DI AGNOSTI C	7, 354	7, 354			1, 016, 768	
60.00		LABORATORY	2, 581	2, 581			1, 984, 862	
63. 00 65. 00		BLOOD STORING, PROCESSING & TRANS. RESPIRATORY THERAPY	0 3, 441	0 3, 441	1	0 2 7	38, 315 826, 287	1
66. 00	1	PHYSI CAL THERAPY	3, 411	3, 411		10	239, 858	
		OCCUPATI ONAL THERAPY	0	0	21, 83		22, 977	
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	89 0	89	34, 73, 122, 72,		20, 162 198, 546	
		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	1, 704, 751	71.00
		IMPL. DEV. CHARGED TO PATIENTS	0	0	1	o c	249, 322	
		DRUGS CHARGED TO PATIENTS	480	480	1		2, 189, 458 0	
76. 00		CARDI AC REHAB	0	0	1		0	
76. 97		CARDIAC REHABILITATION	1, 584	1, 584	75, 26	1 13	0	76. 97
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	715	715	390, 06	3 0	0	88. 00
91. 00		EMERGENCY	7, 488				629, 240	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
118. 00)	SUBTOTALS (SUM OF LINES 1 through 117)	96, 060	96, 060	8, 095, 45	3 216	12, 093, 898	
100.00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	4.4.4			ol lo	0	190. 00
		MARKETING	664	664 0		0 0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1, 45		0	192. 00
		SCOTT PHYSI CI AN GROUP	1 250	1 250	155.07	0 4 0		192. 01 194. 00
		BUHSE CAMPUS MEDICAL SPECIALTY	1, 250 2, 500					194. 00
194. 02	07952	MEDICAL OFFICE	16, 600			0	0	194. 02
		VA PROPERTY	10, 000	0				194. 03
		ALREFAI CAMPUS ORTHO CAMPUS	2,000	2, 000	237, 72	۷ ۴		194. 04 194. 05
194.06	07956	DR. CRAIG CLINIC	0	0)	o c	0	194. 06
		DR. OLABIGE CLINIC URGENT CARE CLINIC	0	0		0		194. 07 194. 08
		DR. PACE	1, 800	1, 800				194. 08
194. 10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	1, 085			0		194. 10
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201.00		Cost to be allocated (per Wkst. B,	501, 055	677, 283	1, 481, 39	3 777, 894	702, 604	
		Part I)						
203. 00 204. 00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	3. 797051	6. 428336	0. 17404	3, 149. 368421 7, 823	0. 058096 12. 632	203. 00 204. 00
_31.00		Part II)			1	7,023	12, 032	

Health Financial Systems	SCOTT MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1		
				From 01/01/2018 To 12/31/2018			
	CAPITAL REL	ATED COSTS					
Cost Center Description	,	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	I NFORMATI ON TECH (# OF COMPUTERS)	ADMITTING (INPATIENT CHARGES)		
	1. 00	2. 00	4. 00	5. 01	5. 02		
205.00 Unit cost multiplier (Wkst. B, Part			0. 00000	0 31. 672065	0. 001044	205. 00	
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1334

Cost Center Description						T.	nom 01/01/2018 n 12/31/2018		
STREET, SERVICE DOST CREATES STREET, STREE			Cost Center Description	PURCHASI NG	CASHI ERI NG/ACC	Reconciliation	OTHER ADMIN		32 am
CONTROL CRIMENS CHARGES COST) CHARGES CHARGE				RECEIVING AND	OUNTS		AND GENERAL	PLANT	
								(SQUARE FEET)	
DENEMAL SERVICE_COST_CENTERS 5.03 5.04 54.05 5.06 7.00				,			(031)		
1.00 00100 CAP PEL COSTS-BUES A FIRX						5A. 05	5. 05	7. 00	
2.00 000000 CAP REL DOSTS-MINEL EDUIL P	1 00			1				I	1 00
4.00 00-000 EMPLOYEE BEREFITS DEPARTMENT		1	•						1
5.02 OSOFO ADMITTING OSOFO ADMITTING OSOFO CASHE EN INCACCUMETS RECEIVABLE OSOFO CASHE EN INCACCUMETS OSOFO CASHE		1	•						1
5.03 000500 DURCHAS ING RECEIV ING AMD STORES 1,052,963 0.4,780,064 0.9000 CONTROL STORE STORES 1,052,065 0.0000 0.0000 0.1,0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000		1	•						
0.0580 CASHIERINK ACCOUNTS RECEIVABLE 0 64,780,664 0 -2,088,519 77,371,385 5.05 5.05 0.0590 CHERA ZADIN AND GENERAL 0 0 0 0 1.026,812 112,481 7.00 0.00		1	•	1 052 002					1
5.05 0.05990 OTHER ADM IN AND GENERAL 0 0 -2.088,519 17.371,385 5.05				1, 052, 963	64. 780. 664				
9.00 00000 DUSENCEP ING				o			17, 371, 385		1
10.00 01000 DETARY 0				0	0	· ·			1
11.00 01100 CAFETERIA 0 0 0 241,709 2,264 11.00 13.00 01300 CAFETERIA 0 10.00 0 0 0 0 12.218 0 14.00 14.00 14.00 14.00 0 0 0 0 282,728 0 14.00 1		1	•	0	0	0		l	
13.00 01300 NURSING ADMINISTRATION 0 0 192, 218 0 13.00				0	0	0		l	1
15.00 01500 PHARMACY 1,500 0 0 372,757 0 15.00 10.00 01500 PHARMACY 1,500 0 0 775,588 1,659 16.00 10.00 0300 0300 NTRINSING CARE UNIT 0 188,564 0 505,800 811 31.00 31.00 03100 INTRINSING CARE UNIT 1 0 188,564 0 505,800 811 31.00 31.00 03100 INTRINSING CARE UNIT 1 0 188,564 0 505,800 811 31.00 31.00 03100 INTRINSING CARE UNIT 1 0 173,700 0 131,715 225,43 30.00 30.00 05000 04500 RABINACY 1 1 1 1 1 1 1 1 1				o	0	0		l	
16.00 01-000 NEDICAL RECORDS & LIBRARY 4,829 0 0 752,588 1,699 16.00		1	l .	0	0			l	1
IMPART ENT ROUTINE SERVICE COST CENTERS 136,003 2,431,052 0 2,492,104 18,009 30.0 30.0 0300 AURIS & PERDIATRIC S 136,003 2,431,052 0 2,492,104 18,009 30.0 30.0 0300 MISTERY 0 173,706 0 151,715 225 43.0 03.0 0300 MISTERY 0 173,706 0 151,715 225 43.0 03.0 0300 MISTERY 0 173,706 0 151,715 225 43.0 03.0 0300 MISTERY 0 173,706 0 151,715 225 43.0 0		1	l .					-	
30.00	10.00			4,027	0	0	752, 566	1,039	10.00
43.00 0.4300 NURSERY AND NURSERY A	30. 00	03000	ADULTS & PEDIATRICS	136, 093	2, 431, 052				30. 00
## ANCILLARY SERVICE COST CENTERS 50.00 05000 DERATING ROM ROM 137,900 2,444,930 0 1,439,844 22,576 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 137,900 57,996 0 55,759 738 52.00 64,000 6460,000				-				l	
50.00	43.00			0	1/3, /06	0	131, /15	225	43.00
52.00 05200 RELIVERY ROOM & LABOR ROOM 0 57, 996 0 55, 759 738 52.00 60.00 6000 LABORATORY 99, 700 12, 923, 259 0 1.606, 741 7.354 54.00 60.00 6000 LABORATORY 99, 700 12, 923, 259 0 1.238, 705 2.581 60.00 6050 RESPIRATORY THERAPY 10, 903 2.488, 980 66.90 0.650 0.6500 RESPIRATORY THERAPY 10, 903 2.488, 980 69.00 0.670 0.6700	50. 00			137, 900	2, 444, 930	0	1, 439, 844	22, 576	50.00
60.00				o					•
63.00 66300 BLOOD STORING, PROCESSING & TRANS. 75, 100 91, 107 0 86, 988 0 63, 00 660, 00 6600 RESPIRATIONY THERAPY 10, 993 2, 458, 990 0 669, 042 3, 411 66, 00 6800 PHYSI CAL THERAPY 10, 993 2, 458, 990 0 669, 042 3, 411 66, 00 6800 CELPTROCARD LITERAPY 0 90, 061 0 27, 532 0 67, 00 6700 0 6000 0 6000 0 6000 0									1
65.00 06500 RESPI RATORY THERAPY 10, 993 2, 293, 027 0 568, 531 3, 441 65.00 66.00 06600 DHYSI CLAI THERAPY 10, 993 2, 488, 990 0 669, 042 3, 411 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 90, 061 0 27, 532 0 67.00 69.00 06800 SPEECH PATHOLICGY 0 0 1, 730, 769 0 208, 659 0 69.00 69.00 06900 ELECTROCARDIOLOGY 0 1, 730, 769 0 208, 659 0 69.00 69.00 DROSCO DREICH CLAIR SPELIES CHARGED TO PATIENT 114, 743 2, 130, 997 0 240, 926 0 71.00 72.00 07200 IMPL DEV CHARGED TO PATIENTS 218, 054 597, 368 0 262, 659 0 72.00 75.00 07200 IMPL DEV CHARGED TO PATIENTS 0 7, 482, 350 0 581, 406 480 73.00 75.00 03020 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 75.00 76.00 03020 CARDI AC REHAB 0 0 0 0 0 0 0 76.00 03020 CARDI AC REHAB 0 0 0 0 0 0 75.00 76.00 03020 CARDI AC REHAB 0 0 0 0 0 0 75.00 76.00 03020 CARDI AC REHAB 1.584 1.584 1.584 1.584 76.97 07697 CARDI AC REHAB 1.584 1.584 1.584 1.584 1.584 76.97 07697 CARDI AC REHAB 1.584 1.584 1.584 1.584 1.584 76.97 07697 CARDI AC REHAB 1.584 1.584 1.584 1.584 1.584 1.584 76.90 09100 DEER CRENCY 1.585 1.585 1.584 1.584 1.584 76.90 09100 DEER CRENCY 1.585 1.585 1.585 1.585 1.585 1.585 76.90 09100 DEER CRENCY 1.585 1.585 1.585 1.585 1.585 1.585 77.50 09100 DEER CRENCY 1.585 1.585 1.585 1.585 1.585 1.585 78.00 19000 DEER CRENCY 1.585 1.585 1.585 1.585 1.585 1.585 78.00 19000 DEER CRENCY 1.585 1.585 1.585 1.585 1.585 1.585 78.00 19000 DEER CRENCY 1.585 1.585 1.585 1.585 1.585 1.585 1.585 78.00 19000 DEER CRENCY 1.585 1.585 1.585 1.585 1.585 1.585 1.585 78.00 19000 DEER CRENCY 1.585 1.585 1.585 1.585 1.585 1.585 1.585 1.585 1.585 1.585 1.585 1.5									1
66.00 06600 PHYSI CAL THERAPY 10,993 2,488, 980 0 669,042 3,411 66.00 67.00 670.00				1				l e	1
68.00 06800 SPECH PATHOLOGY 0 60, 787 0 43, 239 89 68.00 71. 00 07100 LECTROCARDIOLOGY 0 1, 730, 769 0 208, 659 0 69, 00 71. 00 07100 LECTROCARDIOLOGY 0 114, 743 2, 130, 097 0 240, 926 0 71. 00 72. 00 07200 MPL DEV CHARGED TO PATIENTS 218,054 597, 368 0 262,659 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 218,054 597, 368 0 262,659 0 72. 00 75. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 75. 00 76. 00 03010 SLEEP LAB 0 0 0 0 0 0 76. 00 76. 00 03020 CARDI AC REHAB LITATION 943 715,051 0 168,644 1,584 76. 00 07600 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 76. 00 76. 00 07907 CARDI AC REHAB LITATION 943 715,051 0 186,644 1,584 76. 00 07901 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 76. 00 07901 CARDI AC REHAB LITATION 943 715,051 0 186,644 1,584 77. 00 07901 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 78. 00 079010 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 78. 00 07900 DRUGS CHARGED TO PATIENTS 0		1	•	1				l	1
69.00 06-900 06-9700 06-9700 06-9700 06-9700 06-9700 06-9700 06-9700 06-9700 06-9700 06-9700 06-9700 07-9700				0		_		l	1
11.00		1	•	0		_		l	
13. 00 07300 DRUGS CHARCED TO PATIENTS 0 7, 482, 350 0 581, 406 480 73. 00 76. 00 3010 SLEPE LAB 0 0 0 0 0 0 0 0 0		1	•	114, 743					1
75.00 03610 SLEEP LAB 0 0 0 0 0 0 75.00	72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	218, 054	597, 368	0	262, 659	0	72. 00
16. 00 03020 CARDI AC REHAB 0 0 0 168, 644 1,584 15.84 16.97 0.0750 0.0 168, 644 1,584 16.97 0.0 0				0				l	1
16. 97 O76-7 CARDI AC REHABILITATION 943 715, 051 0 168, 644 1, 584 76. 97		1	•	0			0	· ·	
88. 00 08800 RURAL HEALTH CLINIC 0 1, 246,597 0 595,244 715 88. 00 09100 09100 EMERGENCY 185,044 10, 963, 474 0 1, 880,554 7, 488 91. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 92. 00 1300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 1,051,705 64,780,664 -2,088,519 16,234,011 76,582 118. 00 19000 01 77,000 77,0				943	-		168, 644		1
91.00 09100 EMERGENCY 185,044 10,963,474 0 1,880,554 7,488 91.00 92.00 9200 092000 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 092									
92. 00 09200 095ERVATI (ON BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 113. 00 113000 11300 11300 113000 113000 1				-				1	1
SPECIAL PURPOSE COST CENTERS 113.00 11300 1NTEREST EXPENSE 113.00 113.00 1NTEREST EXPENSE 113.00 113.00 1NTEREST EXPENSE 113.00 113.00 103.00 113.00 103.		1	l .	165, 044	10, 903, 474	U	1, 660, 554	7, 400	1
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1,051,705 64,780,664 -2,088,519 16,234,011 76,582 118. 00		SPECI	AL PURPOSE COST CENTERS						
NONREI MBURSABLE COST CENTERS 190. 00 1900		1	l .	4 054 705		0 000 540	47 004 044	7, 500	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 6, 789 664 190. 00 190. 01 19001 MARKETI NG 0 0 0 89, 574 0 190. 01 19001 192. 0	118.00			1, 051, 705	64, 780, 664	-2, 088, 519	16, 234, 011	/6, 582]118. 00]
190. 01 19001 MARKETING 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 99, 453 0 192. 01 19201 SCOTT PHYSICIAN GROUP 0 0 0 0 0 0 0 0 0 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 19201 SCOTT PHYSICIAN GROUP 194. 00 07950 BUHSE CAMPUS 0 0 0 0 0 251, 054 1, 250 194. 00 194. 01 07951 MEDICAL SPECIALTY 1, 163 0 0 174, 004 2, 500 194. 01 194. 02 197952 MEDICAL SPECIALTY 1, 163 0 0 0 174, 004 2, 500 194. 01 194. 02 194. 03 194. 04 194. 05 07952 MEDICAL SPECIALTY 0 0 0 0 0 37, 971 10, 000 194. 03 194. 04 194. 05 07955 ORTHO CAMPUS 0 0 0 0 0 0 0 0 0 0 0 194. 05 194. 05 07955 ORTHO CAMPUS 0 0 0 0 0 0 0 0 0 0 0 194. 05 194. 07956 DR. CRAIG CLINIC 0 0 0 0 0 0 0 0 179 194. 08 07958 DR. CARIG CLINIC 0 0 0 0 0 0 179 194. 08 07959 DR. PACE 0 0 0 0 0 179 194. 08 07959 DR. PACE 0 0 0 0 0 1, 00 194. 07 194. 10 19760 SCOTTSBURG FAMILY PRACTICE (RHC) 0 0 0 0 1, 00 194. 07 194. 08 07950 DR. CRAIG CONTESSURG FAMILY PRACTICE (RHC) 0 0 0 0 0 0 0 1, 10 1, 10 194. 07 195. 10 10 10 10 10 10 10 10 10 10 10 10 10	190.00			O	0	0	6, 789	664	190. 00
192. 01 19201 SCOTT PHYSICIAN GROUP 194. 00 07950 BUHSE CAMPUS 0 0 0 0 251, 054 1, 250 194. 00 194. 01 07951 MEDI CAL SPECIALTY 1, 163 0 0 174, 004 2, 500 194. 01 194. 02 07952 MEDI CAL OFFI CE 0 0 0 0 63, 031 16, 600 194. 02 194. 03 07953 VA PROPERTY 0 0 0 0 37, 971 10, 000 194. 03 194. 04 07954 ALREFAI CAMPUS 0 0 0 0 0 379, 455 2, 000 194. 03 194. 06 07956 DR. CRAIG CLINIC 0 0 0 0 379, 455 2, 000 194. 05 194. 07 07957 DR. OLABIGE CLINIC 0 0 0 0 0 179, 00 194. 07 07959 DR. OLABIGE CLINIC 0 0 0 0 194. 08 194. 08 07958 URGENT CARE CLINIC 0 0 0 0 194. 08 194. 10 07960 SCOTTSBURG FAMILY PRACTICE (RHC) 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 206. 00 Unit cost multiplier (Wkst. B, Part I) 207. 00 00 00 00 00 00 00 00 00 00 00 00 00	190. 01	19001	MARKETI NG	1	0	0	89, 574	0	190. 01
194. 00 07950 BUHSE CAMPUS 0 0 0 251, 054 1, 250 194. 00 194. 01 194. 01 07951 MEDI CAL SPECI ALTY 1, 163 0 0 174, 004 2, 500 194. 01 194. 02 07952 MEDI CAL OFFI CE 0 0 0 0 63, 031 16, 600 194. 01 194. 03 07953 07958 07954 ALREFAI CAMPUS 0 0 0 0 0 0 194. 04 194. 05 07955				0		0	99, 453		
194. 01 07951 MEDICAL SPECIALTY				l o	-) o	251. 054	l e	1
194. 03 07953 VA PROPERTY 194. 04 07954 ALREFAI CAMPUS 0 0 0 0 0 0 0 194. 03 194. 05 07955 ORTHO CAMPUS 0 0 0 0 0 379, 455 2, 000 194. 05 194. 06 0795 DR. CRAIG CLINIC 194. 07 07957 DR. OLABIGE CLINIC 194. 08 07958 DR. PACE 194. 10 07960 SCOTTSBURG FAMILY PRACTICE (RHC) 200. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 206. 00 Unit cost multiplier (Wkst. B, Part III) 205. 00 Unit cost multiplier (Wkst. B, Part III) 206. 00 Unit cost multiplier (Wkst. B, Part III) 207. 00 Unit cost multiplier (Wkst. B, Part III) 208. 00 Unit cost multiplier (Wkst. B, Part IIII) 208. 00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII				1, 163					1
194. 04 07954 ALREFAI CAMPUS 0 0 0 0 0 0 194. 04 194. 05 07955 ORTHO CAMPUS 0 0 0 0 0 0 0 194. 05 194. 06 07956 DR. CRAIG CLINIC 0 0 0 0 0 194. 06 194. 07 07957 DR. OLABIGE CLINIC 0 0 0 0 0 194. 07 194. 08 07958 DR. PACE 0 0 0 0 0 0 194. 08 194. 09 07959 DR. PACE 0 0 0 0 0 0 194. 09 194. 10 07960 SCOTTSBURG FAMILY PRACTICE (RHC) 0 0 0 0 11,095 DR. PACE 0 0 0 0 0 11,095 DR. PACE 0 0 0 0 0 11,095 DR. PACE 0 0 0 0 0 0 11,095 DR. PACE 0 0 0 0 0 0 11,095 DR. PACE 0 0 0 0 0 0 0 11,095 DR. PACE 0 0 0 0 0 0 0 11,095 DR. PACE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0					
194. 05 07955 ORTHO CAMPUS 194. 06 07956 DR. CRAIG CLINIC 194. 07 07957 DR. OLABIGE CLINIC 194. 08 07958 DR. PACE 194. 09 07959 DR. PACE 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 194. 05 07958 DR. CRAIG CLINIC 0 0 0 0 0 194. 05 0 0 0 0 194. 06 0 0 0 0 194. 06 0 0 0 0 194. 07 0 0 0 0 0 194. 07 0 0 0 0 0 0 194. 07 0 0 0 0 0 0 194. 07 0 0 0 0 0 0 194. 07 0 0 0 0 0 0 194. 07 179 0 194. 07 0 0 0 0 0 0 0 194. 07 0 0 0 0 0 194. 07 179 0 194. 07 0 0 0 0 0 0 0 194. 07 179 0 194. 07 0 0 0 0 0 0 0 194. 07 179 0 194. 07 0 0 0 0 0 0 0 194. 07 179 0 194. 07 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	•	0	-	_	37, 971		
194.06 07956 DR. CRAIG CLINIC 0 0 0 0 194.06 194.07 07957 DR. OLABIGE CLINIC 0 0 0 179 0 194.07 194.08 07958 URGENT CARE CLINIC 0 0 0 0 0 194.08 194.09 07959 DR. PACE 0 0 0 0 24,769 1,800 194.09 194.10 07960 SCOTTSBURG FAMILY PRACTICE (RHC) 0 0 0 11,095 1,085 194.09 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 0.121099 0.006220 0.120228 10.226296 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 0.121099 0.006220 0.120228 1270,438 38,526 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.017961 0.000027 0.015568 0.342511 205.00				0			379, 455		
194.08 07958 URGENT CARE CLINIC 0 0 0 0 0 194.08 194.09 07959 DR. PACE 0 0 0 0 24,769 1,800 194.09 194.10 07960 SCOTTSBURG FAMILY PRACTICE (RHC) 0 0 0 11,095 1,085 194.10 200.00 Cross Foot Adjustments Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) 0.121099 0.006220 0.120228 10.226296 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 0.121099 0.006220 0.120228 10.226296 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 0.11761 0.000027 0.015568 0.342511 205.00	194.06	07956	DR. CRAIG CLINIC	O	0	0	0		
194.09 07959 DR. PACE 0 0 0 24,769 1,800 194.09 194.10 07960 SCOTTSBURG FAMILY PRACTICE (RHC) 0 0 11,095 1,085 194.10 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 205.00 Unit cost multiplier (Wkst. B, Part III) 205.00 Unit cost multiplier (Wkst. B, Part IIII) 205.00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII				0	0	0	179	•	
194. 10 07960 SCOTTSBURG FAMILY PRACTICE (RHC) 0 0 11,095 1,085 194. 10 200. 00 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) 0. 121099 0. 006220 204. 00 Cost to be allocated (per Wkst. B, Part II) 270, 438 38,526 204. 00 Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.		1	i e	0	0	0	0 24 760	l	
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 0.121099 0.006220 203.00 Unit cost multiplier (Wkst. B, Part I) 0.121099 0.006220 0.120228 10.226296 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 0.017961 0.000027 0.015568 0.342511 205.00					-	_			
202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 206.00 Unit cost multiplier (Wkst. B, Part I) 207.01 Unit cost multiplier (Wkst. B, Part II) 208.00 Unit cost multiplier (Wkst. B, Part II) 208.00 Unit cost multiplier (Wkst. B, Part II) 208.00 Unit cost multiplier (Wkst. B, Part II) 209.00 Unit cost multiplier (Wkst. B, Part III) 209.00 Unit cost multiplier (Wkst. B, Part III) 209.00 Unit cost multiplier (Wkst. B, Part III) 200.00 Unit cost multiplier (Wkst. B, Part III)	200.00								200. 00
Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 0. 121099 0. 006220 0. 120228 10. 226296 203. 00 1, 718 270, 438 38, 526 204. 00 0. 120228 0. 120228 0. 10. 226296 0. 38, 526 0. 342511 0. 000027 0. 015568 0. 342511 0. 000027				407.515	400 000		2 202 512	1 450 000	201.00
203.00 Unit cost multiplier (Wkst. B, Part I) 0.121099 0.006220 0.120228 10.226296 203.00	202.00	'	1	127, 515	402, 928		2, 088, 519	1, 150, 264	202.00
204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000027 0.015568 0.342511 205.00	203.00	,		0. 121099	0. 006220		0. 120228	10. 226296	203. 00
205.00 Unit cost multiplier (Wkst. B, Part 0.017961 0.000027 0.015568 0.342511 205.00			Cost to be allocated (per Wkst. B,	1					1
	205 00		1	0.0170/1	0 000037		0.0155/0	0.240544	20E 00
	203.00			0.017961	0. 000027		0. 015568	0.342511	203.00
		•		. '			'		

Health Fir	nancial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					rom 01/01/2018		
				1	To 12/31/2018		pared:
						5/30/2019 11:	32 am
	Cost Center Description	PURCHASI NG	CASHI ERI NG/ACC	Reconciliation	OTHER ADMIN	OPERATION OF	
		RECEIVING AND	OUNTS		AND GENERAL	PLANT	
		STORES	RECEI VABLE		(ACCUMULATED	(SQUARE FEET)	
		(COSTED	(GROSS		COST)		
		REQUIS.)	CHARGES)				
		5. 03	5. 04	5A. 05	5. 05	7. 00	
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)						

Health Financial Systems In Lieu of Form CMS-2552-10 SCOTT MEMORIAL HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1334 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/30/2019 11:32 am Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL (MAN HOURS SERVICE & (MAN HOURS) (MEALS SERVED) ADMI NI STRATI ON (CAF)) **SUPPLY** (HOURS SUPE (COSTED REQUIS.) RVI) 9.00 10.00 11.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00

Heal th Financ	cial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/30/2019 11:	
(Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(MAN HOURS)	(MEALS SERVED)	(MAN HOURS	ADMI NI STRATI ON	SERVICE &	
				(CAF))		SUPPLY	
					(HOURS SUPE	(COSTED	
					RVI)	REQUIS.)	
		9.00	10.00	11. 00	13. 00	14. 00	
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)						

Health Financial Systems SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1334 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/30/2019 11:32 am Cost Center Description **PHARMACY** MEDI CAL (COSTED RECORDS & REQUIS.) LI BRARY (GROSS CHARGES) 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00550 INFORMATION TECH 5.01 5. 01 00570 ADMITTING 5.02 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5.05 00590 OTHER ADMIN AND GENERAL 5.05 00700 OPERATION OF PLANT 7.00 7 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICE & SUPPLY 14.00 01500 PHARMACY 15.00 402, 744 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 64, 780, 664 16 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 431, 052 30.00 0 03100 INTENSIVE CARE UNIT 31.00 31.00 0 188, 564 04300 NURSERY 0 43.00 43 00 173, 706 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 2, 444, 930 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 57, 996 52.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 16, 701, 489 54 00 60.00 06000 LABORATORY 12, 923, 259 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 91, 107 63.00 0 06500 RESPIRATORY THERAPY 65.00 2, 293, 027 65.00 06600 PHYSI CAL THERAPY 2, 458, 980 66.00 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 90, 061 67.00 06800 SPEECH PATHOLOGY 68.00 60, 787 68.00 0 69.00 06900 ELECTROCARDI OLOGY 1, 730, 769 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 2, 130, 097 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 597, 368 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 402, 744 7, 482, 350 73.00 03610 SLEEP LAB 75.00 75.00 0 0 03020 CARDIAC REHAB 07697 CARDIAC REHABILITATION 76.00 0 76.00 76.97 0 715, 051 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 1, 246, 597 91.00 09100 EMERGENCY 10, 963, 474 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 402, 744 64, 780, 664 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 190. 01 19001 MARKETI NG 0 0 190. 01 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192. 00 000000000000 0 192. 01 19201 SCOTT PHYSICIAN GROUP 0 192. 01 194. 00 07950 BUHSE CAMPUS 0 l194. 00 194. 01 07951 MEDICAL SPECIALTY 0 194. 01 194. 02 07952 MEDICAL OFFICE 0 194. 02 194.03 07953 VA PROPERTY 194.04 07954 ALREFAI CAMPUS 0 194. 03 0 194. 04 194.05 07955 ORTHO CAMPUS 0 194. 05 194.06 07956 DR. CRAIG CLINIC 0 194.06 194. 07 07957 DR. OLABIGE CLINIC 0 194 07 194. 08 07958 URGENT CARE CLINIC 0 194. 08 194. 09 07959 DR. PACE 0 194. 09 0 194. 10 07960 SCOTTSBURG FAMILY PRACTICE (RHC) 194. 10 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 430, 704 Cost to be allocated (per Wkst. B, 934, 175 202. 00 Part I) Unit cost multiplier (Wkst. B, Part I) 0.014421 203.00 1.069424 203.00 204.00 Cost to be allocated (per Wkst. B, 6,852 33, 031 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.017013 0.000510 205.00 II)

Health Financial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co	CN: 15-1334	Peri od: From 01/01/2018	Worksheet B-1	
				To 12/31/2018	Date/Time Pre 5/30/2019 11:	
Cost Center Description	PHARMACY	MEDI CAL				
	(COSTED	RECORDS &				
	REQUIS.)	LI BRARY				
		(GROSS				
		CHARGES)				
	15. 00	16.00				
206.00 NAHE adjustment amount to be allow	cated					206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. [D,					207. 00
Parts III and IV)						

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1334	Peri od: Worksheet C
		From 01/01/2018 Part
		To 12/21/2010 Data/Tima Dranarada

					To 12/31/2018	Date/Time Pre	pared:
			T: +1 o	xVIII	Hospi tal	5/30/2019 11: Cost	<u>32 am</u>
				: AVIII	Costs	COST	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	cost center bescription	(from Wkst. B.	Adj.	l local costs	Di sal I owance	Total Costs	
		Part I, col.	Auj .		DI Sai i Owance		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30 00	03000 ADULTS & PEDIATRICS	3, 485, 855		3, 485, 85	5 0	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T	625, 561		625, 56		0	
	· ·	164, 243		164, 24		0	1
	ANCILLARY SERVICE COST CENTERS	1		14.7=	-1		1
50.00		2, 055, 089		2, 055, 08	9 0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	97, 788		97. 78		0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 194, 139		2, 194, 13	9 0	0	54.00
60.00	06000 LABORATORY	1, 694, 060		1, 694, 06		0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	121, 981		121, 98		0	1
65. 00	06500 RESPI RATORY THERAPY	747, 105	0	747, 10		0	65.00
66. 00	06600 PHYSI CAL THERAPY	849, 898	0	849, 89		0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	32, 141	0	32, 14	1 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	50, 225	0	50, 22	5 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	272, 792		272, 79	2 0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	335, 760		335, 76	o o	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	369, 652		369, 65		0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 200, 967		1, 200, 96	7 0	0	73. 00
75.00	03610 SLEEP LAB	O			o o	0	75. 00
76.00	03020 CARDI AC REHAB	o			o o	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	236, 274		236, 27	4 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>					1
88. 00	08800 RURAL HEALTH CLINIC	735, 623		735, 62	3 0	0	88. 00
91.00	09100 EMERGENCY	2, 546, 962		2, 546, 96	2 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	943, 935		943, 93	5	0	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	18, 760, 050	0	18, 760, 05	o o	0	200.00
201.00	Less Observation Beds	943, 935		943, 93	5	0	201. 00
202.00	Total (see instructions)	17, 816, 115	0	17, 816, 11	5 o	0	202. 00

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-	1334 Period: Worksheet C From 01/01/2018 Part

12/31/2018 Date/Time Prepared: To 5/30/2019 11:32 am Title XVIII Hospi tal Cost Charges Cost Center Description Inpatient Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 964, 145 03000 ADULTS & PEDIATRICS 1, 964, 145 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 188, 564 188, 564 31.00 04300 NURSERY 173, 706 173, 706 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 1, 909, 157 2, 444, 930 0.840551 0.000000 50.00 05000 OPERATING ROOM 535, 773 52.00 05200 DELIVERY ROOM & LABOR ROOM 55, 145 2, 851 57, 996 1.686116 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 016, 768 15, 684, 721 16, 701, 489 0.131374 0.000000 54.00 10, 938, 397 06000 LABORATORY 12, 923, 259 0.131086 0.000000 60.00 1, 984, 862 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 1. 338876 0.000000 63.00 38.315 52, 792 91, 107 63.00 65.00 06500 RESPIRATORY THERAPY 826, 287 1, 466, 740 2, 293, 027 0.325816 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 239, 858 2, 219, 122 2, 458, 980 0.345630 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 22, 977 90,061 67.00 67,084 0.356880 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 20, 162 40, 625 60, 787 0.826246 0.000000 68.00 06900 ELECTROCARDI OLOGY 198, 546 1, 532, 223 1, 730, 769 0.157613 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 704, 751 425, 346 2, 130, 097 0.157627 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 249.322 597, 368 0.618801 72 00 348, 046 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 189, 458 5, 292, 892 7, 482, 350 0.160507 0.000000 73.00 03610 SLEEP LAB 0.000000 0.000000 75.00 0 0 75.00 03020 CARDI AC REHAB 0.000000 76.00 0 0.000000 76.00 07697 CARDI AC REHABI LI TATI ON 76.97 0 715, 051 715, 051 0.330430 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 1, 246, 597 1, 246, 597 88.00 91 00 09100 EMERGENCY 629, 240 10, 334, 234 10, 963, 474 0. 232313 0.000000 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 56,019 410,888 466, 907 2.021677 0.000000 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 12, 093, 898 52, 686, 766 64, 780, 664 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 12, 093, 898 52, 686, 766 64, 780, 664 202.00

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1334	From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Ti me Prepared: 5/30/2019 11:32 am

				5/30/2019 11:32 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
60. 00 06000 LABORATORY	0. 000000			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
75. 00 03610 SLEEP LAB	0. 000000			75. 00
76. 00 03020 CARDI AC REHAB	0. 000000			76.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88. 00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 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
				· ·

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1334	From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/30/2019 11:32 am

					To 12/31/2018	Date/Time Pre 5/30/2019 11:	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	T					
30. 00	03000 ADULTS & PEDIATRICS	3, 485, 855		3, 485, 85		3, 485, 855	
	03100 INTENSIVE CARE UNIT	625, 561		625, 56		625, 561	
43. 00	04300 NURSERY	164, 243		164, 24	3 0	164, 243	43. 00
	ANCILLARY SERVICE COST CENTERS	T		T	-1		
50. 00	05000 OPERATING ROOM	2, 055, 089		2, 055, 08		2, 055, 089	
52.00	05200 DELIVERY ROOM & LABOR ROOM	97, 788		97, 78		97, 788	
	05400 RADI OLOGY-DI AGNOSTI C	2, 194, 139		2, 194, 13		2, 194, 139	
60.00	06000 LABORATORY	1, 694, 060		1, 694, 06		1, 694, 060	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	121, 981		121, 98		121, 981	
65. 00	06500 RESPI RATORY THERAPY	747, 105		747, 10		747, 105	
66. 00	06600 PHYSI CAL THERAPY	849, 898	0	849, 89		849, 898	
67. 00	06700 OCCUPATI ONAL THERAPY	32, 141	0	32, 14		32, 141	
68. 00	06800 SPEECH PATHOLOGY	50, 225		50, 22		50, 225	
	06900 ELECTROCARDI OLOGY	272, 792		272, 79		272, 792	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	335, 760		335, 76		335, 760	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	369, 652		369, 65		369, 652	
		1, 200, 967		1, 200, 96	7 0	1, 200, 967	
	03610 SLEEP LAB	0			0	0	
	03020 CARDI AC REHAB	0			0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	236, 274		236, 27	4 0	236, 274	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	735, 623		735, 62		735, 623	
91. 00	09100 EMERGENCY	2, 546, 962		2, 546, 96	2 0	2, 546, 962	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	943, 935		943, 93	5	943, 935	92. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
200.00		18, 760, 050				18, 760, 050	
201.00	1 1	943, 935		943, 93		943, 935	
202.00	Total (see instructions)	17, 816, 115	0	17, 816, 11	5 0	17, 816, 115	202. 00

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-	1334 Period: Worksheet C From 01/01/2018 Part

12/31/2018 Date/Time Prepared: To 5/30/2019 11:32 am Title XIX Hospi tal Cost Charges Cost Center Description Inpatient Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 964, 145 03000 ADULTS & PEDIATRICS 1, 964, 145 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 188, 564 188, 564 31.00 173, 706 04300 NURSERY 173, 706 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 1, 909, 157 2, 444, 930 0.840551 0.000000 50.00 05000 OPERATING ROOM 535, 773 52.00 05200 DELIVERY ROOM & LABOR ROOM 55, 145 2, 851 57, 996 1.686116 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 016, 768 15, 684, 721 16, 701, 489 0.131374 0.000000 54.00 10, 938, 397 06000 LABORATORY 12, 923, 259 0.131086 0.000000 60.00 1, 984, 862 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 1. 338876 0.000000 63.00 38.315 52, 792 91, 107 63.00 65.00 06500 RESPIRATORY THERAPY 826, 287 1, 466, 740 2, 293, 027 0.325816 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 239, 858 2, 219, 122 2, 458, 980 0.345630 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 22, 977 90,061 67.00 67,084 0.356880 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 20, 162 40, 625 60, 787 0.826246 0.000000 68.00 06900 ELECTROCARDI OLOGY 198, 546 1, 532, 223 1, 730, 769 0.157613 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 704, 751 425, 346 2, 130, 097 0.157627 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 249.322 597, 368 0.618801 72 00 348, 046 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 189, 458 5, 292, 892 7, 482, 350 0.160507 0.000000 73.00 03610 SLEEP LAB 0.000000 0.000000 75.00 0 0 75.00 03020 CARDI AC REHAB 0.000000 76.00 0 0.000000 76.00 07697 CARDI AC REHABI LI TATI ON 76.97 0 715, 051 715, 051 0.330430 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0. 590105 88.00 1, 246, 597 1, 246, 597 0.000000 88.00 91 00 09100 EMERGENCY 629, 240 10, 334, 234 10, 963, 474 0 232313 0.000000 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 56,019 410,888 466, 907 2.021677 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 12, 093, 898 52, 686, 766 64, 780, 664 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 12, 093, 898 52, 686, 766 64, 780, 664 202.00

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Ti me Prepared: 5/30/2019 11:32 am
	Title XIX	Hospi tal	Cost

				5/30/2019 11:3	32 am
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
75. 00 03610 SLEEP LAB	0. 000000				75.00
76. 00 03020 CARDI AC REHAB	0. 000000				76.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000				76. 97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0. 000000				88. 00
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
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

Health Financial Systems	SCOTT MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der CCN: 15-1334	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/30/2019 11:32 am

					-rom 01/01/2018 Fo 12/31/2018	Part II Date/Time Pre	pared:
						5/30/2019 11:	32 am_
				XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col . 1 ÷ col .	Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	I	1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	T		1			
	05000 OPERATI NG ROOM	272, 843				23, 897	50. 00
	05200 DELIVERY ROOM & LABOR ROOM	9, 765				0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	118, 297				3, 189	54. 00
60.00	06000 LABORATORY	62, 859				· ·	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	3, 784				991	63. 00
	06500 RESPI RATORY THERAPY	50, 522				· ·	65. 00
66. 00	06600 PHYSI CAL THERAPY	50, 629				1, 578	66. 00
	06700 OCCUPATI ONAL THERAPY	501	90, 061			0	67.00
	06800 SPEECH PATHOLOGY	1, 667				205	68. 00
69. 00	06900 ELECTROCARDI OLOGY	5, 204					69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 223	2, 130, 097	0. 004799	851, 404	4, 086	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11, 411	597, 368	0. 019102	179, 917	3, 437	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	27, 500	7, 482, 350	0. 00367	858, 692	3, 156	73. 00
75.00	03610 SLEEP LAB	0	0	0.000000	0	0	75.00
76.00	03020 CARDI AC REHAB	0	0	0.000000	0	0	76.00
76. 97	07697 CARDIAC REHABILITATION	21, 056	715, 051	0. 02944	7 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	21, 613	1, 246, 597	0. 017338	3 0	0	88. 00
91.00	09100 EMERGENCY	125, 262	10, 963, 474	0. 01142	292, 620	3, 343	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	74, 133	466, 907	0. 15877!	26, 221	4, 163	92.00
200. 00	Total (lines 50 through 199)	867, 269	62, 454, 249	1	4, 378, 700	60, 379	200. 00

Health Financial Systems	SCOTT MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-1334	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

					5/30/2019 11:	32 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	C	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54. 00
60. 00 06000 LABORATORY	0	0	C	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	C	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
75. 00 03610 SLEEP LAB	0	0	C	0	0	75. 00
76. 00 03020 CARDI AC REHAB	0	0	l c	0	0	76. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	l c	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS			•	*		
88. 00 08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
91. 00 09100 EMERGENCY	0	0	l c	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92. 00
200.00 Total (lines 50 through 199)	0	0	C	0	0	200. 00

Health Financial Systems	SCOTT MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1334	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

			1	To 12/31/2018	Date/Time Prep 5/30/2019 11:	
			XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
	4.00		and 4)	7.00	0.00	
ANGLE ARY OFRICE COOT OFFITTED	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				0 444 000	0.00000	F0 00
50. 00 05000 OPERATING ROOM	0	0		2, 444, 930		
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		57, 996		1
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0		16, 701, 489		
60. 00 06000 LABORATORY	0	0		12, 923, 259		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		91, 107		
65. 00 06500 RESPIRATORY THERAPY	0	0		2, 293, 027		
66. 00 06600 PHYSI CAL THERAPY	0	0	(2, 458, 980		1
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(90, 061		1
68. 00 06800 SPEECH PATHOLOGY	0	0	(60, 787		
69. 00 06900 ELECTROCARDI OLOGY	0	0		1, 730, 769		
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	(2, 130, 097		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(597, 368		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	(7, 482, 350		1
75. 00 03610 SLEEP LAB	0	0	(0	0.000000	1
76. 00 03020 CARDI AC REHAB	0	0	(0	0.000000	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	(715, 051	0.000000	76. 97
OUTPATIENT SERVICE COST CENTERS	_	_	1			
88. 00 08800 RURAL HEALTH CLINIC	0	0	(1, 246, 597		1
91. 00 09100 EMERGENCY	0	0	(10, 963, 474		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(466, 907		1
200.00 Total (lines 50 through 199)	0	0	(62, 454, 249		200. 00

Health Financial Systems SCOTT MEMORIAL HOSPITAL In Lieu						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER PASS	Provider C		Period: From 01/01/2018 To 12/31/2018		pared: 32 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	·					
50.00 05000 OPERATING ROOM	0. 000000	214, 137		0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
	1		1	_	l _	1

Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	214, 137	0	0	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	450, 176	0	0	0	54.00
60. 00 06000 LABORATORY	0. 000000	954, 038	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	23, 871	0	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	334, 324	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	76, 628	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	7, 493	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	109, 179	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	851, 404	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	179, 917	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	858, 692	0	0	0	73. 00
75. 00 03610 SLEEP LAB	0. 000000	0	0	0	0	75. 00
76. 00 03020 CARDI AC REHAB	0. 000000	0	0	0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88. 00
91. 00 09100 EMERGENCY	0. 000000	292, 620	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	26, 221	0	0	0	92.00
200.00 Total (lines 50 through 199)		4, 378, 700	0	0	0	200. 00
			. '			

Health Financial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T	1		.1 _	_	
50. 00 05000 OPERATI NG ROOM	0. 840551	l .	570, 08		0	00.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 686116	l .		0	0	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 131374	l .	4, 766, 63		0	54.00
60. 00 06000 LABORATORY	0. 131086	l .	3, 476, 90		0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1. 338876	l .	26, 64		0	63. 00
65. 00 06500 RESPI RATORY THERAPY	0. 325816		554, 60		0	00.00
66. 00 06600 PHYSI CAL THERAPY	0. 345630		816, 10		0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 356880		37, 33		0	
68. 00 06800 SPEECH PATHOLOGY	0. 826246		9, 24		0	
69. 00 06900 ELECTROCARDI OLOGY	0. 157613		568, 58		0	07.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 157627	l .	161, 62		0	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 618801		48, 50		0	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 160507		1, 423, 69	6 3, 062	0	73. 00
75. 00 03610 SLEEP LAB	0. 000000			0	0	75. 00
76. 00 03020 CARDI AC REHAB	0. 000000	l .		0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 330430	0	240, 79	4 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS		ī	ı	1		
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			2 540	0	
91. 00 09100 EMERGENCY	0. 232313	l .	-1		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2. 021677	0	141, 24			92.00
200.00 Subtotal (see instructions)	-	0	15, 338, 97	8 5, 575	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges			15 220 07			202 00
202.00 Net Charges (line 200 - line 201)	I	0	15, 338, 97	8 5, 575	0	202. 00

Health Financial Systems	SCOTT MEMORIAL F	HOSPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1334	Peri od:	Worksheet D

Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 479, 185 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 626, 212 0 54.00 06000 LABORATORY 0 60.00 455, 773 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 35, 680 63.00 06500 RESPIRATORY THERAPY 0 65.00 180, 698 65.00 0 06600 PHYSI CAL THERAPY 282, 071 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 13, 323 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 7,638 68.00 06900 ELECTROCARDI OLOGY 89, 616 69.00 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 25, 476 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 30, 015 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 228, 513 491 73.00 03610 SLEEP LAB 75.00 0 0 75.00 76.00 03020 CARDI AC REHAB 0 76.00 76. 97 07697 CARDIAC REHABILITATION 79, 566 76. 97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 91.00 09100 EMERGENCY 580,083 584 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 285, 546 92.00 200.00 Subtotal (see instructions) 3, 399, 395 200. 00 1,075 201.00 Less PBP Clinic Lab. Services-Program 201. 00 Only Charges 202.00 Net Charges (line 200 - line 201) 3, 399, 395 1, 075 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1334 Peri od: Worksheet D From 01/01/2018 Part V Component CCN: 15-Z334 12/31/2018 Date/Time Prepared: To 5/30/2019 11:32 am Title XVIII Swing Beds - SNF Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.840551 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1.686116 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 131374 0 54.00 0 0 0 60.00 06000 LABORATORY 0.131086 0 0 60.00 1. 338876 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 0 65.00 06500 RESPIRATORY THERAPY 0.325816 0 0 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 0. 345630 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.356880 0 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 0.826246 0 68.00 06900 ELECTROCARDI OLOGY 69.00 0. 157613 0 0 69 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 157627 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.618801 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.160507 0 0 73.00 0 03610 SLEEP LAB 75.00 0 0.000000 Ω 75.00 76.00 03020 CARDI AC REHAB 0.000000 0 0 0 76.00 07697 CARDIAC REHABILITATION 0. 330430 0 76. 97 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 91.00 09100 EMERGENCY 0. 232313 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2.021677 0 92.00 0 0 Subtotal (see instructions) 200.00 0 0 200, 00

201. 00

0 202.00

0

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL, OTHER HEALT	SERVICES AND VACCINE COST Provider	CCN: 15-1334 Peri od: From 01/01/2018	Worksheet D Part V
	Componen	t CCN: 15-Z334 To 12/31/2018	Date/Time Prepared: 5/30/2019 11:32 am
	Ti t	le XVIII Swing Beds - SNF	Cost
	Costs		

		Component	CCN: 15-Z334	То	12/31/20	0ate/Time Pre 5/30/2019 11:	
		Title	XVIII	Swi no	Beds - S	Cost	02 dill
	Co:	sts		1-11-12	,	 	
Cost Center Description	Cost	Cost	1				
· ·	Rei mbursed	Rei mbursed					
	Servi ces	Services Not					
	Subject To	Subject To					
	Ded. & Coins.	Ded. & Coins.					
	(see inst.)	(see inst.)					
	6. 00	7. 00					
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0)				50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0					52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0					54. 00
60. 00 06000 LABORATORY	0	0					60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0					63. 00
65. 00 06500 RESPI RATORY THERAPY	0	0)				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0)				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0)				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0)				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0)				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)				72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0)				73. 00
75. 00 03610 SLEEP LAB	0	0)				75. 00
76. 00 03020 CARDI AC REHAB	0	0)				76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0					76. 97
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0					88. 00
91. 00 09100 EMERGENCY	0	0					91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1				92. 00
200.00 Subtotal (see instructions)	0	0	1				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0)					201. 00
Only Charges	_	_					
202.00 Net Charges (line 200 - line 201)	0	0	1				202. 00

Health Financial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/30/2019 11:	epared: 32 am
		Ti tl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
	1.00		(see inst.)	(see inst.)		
ANOTHER DESIGNATION OF THE PROPERTY OF THE PRO	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.040554		07.00	7		
50. 00 05000 OPERATING ROOM	0. 840551	0	37, 00	0	0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	1. 686116		200.00	0	0	
	0. 131374	l .	300, 00		0	
	0. 131086	l .	271, 42		0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	1. 338876	l .	2, 06		0	
65. 00 06500 RESPI RATORY THERAPY	0. 325816	l .	7, 98		0	
66. 00 06600 PHYSI CAL THERAPY	0. 345630	l .	19, 88	9 0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 356880			0	0	
68. 00 06800 SPEECH PATHOLOGY	0. 826246		0.4.00	0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 157613	l e	24, 99		0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 157627	0	4, 67	4 0	0	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 618801	0		0	0	1 , 2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 160507	0	64, 07	4 0	0	1 , 0. 00
75. 00 03610 SLEEP LAB 76. 00 03020 CARDI AC REHAB	0.000000	l e		0	0	70.00
	0.000000	l e		0	Ĭ	70.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0. 330430	<u> </u>		0 0	0	10.91
88. 00 08800 RURAL HEALTH CLINIC	0. 590105		I		0	88. 00
91. 00 09100 EMERGENCY	0. 232313		354, 01	2		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2. 021677		5, 34			
200.00 Subtotal (see instructions)	2.021077		1, 091, 46			200.00
201.00 Less PBP Clinic Lab. Services-Program		١	1, 071, 40	0		200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)		О	1, 091, 46	3 0	О	202. 00

| Peri od: | Worksheet D | From 01/01/2018 | Part V | To | 12/31/2018 | Date/Time Prepared:

					То	12/31/2018	Date/Time Pro 5/30/2019 11:	
			Ti tl	e XIX	H	Hospi tal	Cost	
		Cos	sts					
	Cost Center Description	Cost	Cost					
		Rei mbursed	Reimbursed					
		Servi ces	Services Not					
		Subject To	Subject To					
			Ded. & Coins.					
		(see inst.)	(see inst.)					
		6. 00	7. 00					
	CILLARY SERVICE COST CENTERS							
	OOO OPERATING ROOM	31, 106	0					50. 00
	200 DELIVERY ROOM & LABOR ROOM	0	0					52. 00
	400 RADI OLOGY-DI AGNOSTI C	39, 413	0					54. 00
	000 LABORATORY	35, 579	0					60. 00
1	300 BLOOD STORING, PROCESSING & TRANS.	2, 758	0					63. 00
	500 RESPI RATORY THERAPY	2, 600	0					65. 00
	600 PHYSI CAL THERAPY	6, 874	0					66. 00
	700 OCCUPATI ONAL THERAPY	0	0					67. 00
1	800 SPEECH PATHOLOGY	0	0					68. 00
	900 ELECTROCARDI OLOGY	3, 939	0					69. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	737	0					71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0					72. 00
	300 DRUGS CHARGED TO PATIENTS	10, 284	0					73. 00
	610 SLEEP LAB	0	0					75. 00
76. 00 03	020 CARDI AC REHAB	0	0					76. 00
	697 CARDI AC REHABI LI TATI ON	0	0					76. 97
	TPATIENT SERVICE COST CENTERS							
	800 RURAL HEALTH CLINIC	0	0					88. 00
	100 EMERGENCY	82, 242	0					91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	10, 798	0					92. 00
200.00	Subtotal (see instructions)	226, 330	0					200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0						201. 00
	Only Charges							
202. 00	Net Charges (line 200 - line 201)	226, 330	0					202. 00

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lie	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-133	From 01/01/2018	Worksheet D-1 Date/Time Prepared: 5/30/2019 11:32 am		
	Ti +l a YVIII	Hospi tal	Cost		

		Title XVIII	Hospi tal	5/30/2019 11: Cost	32 am_
	Cost Center Description		·	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	I NPATI ENT DAYS			2 770	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			3, 778 3, 290	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	<i>3</i> ,	vate room days,	0, 270	3. 00
	do not complete this line.		,		
4.00	Semi-private room days (excluding swing-bed and observation be		21 of the cost	2, 274	4.00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through becember	31 OF THE COST	462	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December :	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	m days) through December	31 of the cost	26	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roor	m days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swi ng-bed and	1, 203	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	416	10.00
	through December 31 of the cost reporting period (see instruc	tions)	,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, en		oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room davs)	0	12. 00
	through December 31 of the cost reporting period	3 .	,		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	am (exercaring eming zea)	, au j	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
17.00	reporting period	es thi dagir becember 51 0	the cost		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through Docombor 21 of	the cost	0.00	19. 00
19.00	reporting period	s till dugit becelliber 31 of	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	s)		3, 485, 855	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0, 403, 033	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reportion	ng period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December (x, y)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			429, 230	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 056, 625	
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			-	20.00
28. 00 29. 00	Private room charges (excluding swing-bed private room charges (excluding swing-bed charges)	a and observation bed cha	arges)	0	28. 00 29. 00
30. 00	Semi -pri vate room charges (excluding swing bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0. 00 0. 00	33. 00 34. 00
35. 00	Average per diem private room cost differential (line 34 x line)		11 0113)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	ŕ		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	3, 056, 625	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	*		929. 07	38. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		1, 117, 671 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	,		1, 117, 671	
		,	1		

Heal th	Financial Systems SCOTT MEMORIAL HOSPITAL In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-1334 Period: From 01/01/2018	Worksheet D-1	
	To 12/31/2018	Date/Time Prep 5/30/2019 11:3	
	Title XVIII Hospital	Cost	52 aiii
	Cost Center Description Total Total Average Per Program Days Inpatient Cost Inpatient Days Diem (col. 1 ÷	Program Cost	
	col . 2)	4)	
42 00	1.00 2.00 3.00 4.00 NURSERY (title V & XIX only) 0 0 0.00 0	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units		
43. 00 44. 00	INTENSIVE CARE UNIT 625, 561 145 4, 314. 21 71 CORONARY CARE UNIT	306, 309	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT		45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)		46. 00 47. 00
47.00	Cost Center Description		47.00
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1. 00 1, 059, 319	48. 00
	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2, 483, 299	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0	50. 00
30.00			50.00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	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 excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54. 00 55. 00	Program discharges Target amount per discharge	0.00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)	0.00	56.00
57. 00		0	57. 00 58. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0. 00	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60. 00
61. 00		0.00	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		
62. 00	Relief payment (see instructions)	0	62. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	386, 493	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	o	65. 00
// 00	instructions)(title XVIII only)	207 402	// 00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	386, 493	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
	PART III - SKILLED NURSINĞ FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	
70. 00 71. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line 71)		72.00
73. 00 74. 00	Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (line 72 + line 73)		73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00	Program capital -related costs (line 75 + line 76)		77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records)		78. 00 79. 00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80. 00
81.00	Inpatient routine service cost per diem limitation		81.00
82. 00 83. 00	Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions)		82. 00 83. 00
84. 00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	<u> </u>	86. 00
87. 00	Total observation bed days (see instructions)	1, 016	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	929. 07 943, 935	88. 00 89. 00

Health Financial Systems	SCOTT MEMORIA	L HOSPI 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		
					5/30/2019 11:	32 am_
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	273, 765	3, 485, 855	0. 07853	6 943, 935	74, 133	90.00
91.00 Nursing School cost	0	3, 485, 855	0.00000	0 943, 935	0	91.00
92.00 Allied health cost	0	3, 485, 855	0.00000	0 943, 935	0	92.00
93.00 All other Medical Education	0	3, 485, 855	0.00000	0 943, 935	0	93. 00

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1334	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/30/2019 11:32 am	
	Ti +l o Yl Y	Hospi tal	Cost	

		Title XIX	Hospi tal	5/30/2019 11: Cost	32 am
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			3, 778	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day	<i>y</i> ,	vate room days	3, 290 0	2. 00 3. 00
0.00	do not complete this line.	ys). It you have omly pri	vate room days,	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation be			2, 274	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roof	om days) through December	31 of the cost	462	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	26	7. 00
0.00	reporting period				0.00
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) arter December 3	or the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	swing-bed and	372	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	416	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		noom dovo)	0	12. 00
12.00	through December 31 of the cost reporting period	3 .	,	U	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			104	
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			98	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		3, 485, 855	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	3, 465, 655	22.00
	5 x line 17)	•			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportin	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December (x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			429, 230	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		3, 056, 625	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi -private room charges (excluding swing-bed charges)	1: 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 -	÷ 11 ne 28)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line		110113)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dit	ferential (line	3, 056, 625	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see		ı	929. 07	38. 00
39. 00	Program general inpatient routine service cost per drem (see	•		345, 614	39.00
40. 00	Medically necessary private room cost applicable to the Progra	•		0	40.00
	Total Program general inpatient routine service cost (line 39	•		345, 614	

	Financial Systems	SCOTT MEMORI AI		ON. 1E 1004		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1334	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Pre 5/30/2019 11:	pared:
			Ti tl	e XIX	Hospi tal	Cost	02 diii
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (+: +1 - W 0 VIV1)	1.00	2.00	3.00	4. 00	5.00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	164, 243	104	1, 579.	26 98	154, 767	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	625, 561	145	4, 314.	21 30	129, 426	43. 00 44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						45. 00 46. 00 47. 00
47.00	Cost Center Description					1. 00	47.00
48. 00	Program inpatient ancillary service cost (Wk					65, 799	1
49. 00 50. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	<u> </u>		,	m of Parts I and	695, 606	1
51. 00	Pass through costs applicable to Program inp		•	•		0	
52.00	and IV) Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		aled, non-phy	vsician anesti	netist, and	0	53. 00
	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 tar	get amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions)					0 0. 00	58. 00 59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by					0. 00 0	60. 00 61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		(lines 54 x	60), or 1% o	f the target		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	,	tions)			0 0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decem	nber 31 of the	cost report	ing period (See	386, 493	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the d	cost reportin	g period (See	0	65. 00
66.00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)				•	386, 493	
67. 00 68. 00	(line 12 x line 19)	-				0	67. 00
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient			·	or tring period		69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N						70.00
70.00	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		(II: 14 II:	25)			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service			Part II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	76)					76. 00 77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovi der record	ls)			78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the co			nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (83. 00
84.00	Program inpatient ancillary services (see in		nc)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•	*				85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	/				
87.00	Total observation bed days (see instructions		0)			1, 016	1
88. 00	Adjusted general inpatient routine cost per	alem (line // ∸	line 2)			929. 07	ו מא טויי

Health Financial Systems	SCOTT MEMORIA	AL HOSPITAL		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		oared: 32 am_
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	273, 765	3, 485, 855	0. 07853	6 943, 935	74, 133	90.00
91.00 Nursing School cost	0	3, 485, 855	0.00000	943, 935	0	91.00
92.00 Allied health cost	0	3, 485, 855	0.00000	943, 935	0	92.00
93.00 All other Medical Education	0	3, 485, 855	0. 00000	943, 935	0	93. 00

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Li∈	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-13		Worksheet D-3	
		From 01/01/2018 To 12/31/2018		pared:
	Title XVIII	Hospi tal	Cost	JZ alli
Cost Center Description	Ratio of		Inpati ent	
	To Cha		Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1.0	0 2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS		836, 758		30. 00
31.00 03100 INTENSIVE CARE UNIT		84, 290		31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0.	840551 214, 137	179, 993	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.	686116 0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.	131374 450, 176	59, 141	54.00
60. 00 06000 LABORATORY	0.	131086 954, 038	125, 061	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1.	338876 23, 871	31, 960	63. 00
65. 00 06500 RESPIRATORY THERAPY	0.	325816 334, 324	108, 928	65. 00
66. 00 06600 PHYSI CAL THERAPY	0.	345630 76, 628	26, 485	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0.	356880 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		826246 7, 493		
69. 00 06900 ELECTROCARDI OLOGY	0.	157613 109, 179	17, 208	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.	157627 851, 404	134, 204	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.	618801 179, 917	111, 333	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.	160507 858, 692	137, 826	73. 00
75. 00 03610 SLEEP LAB	0.	000000	0	75. 00
76. 00 03020 CARDI AC REHAB	0.	000000	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0.	330430 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC		000000	0	
01 00 00100 EMEDGENCY	1 0	222212 202 (20	/7 070	1 01 00

0. 000000 0. 232313

2. 021677

292, 620 26, 221

4, 378, 700

4, 378, 700

201. 00 202. 00

67, 979 91. 00 53, 010 92. 00

1, 059, 319 200. 00

200.00

201.00 202.00

91. 00 09100 EMERGENCY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

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

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

Heal th	Financial Systems	SCOTT MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der (CCN: 15-1334	Peri od:	Worksheet D-3	
					From 01/01/2018		
			Component	CCN: 15-Z334	To 12/31/2018	Date/Time Pre 5/30/2019 11:	
			Ti +I	e XVIII	Swing Beds - SNF		JZ alli
	Cost Center Description		11 (1	Ratio of Cos		Inpati ent	
	0001 0011101 200011 pt 1011			To Charges	Program	Program Costs	
						(col. 1 x col.	
						2)	
				1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS				0		30. 00
	03100 I NTENSI VE CARE UNI T				0		31. 00
43.00	04300 NURSERY						43. 00
	ANCILLARY SERVICE COST CENTERS						1
	05000 OPERATI NG ROOM			0. 84055			
	05200 DELIVERY ROOM & LABOR ROOM			1. 68611		0	02.00
	05400 RADI OLOGY-DI AGNOSTI C			0. 13137			
	06000 LABORATORY			0. 13108			
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.			1. 33887			
	06500 RESPI RATORY THERAPY			0. 32581			
66. 00	06600 PHYSI CAL THERAPY			0. 34563			1
	06700 OCCUPATI ONAL THERAPY			0. 35688	•		
	06800 SPEECH PATHOLOGY			0. 82624			
	06900 ELECTROCARDI OLOGY			0. 15761			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 15762			
	07200 IMPL. DEV. CHARGED TO PATIENTS			0. 61880		1	1 . 2. 00
	07300 DRUGS CHARGED TO PATIENTS			0. 16050		22, 143	73.00

0.000000

0.000000

0. 330430

0.000000

0. 232313

2.021677

747, 755

0

0 76. 97

166, 230 200. 00

75.00

76.00 0

88.00

91. 00 Ω

92.00 0

201. 00 202. 00

75.00

76.00

76. 97

200.00

201.00

202.00

03610 SLEEP LAB

91. 00 09100 EMERGENCY

03020 CARDI AC REHAB 07697 CARDI AC REHABI LI TATI ON

OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

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

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

	MEMORIAL HOSPITAL			u of Form CMS-2	<u> 2552-10</u>
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2018 To 12/31/2018	Date/Time Prep	narod:
			10 12/31/2010	5/30/2019 11:3	32 am
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cost	Inpati ent	I npati ent	
· ·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			24, 302		30.00
31.00 03100 INTENSIVE CARE UNIT			7, 164		31.00
43. 00 04300 NURSERY			2, 315		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 84055	1 28, 095	23, 615	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		1. 68611	6 1, 532	2, 583	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13137	4 35, 088	4, 610	54.00
60. 00 06000 LABORATORY		0. 13108	6 46, 164	6, 051	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		1. 33887	6 515	690	63.00
65. 00 06500 RESPIRATORY THERAPY		0. 32581	6 11, 941	3, 891	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 34563	0 8, 163	2, 821	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 35688	0 0	o	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 82624	6 0	ol	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 15761	3, 900	615	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 15762	7 19, 185	3, 024	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 61880	1 0	ol	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 16050	7 52, 101	8, 363	73. 00
75. 00 03610 SLEEP LAB		0.00000	0 0	0	75. 00
76. 00 03020 CARDI AC REHAB		0.00000		0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 33043		0	76. 97
OUTPATIENT SERVICE COST CENTERS					
00 00 00000 DUDAL HEALTH CLIMIC		0 50010	-		00 00

0. 590105 0. 232313

2.021677

18, 788 2, 558

228, 030

228, 030

91. 00 92. 00

201. 00 202. 00

0 88.00

65, 799 200. 00

4, 365

5, 171

08800 RURAL HEALTH CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

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

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

91. 00 09100 EMERGENCY

200.00

201.00 202.00

			10 12/31/2010	5/30/2019 11:	
		Title XVIII	Hospi tal	Cost	02 diii
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3, 400, 470	
2.00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		0	
3.00	OPPS payments			0	
4.00	Outlier payment (see instructions)			0	
4. 01	Outlier reconciliation amount (see instructions)	-+:>		0	
5.00	Enter the hospital specific payment to cost ratio (see instructions 2 times line 5	ctions)		0.000	1
6. 00 7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0 0. 00	
8. 00	Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV col 13 line 200		0	
10.00	Organ acquisitions	14, 661. 16, 11116 266		Ö	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			3, 400, 470	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				1
12.00	Ancillary service charges			0	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)		0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for patients and actually collected from patients liable for patients.			0	
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(1 3	n a c n argebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17.00
	Total customary charges (see instructions)			0.000000	l
19. 00	Excess of customary charges over reasonable cost (complete onl	lv if line 18 exceeds li	ne 11) (see	0	l
17.00	instructions)	Ty TT TTHE TO EXCEEDED TT	10 11) (300	Ĭ	17.00
20.00	Excess of reasonable cost over customary charges (complete onl	ly if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)		, ,		
21.00	Lesser of cost or charges (see instructions)			3, 434, 475	21.00
22.00	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	•	inti ana)	54, 165	
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26);	•		2, 359, 885 1, 020, 425	
27.00	instructions)	prus the sum of filles 22	and 23] (See	1, 020, 425	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ine 50)		0	28. 00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	ŕ		0	29.00
30.00	Subtotal (sum of lines 27 through 29)			1, 020, 425	30.00
31.00	Primary payer payments			621	31.00
32.00	Subtotal (line 30 minus line 31)			1, 019, 804	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			574, 589	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	rustions)		373, 483 352, 614	
	Subtotal (see instructions)	ructions)		1, 393, 287	
	MSP-LCC reconciliation amount from PS&R			1, 373, 207	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			Ö	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		Ü	39. 50
39. 97	Demonstration payment adjustment amount before sequestration	-,		0	l
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39. 98
	RECOVERY OF ACCELERATED DEPRECIATION		,	0	1
40.00	Subtotal (see instructions)			1, 393, 287	40.00
40. 01	Sequestration adjustment (see instructions)			27, 866	40. 01
40.02	Demonstration payment adjustment amount after sequestration			0	40. 02
41.00			1, 378, 774		
42.00	Tentative settlement (for contractors use only)			0	
43.00	Balance due provider/program (see instructions)			-13, 353	
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, (chapter 1,	0	44.00
	§115. 2				
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90.00	Outlier reconciliation adjustment amount (see instructions)			0	l
	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)			-	94.00
94.00	IOTAL (SUM OF LINES 97 and 93)			0	94.

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E-1 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: | 5/30/2019 11: 32 am Health Financial Systems SCC ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1334

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						5/30/2019 11: 3	32 am_
1.00							
1.00 7 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 2.00 3.00 4.00 1.00 1.00 1.00 2.00 1.00 1.00 2.00 1.00 1.00 2.00 2.00 1.00 2.0			Inpatier	nt Part A	Pai	rt B	
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interfim payments payable on Individual bills, either submitted or to be submitted for to be submitted for to be submitted for the submitted for the submitted for the cost reporting period. If none, write "NoNE" or enter a zero.			1.00				
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NoNE" or enter a zero				1, 822, 57	8		1. 00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero write "NONE" or enter a zero (1) Services reporting period. Also show date of each payment. If none, write "NONE" or enter a zero (1) Services reporting period. Also show date of each payment. If none, write "NONE" or enter a zero (1) Services reporting period. Also show date of each payment. If none, write "NONE" or enter a zero (1) Services reporting period. Also show date of each payment. If none, write "NONE" or enter a zero (1) Services reporting period. Also show date of each payment. If none, write "NONE" or enter a zero (1) Services reporting period. Also show date of each payment. If none, write many the payment is sum of lines 1, 2, and 3, 99 1, 822, 578 1, 378, 774 4, 00 1, 35, 35, 35, 35, 36, 36, 36, 37, 38, 36, 37, 38, 38, 39, 39, 30, 30, 30, 30, 30, 30, 30, 30, 30, 30	2.00				O	0	2.00
### Write "NONE" or enter a zero 1. OL ist 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 2. OL I STATINE TO PROVIDER 2. OL I STATINE TO PROVIDER 3. OL I STATINE TO PROVIDER 3. OL I STATINE TO PROGRAM 4. OL I STATINE TO PROGRAM 5. OL I STATINE TO PROGRAM 6. OL I STATILE TO PROGRAM 6. OL I STATILE TO PROGRAM 6. OL I STATILE MENT TO PROGRAM 6. OL I STATILE MENT TO PROGRAM 6. OL I STATILE MENT TO PROGRAM 7. OL I STATINE MENT TO PROG							
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)							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROVIDER 0 0 08/15/2018 86, 200 3. 01 3.03 3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 0 3. 3.50 3.51 3.52 0 0 0 0 3. 3.51 3.53 3.54 0 0 0 0 3. 3.53 3.54 3.59 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 3. 50 0 86, 200 3. 3. 50 3. 50. 3. 99 4. 00 Total interlin payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR by Contractor (1) Program to Provider TENTATIVE TO PROGRAM 0 0 0 5.00 5.00 Provider to Program 1 ETENTATIVE TO PROGRAM 0 0 0 5.00 5.00 Provider to Program 1 ETENTATIVE TO PROGRAM 0 0 0 5.00 5.00 5.00 Frounder to Program 1 ETENTATIVE TO PROGRAM 0 0 0 5.00 5.00 5.00 Frounder to Program 2 0 0 0 5.00 5.00 5.00 Frounder to Program 2 0 0 0 5.00 5.00 5.00 Frounder to Program 2 0 0 0 5.00 5.00 5.00 Frounder to Program 2 0 0 0 5.00 5.00 5.00 Frounder to Program 5.50 5.50 5.50 5.50 5.50 5.50 5.50 5.5							
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. 00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider ADJUSTMENTS TO PROVIDER							
ADJUSTMENTS TO PROVIDER			L	<u> </u>			
3.02 3.03 3.03 3.04 3.05 3.05 3.05 3.06 3.06 3.07	2 01				00/15/2010	94 200	2 01
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.51 3.52 3.53 3.54 3.99 3.50.3 98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wist. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR Write "NONE" or enter a zero. (1) Program to Provider to Program TENTATIVE TO PROGRAM 0		ADJUSTIMENTS TO PROVIDER		1			
3.04				1			
3. 05				l .			
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 0 3.55							
ADJUSTMENTS TO PROGRAM 0	3.00	Provider to Program			J		3. 03
3.51 3.52 3.53 0	3 50				า	0	3 50
3.52 3.53 3.54 3.99 3.50		ADSOSTWENTS TO TROOKAW		1	-		
3.53 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.59 3.50-3.98						1	
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,822,578 1,378,774 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR				l .			
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,822,578 1,378,774 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,822,578 1,378,774 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,822,578 1,378,774 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,822,578 1,378,774 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,822,578 1,378,774 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,822,578 1,378,774 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,822,578 1,378,774 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,822,578 1,378,774 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,822,578 5.00 5.00 Tetal interim payments (sum of lines 1, 2, and 3.99) 1,378,774 4.00 4.0				1	~	1 -1	3. 54
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR		Subtotal (sum of lines 3 O1-3 49 minus sum of lines		l .			
A.00	0. ,,					00,200	0. , ,
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4.00			1, 822, 57	8	1, 378, 774	4. 00
TO BE COMPLÉTED BY CONTRACTOR S. 00		(transfer to Wkst. E or Wkst. E-3, line and column as					
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		appropri ate)					
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		TO BE COMPLETED BY CONTRACTOR					
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5. 00
Program to Provider							
TENTATI VE TO PROVI DER							
5. 02 0			Г	1	1		
Description		TENTATI VE TO PROVI DER		1	~		
Provider to Program							
TENTATIVE TO PROGRAM 0	5.03				J	0	5. 03
5.51 0	F F0		I	1			F F0
5.52 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 284,081 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 13,353 6.02 7.00 Total Medicare program liability (see instructions) 2,106,659 1,365,421 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00 Contractor NPR Date (Mo/Day/Yr) 0 Contractor NPR Date (Mo/Day/Yr) Contractor NPR Date (M		IENIATIVE TO PROGRAM		1			
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1. 00 2. 00				1		1 -1	
5.50-5.98 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 284,081 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 13,353 6.02 7.00 Total Medicare program liability (see instructions) 2,106,659 1,365,421 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00 Contractor NPR Date (Mo/Day/Yr) 0 Contractor NPR Date (Mo/Day/Yr) Contractor NPR Date (Mo/Day/		Subtotal (sum of lines 5 01-5 40 minus sum of lines			-	1 -1	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	J. 77	· ·					5. 79
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 284,081 0 6.01 13,353 6.02 2,106,659 1,365,421 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6 00	1 2 2 2 2 2 2					6 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5.00	,					0.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 13,353 6.02 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6, 01			284. 08	1	n	6. 01
7.00 Total Medicare program liability (see instructions) 2,106,659 1,365,421 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				· ·		1 -1	6. 02
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00				1	9		7. 00
Number (Mo/Day/Yr) 0 1.00 2.00		,					
0 1.00 2.00							
8.00 Name of Contractor 8.00				0	1. 00		
	8.00	Name of Contractor					8. 00

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

		Component	JUN. 13-Z334 1	0 12/31/2016	5/30/2019 11:	
		Title	XVIII S	wing Beds - SNF		
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		498, 071		0	1. 00
2.00	Interim payments payable on individual bills, either		(0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					ļ
2 01	Program to Provider			\ \		2 01
3. 01	ADJUSTMENTS TO PROVIDER		(0	3. 01 3. 02
3. 02		•	(
3.03		•	(0	3. 03
3. 04 3. 05		•			0	3. 04
3.05	Provider to Program)	0	3. 05
3. 50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51	ADJUSTIMENTS TO TROURAM				0	3. 51
3. 52					0	3. 52
3. 53		•			Ö	3. 53
3. 54					Ö	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		498, 071		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provider	I		\	1 0	- 01
5. 01 5. 02	TENTATI VE TO PROVI DER				0	5. 01 5. 02
5. 02					0	5. 02
5.05	Provider to Program			<u>/ </u>	0	3.03
5. 50	TENTATI VE TO PROGRAM				0	5. 50
5. 51	TENTATI VE TO TROOKAW				l ő	5. 51
5. 52					Ö	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
0. , ,	5. 50-5. 98)					0. , ,
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		38, 015	5	0	6. 01
6.02	SETTLEMENT TO PROGRAM		C		0	6. 02
7.00	Total Medicare program liability (see instructions)		536, 086	b	0	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8.00

Heal th	Financial Systems S	SCOTT MEMORIAL HOSPITAL	In Lie	u of Form CMS-:	2552-10
CALCUL					pared: 32 am
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD CO				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AN				
1.00	Total hospital discharges as defined in AARA §47	102 from Wkst. S-3, Pt. I col. 15 line	14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum	of lines 1, 8-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6.	. line 2			3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum	of lines 1, 8-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col.	8 line 200			5. 00
6.00	Total hospital charity care charges from Wkst. S	S-10, col. 3 line 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the line 168	purchase of certified HIT technology N	Wkst. S-2, Pt. I		7. 00
8. 00	Calculation of the HIT incentive payment (see in	nstructions)			8. 00
9.00					9. 00
10.00					10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAF	H			
30.00	Initial/interim HIT payment adjustment (see ins	tructions)			30.00
	Other Adjustment (specify)	,			31.00
				32. 00	

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

				5/30/2019 11:	32 am_
		Title XVIII	Swing Beds - SNF	•	
			Part A	Part B	
	PONULTATION OF MET COOT OF COMPETE CERTIFICATION		1. 00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		200 250	0	1 00
1.00	Inpatient routine services - swing bed-SNF (see instructions)		390, 358	0	1.00
2. 00 3. 00	Inpatient routine services - swing bed-NF (see instructions) Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,	and sum of Wkst D	167, 892	0	2. 00 3. 00
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instru		107, 092	U	3.00
4.00	Per diem cost for interns and residents not in approved teaching			0. 00	4. 00
1. 00	instructions)	program (see		0.00	1.00
5.00	Program days		416	0	5. 00
6. 00	Interns and residents not in approved teaching program (see instr	uctions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method		0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		558, 250	0	8. 00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		558, 250	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable)	e to physician	0	0	11.00
	professional services)	1 3			
12.00	Subtotal (line 10 minus line 11)		558, 250	0	12. 00
13.00	Coinsurance billed to program patients (from provider records) (e	xcl ude coi nsurance	11, 223	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	14. 00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		547, 027	0	15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstrati	on) payment	0		16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see instruct	i ons)	0	0	18. 00
19. 00	Total (see instructions)		547, 027	0	19. 00
19. 01	Sequestration adjustment (see instructions)		10, 941	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
20.00	Interim payments		498, 071	0	20.00
21. 00	Tentative settlement (for contractor use only)	0.4.)	0	0	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, and	•	38, 015	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	O	0	23. 00
	chapter 1, §115.2	an) Adiustment			
200.00	Rural Community Hospital Demonstration Project (§410A Demonstration Is this the first year of the current 5-year demonstration period				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	under the 21st			200.00
	Cost Reimbursement				
201 00	Medicare swing-bed SNF inpatient routine service costs (from Wkst	D-1 Pt II line			201. 00
201.00	66 (title XVIII hospital))	. b 1, 1 t. 11, 1111c			201.00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (from Wk	st D-3 col 3 line			202. 00
202.00	200 (title XVIII swing-bed SNF))	31. 2 0, 33 3, 11			202.00
203.00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in fir	st year of the curren	t 5-year demonst	ration	
	peri od)	•	,		
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times	line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme	nt			
207.00	Program reimbursement under the §410A Demonstration (see instruct	i ons)			207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, c	ol. 1, sum of lines 1			208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instructio	ns)			209. 00
210.00	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement				
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209	plus line 210) (see			215. 00
	instructions)				l

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1334	From 01/01/2018	Worksheet E-3 Part V Date/Time Prepared: 5/30/2019 11:32 am
	T: +1 - W/III	11	C+

Title XVIII					5/30/2019 11:	32 am
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT			Title XVIII	Hospi tal	Cost	
PART V - CALCULATION OF REMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT						
1.00					1.00	
2.00		PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
3.00 Crgan acquisition 2, 483,299 Action 2, 483,299 Action 2, 493,209 Action 2, 499,801 Ac	1.00				2, 483, 299	1. 00
A 00 Subtotal (sum of lines 1 through 3) 2, 483,299 4, 00	2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2. 00
Primary payer payments	3.00	Organ acqui si ti on			0	3. 00
Primary payer payments	4.00	Subtotal (sum of lines 1 through 3)			2, 483, 299	4. 00
Total cost (line 4 less line 5). For CAH (see instructions) 2,499,801 6.00	5.00	,				5. 00
COMPUTATION OF LESSER OF COST OR CHARGES	6.00				2, 499, 801	6. 00
Reasonable charges						
Routine service charges		Reasonable charges				
8.00 Ancillary service charges 0 8.00 0.00 0.00 1.0	7.00				0	7. 00
9.00 Total reasonable charges 0 9.00 Total reasonable charges 0 0.00 Total reasonable charges 0 0.00 Total reasonable charges 0 0.00 1.00 2.						
10. 00 Total reasonable charges						
Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 11. 00 12. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 12. 00 13. 00 13. 00 13. 00 13. 00 14. 00 1						
11. 00 Aggregate amount actually collected 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 Ratio of line 11 to line 12 (not to exceed 1.000000) 15. 00 Excess of customary charges (see instructions) 16. 00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16. 00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17. 00 Cost of physicians' services in a teaching hospital (see instructions) 18. 00 Direct graduate medical education payments (from Worksheet E-4, line 49) 19. 00 Deductibles (exclude professional component) 20. 00 Subtotal (line 19 minus line 20 and 21) 21. 00 Excess of covered services (sum of lines 6, 17 and 18) 22. 00 Subtotal (line 19 minus line 20) 23. 00 Coinsurance 24. 00 Subtotal (line 22 minus line 23) 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 00 Demonstration payment adjustment amount before sequestration 29. 00 Demonstration payment (see instructions) 20. 01 Demonstration payment adjustment amount after sequestration 20. 02. 03. 00 Colleges (see instructions) 20. 01 Demonstration payment adjustment amount after sequestration 20. 02. 02. 03. 03. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 30. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 31. 00 Defected amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,					_	
12.00 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) 0.000000 13.00 13.00 14.00 10.000000 15.00 14.00	11. 00		payment for services on	a charge basis	0	11. 00
had such payment been made in accordance with 42 CFR 413.13(e) Ratio of Fine 11 to Fine 12 (not to exceed 1.000000) 13.00 13.00 14.00 15.00 Excess of customary charges (see instructions) 0.000000 13.00 15.00 Excess of customary charges over reasonable cost (complete only if Fine 14 exceeds line 6) (see 0 15.00 15.00 Excess of reasonable cost over customary charges (complete only if Fine 6 exceeds line 14) (see 0 16.00 17.0		33 3		9	0	
13.00 Ratio of line 11 to line 12 (not to exceed 1.000000) 0.000000 13.00 14.00 Total customary charges (see instructions) 0.14.00 15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 0.000000 15.00 15.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 0.000000 17.00 17.00 Cost of physicians' services in a teaching hospital (see instructions) 0.00 17.00 18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 0.00					_	
14. 00 Total customary charges (see instructions) 15. 00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16. 00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17. 00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17. 00 Cost of physicians' services in a teaching hospital (see instructions) 18. 00 Direct graduate medical education payments (from Worksheet E-4, line 49) 19. 00 Cost of covered services (sum of lines 6, 17 and 18) 19. 00 Excess reasonable cost (from line 16) 20. 00 Excess reasonable cost (from line 26) 20. 00 Excess reasonable cost (from line 30 minus lines 20.01, 30.02, 31, and 32) 20. 00 Excess reasonable cost (from line 26) 20. 00 Excess reasonable cost (from lin	13. 00		,		0. 000000	13. 00
15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Cost of physic lans' services in a teaching hospital (see instructions) 18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 20.00 Deductibles (exclude professional component) 21.00 Excess reasonable cost (from line 16) 22.00 Subtotal (line 19 minus line 20 and 21) 23.00 Coinsurance 24.00 Subtotal (line 22 minus line 23) 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 Other Allowable bad debts (see instructions) 29.00 Other Allowable bad debts (see instructions) 29.00 Demonstration payment adjustment (see instructions) 39.00 Demonstration payment adjustment (see instructions) 30.00 Subtotal (see instructions) 30.00 Subtotal (see instructions) 30.00 Demonstration payment adjustment (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount before sequestration 30.02 Demonstration payment adjustment amount after sequestration 30.03 Demonstration payment adjustment amount after sequestration 30.04 Demonstration payment adjustment amount after sequestration 30.05 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see of physicians' services in a teaching hospital (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 20.00 Deductibles (exclude professional component) 21.00 Excess reasonable cost (from line 16) 22.00 Subtotal (line 19 minus line 20 and 21) 23.00 Coinsurance 24.00 Subtotal (line 22 minus line 23) 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 THER ADUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.00 Pioneer ACO demonstration payment adjustment (see instructions) 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment (see instructions) 30.03 Subtotal (see instructions) 30.04 Subtotal (see instructions) 30.05 Demonstration payment (see instructions) 30.06 Demonstration payment (see instructions) 30.07 Subtotal (see instructions) 30.08 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 30.08 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 30.08 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 30.08 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		,	lv if line 14 exceeds li	ne 6) (see		
16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			.ye execute	0) (550	Ü	10.00
Instructions Cost of physicians' services in a teaching hospital (see instructions) 17. 00 17. 00 18. 00 19.	16, 00		lv if line 6 exceeds line	e 14) (see	0	16. 00
18. 00 Direct graduate medical education payments (from Worksheet E-4, line 49) 0 18. 00			,	, ,		
18. 00 Direct graduate medical education payments (from Worksheet E-4, line 49) 18. 00 18. 00 19. 00 20. 00 Deductibles (exclude professional component) 390, 992 20. 00 21. 00 22. 00 22. 00 23. 00 24. 00 24. 00 25.	17.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17. 00
19.00 Cost of covered services (sum of lines 6, 17 and 18) 2, 499, 801 19.00 20.00 Deductibles (exclude professional component) 390, 992 20.00 21.00 Excess reasonable cost (from line 16) 0 21.00 22.00 Subtotal (line 19 minus line 20 and 21) 2, 108, 809 22.00 23.00 Coinsurance 14,070 23.00 24.00 Subtotal (line 22 minus line 23) 2, 094, 739 24.00 25.00 All lowable bad debts (exclude bad debts for professional services) (see instructions) 84, 482 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 54, 913 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 39, 928 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 2, 149, 652 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.50 29.99 Demonstration payment adjustment disecutions 0 29.50 30.01 Sequestration adjustment (see instructions) 2, 149, 652 30.00 30.02 Demonstration payment adjustment amount after sequestration 0 2		COMPUTATION OF REIMBURSEMENT SETTLEMENT	·			
20.00 Deductibles (exclude professional component) 21.00 Excess reasonable cost (from line 16) 22.00 Subtotal (line 19 minus line 20 and 21) 23.00 Coinsurance 24.00 Subtotal (line 22 minus line 23) 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 30.01 Sequestration payment adjustment amount before sequestration 30.02 Demonstration payment adjustment (see instructions) 30.03 Sequestration payment adjustment amount after sequestration 30.02 Demonstration payment adjustment amount after sequestration 30.03 Demonstration payment adjustment amount after sequestration 30.04 Demonstration payment adjustment amount after sequestration 30.05 Demonstration payment adjustment amount after sequestration 30.06 Demonstration payment adjustment amount after sequestration 30.07 Demonstration payment adjustment amount after sequestration 30.08 Demonstration payment adjustment amount after sequestration 30.09 Demonstration payment adjustment amount after sequestration 30.00 Demonstration payment adjustment amount after sequestration 30.00 Demonstration payment adjustment amount after sequestration 30.01	18.00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	18. 00
21.00 Excess reasonable cost (from line 16) 22.00 Subtotal (line 19 minus line 20 and 21) 23.00 Coinsurance 24.00 Subtotal (line 22 minus line 23) 25.00 All owable bad debts (exclude bad debts for professional services) (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 All owable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pi oneer ACO demonstration payment adjustment (see instructions) 29.90 Demonstration payment adjustment (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.02 Demonstration payment adjustment (see instructions) 30.03 Demonstration payment adjustment (see instructions) 30.04 Demonstration payment adjustment amount after sequestration 30.02 Demonstration payment adjustment (see instructions) 30.03 Demonstration payment adjustment (see instructions) 30.04 Demonstration payment adjustment amount after sequestration 30.02 Demonstration payment adjustment (see instructions) 31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	19.00	Cost of covered services (sum of lines 6, 17 and 18)			2, 499, 801	19.00
22. 00 Subtotal (line 19 minus line 20 and 21) 2, 108, 809 22. 00 23. 00 Coinsurance 14, 070 23. 00 24. 00 Subtotal (line 22 minus line 23) 2, 094, 739 24. 00 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 84, 482 25. 00 26. 00 Adjusted reimbursable bad debts (see instructions) 54, 913 26. 00 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 39, 928 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 2, 149, 652 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29. 50 29. 99 Demonstration payment adjustment amount before sequestration 0 29. 50 30. 01 Subtotal (see instructions) 2, 149, 652 30. 00 30. 02 Interim payment 0 30. 02 31. 00 Interim payments 1, 822, 578 10. 02 32. 00 Tentative settlement (for contractor use only) 32. 00 33. 00 <td>20.00</td> <td>Deductibles (exclude professional component)</td> <td></td> <td></td> <td>390, 992</td> <td>20.00</td>	20.00	Deductibles (exclude professional component)			390, 992	20.00
22. 00 Subtotal (line 19 minus line 20 and 21) 2, 108, 809 22. 00 23. 00 Coinsurance 14, 070 23. 00 24. 00 Subtotal (line 22 minus line 23) 2, 094, 739 24. 00 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 84, 482 25. 00 26. 00 Adjusted reimbursable bad debts (see instructions) 54, 913 26. 00 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 39, 928 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 2, 149, 652 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29. 50 29. 99 Demonstration payment adjustment amount before sequestration 0 29. 50 30. 01 Subtotal (see instructions) 2, 149, 652 30. 00 30. 02 Interim payment 0 30. 02 31. 00 Interim payments 1, 822, 578 10. 02 32. 00 Tentative settlement (for contractor use only) 32. 00 33. 00 <td>21.00</td> <td>Excess reasonable cost (from line 16)</td> <td></td> <td></td> <td>0</td> <td>21. 00</td>	21.00	Excess reasonable cost (from line 16)			0	21. 00
24.00 Subtotal (line 22 minus line 23) 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.99 Demonstration payment adjustment amount before sequestration 29.99 Subtotal (see instructions) 29.99 Subtotal (see instructions) 29.99 Demonstration payment adjustment amount before sequestration 29.99 Subtotal (see instructions) 20.00 Subtotal (see instructions) 20.10 Sequestration adjustment (see instructions) 20.01 Sequestration adjustment (see instructions) 20.02 Demonstration payment adjustment amount after sequestration 20.03 Demonstration payment adjustment amount after sequestration 20.00 Tentative settlement (for contractor use only) 20.00 Salance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 284,081 33.00 284,081 33.00 294.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	22.00				2, 108, 809	22. 00
25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 99 Demonstration payment adjustment amount before sequestration 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Demonstration payment adjustment contractor use only) 31. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	23.00	Coinsurance			14, 070	23. 00
26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 90 Demonstration payment adjustment amount before sequestration 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Interim payments 31. 00 Interim payments 32. 00 Fentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	24.00	Subtotal (line 22 minus line 23)			2, 094, 739	24.00
27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Interim payments 30. 02 Tentative settlement (for contractor use only) 31. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 32. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	25.00	Allowable bad debts (exclude bad debts for professional servi-	ces) (see instructions)		84, 482	25. 00
28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Interim payments 31. 00 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	26.00	Adjusted reimbursable bad debts (see instructions)			54, 913	26. 00
29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Interim payments 31. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	27.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		39, 928	27. 00
29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Interim payments 31. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	28.00	Subtotal (sum of lines 24 and 25, or line 26)			2, 149, 652	28. 00
29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 29. 99 2, 149, 652 30. 00 42, 993 30. 01 0 30. 02 1, 822, 578 31. 00 0 32. 00 284, 081 33. 00	29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 31. 00 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34. 00	29. 50		s)		0	29. 50
30.00 Subtotal (see instructions) 2, 149, 652 30.00 30.01 Sequestration adjustment (see instructions) 42, 993 30.01 30.02 Demonstration payment adjustment amount after sequestration 0 30.02 31.00 Interim payments 1, 822, 578 31.00 32.00 Tentative settlement (for contractor use only) 32.00 0 32.00 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 284,081 33.00 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	29, 99		•		0	29. 99
30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	30.00				2, 149, 652	30. 00
30.02 Demonstration payment adjustment amount after sequestration 31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 30.02 1,822,578 31.00 2284,081 33.00 284,081 33.00		· · · · · · · · · · · · · · · · · · ·				
31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 1,822,578 31.00 32.00 32.00 284,081 33.00 34.00		, ,			· ·	
32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00		, , , , , , , , , , , , , , , , , , , ,			-	
33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00						
34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00			2. 31. and 32)		-	
				chapter 1.		
				F		

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1334	Peri od: Worksheet E-3 Part VII Date/Time Prepared: 5/20/2010 11:23 cm

			lo 12/31/2018	Date/lime Pre 5/30/2019 11:	
		Title XIX	Hospi tal	Cost	<u> </u>
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		695, 606		1.00
2.00	Medical and other services			226, 330	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		695, 606	226, 330	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		695, 606	226, 330	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		33, 781		8. 00
9.00	Ancillary service charges		228, 030	1, 091, 463	
10. 00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		261, 811	1, 091, 463	12. 00
40.00	CUSTOMARY CHARGES	<u>.</u>	1		
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14. 00	basis	normant for compless on	0	0	14 00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with			U	14. 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CFR 9413. 13(e)	0. 000000	0.000000	15. 00
16. 00	Total customary charges (see instructions)		261, 811	1, 091, 463	
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	201, 011	865, 133	1
17.00	line 4) (see instructions)	y 11 1111e 10 exceeds		000, 100	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	433, 795	0	18. 00
	16) (see instructions)	,	,		
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1	16)	695, 606	226, 330	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	ers.		
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		695, 606	226, 330	29. 00
00.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		400 705		00.00
30.00	Excess of reasonable cost (from line 18)		433, 795	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1	695, 606	226, 330	1
32. 00	Deducti bl es		0	0	
33. 00 34. 00	Coinsurance		0	0	
	Allowable bad debts (see instructions) Utilization review		0	U	34. 00 35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	4 33)	695, 606	226, 330	•
37. 00	ADJUSTMENT TO FORCE O SETTLEMENT	1 33)	-589, 151	-1, 746	1
	Subtotal (line 36 ± line 37)		106, 455	224, 584	1
	Direct graduate medical education payments (from Wkst. E-4)		100, 433	224, 304	39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		106, 455	224, 584	40.00
41. 00	Interim payments		106, 455	224, 584	
42. 00	Balance due provider/program (line 40 minus line 41)		100, 433	224, 304	
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	0	0	•
	chapter 1, §115.2			Ŭ	
	· · · · · · · · · · · · · · · · · · ·		'		

Health Financial Systems SCOTT MEMO BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-1334

Peri od: Worksheet G From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/30/2019 11: 32 am

J J7		General Fund	Speci fi c	Endowment Fund	5/30/2019 11: Plant Fund	32 am
			Purpose Fund			
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	Cash on hand in banks	25, 958	C	0	0	1.00
2.00	Temporary investments	0	C	ا ۱	0	1
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	0 3, 737, 759	C	0	0	
5. 00	Other receivable	2, 903, 495			0	
6. 00	Allowances for uncollectible notes and accounts receivable	0	ď	Ó	0	6. 00
7.00	Inventory	603, 299		o	0	
8.00	Prepai d expenses	249, 993	C	0	0	8. 00
9. 00 10. 00	Other current assets Due from other funds	0			0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	7, 520, 504	1	ا ۱	0	11.00
	FI XED ASSETS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		-1	_	
12. 00	Land	840, 000		- 1	0	1
13. 00	Land improvements	466, 199			0	13.00
14. 00 15. 00	Accumulated depreciation Buildings	-167, 071 3, 056, 163	C	=	0	14. 00 15. 00
16. 00	Accumul ated depreciation	-1, 341, 729			0	16.00
17. 00	Leasehold improvements	0	C	o	0	17. 00
18. 00	Accumulated depreciation	0	C	0	0	18. 00
19. 00	Fixed equipment	756, 517	C		0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	-121, 030 0	C	=	0	20.00
22. 00	Accumulated depreciation	0		=	0	22. 00
23.00	Maj or movable equipment	2, 292, 896	C	o	0	23. 00
24. 00	Accumul ated depreciation	-1, 208, 705		0	0	24. 00
25. 00	Mi nor equipment depreciable	3, 942, 189		0	0	25. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	-2, 380, 455			0	26. 00 27. 00
28. 00	Accumulated depreciation				0	28.00
29. 00	Mi nor equi pment-nondepreci abl e	Ö	ď	Ó	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	6, 134, 974	<u> </u>	o	0	30. 00
	OTHER ASSETS	1	1			
31. 00 32. 00	Investments Deposits on Leases	0	C		0	31. 00 32. 00
33. 00	Due from owners/officers				0	33.00
34. 00	Other assets	380, 203		o	0	34. 00
35.00	Total other assets (sum of lines 31-34)	380, 203	[c	o	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	14, 035, 681	C	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	577, 744	1 0	ol	0	37.00
38. 00	Salaries, wages, and fees payable	640, 602		=	0	38.00
39. 00	Payrol I taxes payable	176, 743	•	o	0	39. 00
40.00	Notes and Loans payable (short term)	0	C	0	0	40. 00
41. 00	Deferred income	0	C	0	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	0	,		0	42. 00 43. 00
44. 00	Other current liabilities	75, 930			0	
45.00	Total current liabilities (sum of lines 37 thru 44)	1, 471, 019		0		
	LONG TERM LIABILITIES		T	T _T		
46. 00	Mortgage payable	8, 249, 829		ا ۱	0	46.00
47. 00 48. 00	Notes payable Unsecured Loans	118, 269	C	- 1	0	47. 00 48. 00
49. 00	Other long term liabilities	0		=	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	8, 368, 098	C	o	0	50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	9, 839, 117	C	0	0	51. 00
52. 00	CAPITAL ACCOUNTS General fund balance	4, 196, 564	I			52.00
53. 00	Specific purpose fund	4, 190, 304				53.00
54. 00	Donor created - endowment fund balance - restricted		1	o		54. 00
55.00	Donor created - endowment fund balance - unrestricted			O		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	4, 196, 564	c	ol	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	14, 035, 681	•	o o	0	
	[59]	I	I			I

Provider CCN: 15-1334

					То	12/31/2018	Date/Time Prep 5/30/2019 11:3	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	<u> </u>
				,				
1.00	TE	1. 00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		5, 566, 010			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-856, 823					2.00
3.00	Total (sum of line 1 and line 2)		4, 709, 187		0	0	0	3. 00 4. 00
4. 00 5. 00	Additions (credit adjustments) (specify)				0		0	4. 00 5. 00
6.00					0		0	6. 00
7. 00					0		0	7. 00
8. 00					0		0	8. 00
9. 00					0		0	9. 00
10.00	Total additions (sum of line 4-9)		0		J	0	ĭ	10. 00
11. 00	Subtotal (line 3 plus line 10)		4, 709, 187			0		11. 00
12. 00	I NCOME TAX	392, 190	1,707,107		0	J	0	12. 00
13. 00	ADJUSTMENTS TO RETAINED EARNINGS	120, 433			0		ol	13. 00
14. 00		0			0		ol	14. 00
15.00		O			0		0	15.00
16.00		o			0		0	16.00
17. 00		0			0		0	17.00
18.00	Total deductions (sum of lines 12-17)		512, 623			0		18.00
19. 00	Fund balance at end of period per balance		4, 196, 564			0		19.00
	sheet (line 11 minus line 18)		51					
		Endowment Fund	PI ant	Funa				
		6. 00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0.00	7.00	0.00	0			1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)				Ŭ			2. 00
3.00	Total (sum of line 1 and line 2)	O			0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4.00
5.00			0					5.00
6.00			0					6.00
7.00			0					7.00
8.00			0					8.00
9.00			0					9. 00
10. 00	Total additions (sum of line 4-9)	0			0			10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12. 00	I NCOME TAX		0					12. 00
13. 00	ADJUSTMENTS TO RETAINED EARNINGS		0					13.00
14.00			0					14.00
15.00			0					15. 00
16.00		1	0					16. 00 17. 00
17. 00 18. 00	Total deductions (sum of lines 12-17)		U		0			17.00
19. 00	Fund balance at end of period per balance				0			19. 00
17.00	sheet (line 11 minus line 18)				J			17.00
	12	1	'	ı			'	

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1334

			10 12/31/2018	5/30/2019 11:	
	Cost Center Description	Inpati ent	Outpati ent	Total	
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	1, 808, 16	5	1, 808, 165	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	155, 98)	155, 980	5. 00
6.00	Swing bed - NF)	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	1, 964, 14	5	1, 964, 145	10.00
	Intensive Care Type Inpatient Hospital Services		- 1		
11. 00	INTENSIVE CARE UNIT	188, 56	4	188, 564	11. 00
12. 00	CORONARY CARE UNIT				12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	188, 56	4	188, 564	16. 00
	11-15)	100,00		100,001	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	2, 152, 70	9	2, 152, 709	17. 00
18. 00	Ancillary services	8, 987, 52		49, 648, 808	18. 00
19. 00	Outpati ent servi ces	685, 25		11, 430, 381	19. 00
20. 00	RURAL HEALTH CLINIC	1	1, 246, 597	1, 246, 597	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY			· ·	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	NURSERY	173, 70	5	173, 706	27. 00
27. 01	PRI VATE PHYSI CI AN OFFI CES		660, 519	660, 519	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	11, 999, 19		65, 312, 720	28. 00
20.00	G-3, line 1)	11,777,17	5 55,515,521	00,012,720	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		21, 687, 909		29. 00
30. 00	ADD (SPECIFY))		30.00
31. 00					31. 00
32. 00					32. 00
33. 00			o o		33. 00
34. 00		•	o o		34. 00
35. 00			Ď		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	IMPUTED INCOME TAX	392, 19	n		37. 00
38. 00	TIME OTED THOOME TAX		o l		38. 00
39. 00					39. 00
40. 00					40. 00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)	1	392, 190		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	er	21, 295, 719		43. 00
43.00	to Wkst. G-3, line 4)	~' [21,275,717		73.00
	10	1	T	ı	

Heal th	Financial Systems	SCOTT MEMORIAL HOSPITAL	In lie	u of Form CMS-2	2552-10	
	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1334	Peri od:	Worksheet G-3		
			From 01/01/2018 To 12/31/2018		pared:	
				1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Part I,	column 3 line 28)		65, 312, 720	1. 00	
2.00	Less contractual allowances and discounts on pa			45, 548, 070	2. 00	
3.00	Net patient revenues (line 1 minus line 2)	atronts accounts		19, 764, 650	3. 00	
4. 00	Less total operating expenses (from Wkst. G-2,	Part II line 43)		21, 295, 719		
5. 00	Net income from service to patients (line 3 mir			-1, 531, 069	5. 00	
	OTHER I NCOME			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
6.00	Contributions, donations, bequests, etc			1, 484	6. 00	
7.00	Income from investments			10, 181	7. 00	
8.00						
9.00	9.00 Revenue from television and radio service					
10.00	10. 00 Purchase di scounts					
11.00	Rebates and refunds of expenses			0	11.00	
12.00	Parking Lot receipts			0	12.00	
13.00	Revenue from Laundry and Linen service			0	13.00	
14.00	Revenue from meals sold to employees and guests	5		96, 944	14.00	
15.00	Revenue from rental of living quarters			0	15.00	
16.00	Revenue from sale of medical and surgical suppl	ies to other than patients		0	16.00	
	Revenue from sale of drugs to other than patier			0		
18.00	Revenue from sale of medical records and abstra	acts		24	18.00	
	Tuition (fees, sale of textbooks, uniforms, etc			0	19.00	
20.00	Revenue from gifts, flowers, coffee shops, and	canteen		0	20.00	
	Rental of vending machines			1, 129		
22. 00	Rental of hospital space			564, 484		
23. 00	Governmental appropriations			0	23.00	
24.00	OTHER (SPECIFY)			0	24.00	
25. 00	Total other income (sum of lines 6-24)			674, 246		
26. 00	Total (line 5 plus line 25)			-856, 823		
	OTHER EXPENSES (SPECIFY)			0		
	Total other expenses (sum of line 27 and subscr			0		
29. 00	Net income (or loss) for the period (line 26 mi	nus line 28)		-856, 823	29. 00	

Heal th	Financial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component	CCN: 15-8523	From 01/01/2018 To 12/31/2018		narod:
			Component	CCN. 15-6525	10 12/31/2010	5/30/2019 11:	32 am
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	146, 059	0	146, 05	0	146, 059	1. 00
2.00	Physici an Assistant	0	0		0	0	2.00
3.00	Nurse Practitioner	103, 940	0	103, 94	0 0	103, 940	3. 00
4.00	Visiting Nurse	0	0)	0 0	0	4. 00

		Compensation	other costs	+ col . 2)	ons	Trial Balance (col. 3 + col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	146, 059	0	146, 059	0	146, 059	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	103, 940	0	103, 940	0	103, 940	3. 00
4.00	Visiting Nurse	0	0	0	0	0	4. 00
5.00	Other Nurse	92, 853	0	92, 853	0	92, 853	5. 00
6.00	Clinical Psychologist	0	0	0	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	0	0	0	0	0	9. 00
10. 00	Subtotal (sum of lines 1 through 9)	342, 852	0	342, 852	0	342, 852	10. 00
11. 00	Physician Services Under Agreement	0	0	0	0	0	11. 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
	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14. 00
15. 00	1 ''	0	39, 350	39, 350	0	39, 350	
16.00	, , , , ,	0	0	0	0	0	16. 00
	Depreciation-Medical Equipment	0	0	0	0	0	17. 00
	Professional Liability Insurance	0	0	0	0	0	18.00
	Other Health Care Costs	0	0	0	Ü	0	19.00
	Allowable GME Costs						20. 00
21. 00		0 40 050	39, 350		0	39, 350	21. 00
22. 00		342, 852	39, 350	382, 202	0	382, 202	22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
23 00	Pharmacy	0	0	0	0	0	23. 00
24. 00	Dental	0	0	0	0		24. 00
25. 00	Optometry	0	0	0	0		25. 00
25. 01	Tel eheal th	o o	0	0	0		25. 01
25. 02	Chronic Care Management	0	0	0	0		25. 02
26. 00	All other nonreimbursable costs	0	0	0	0		26. 00
27. 00	Nonallowable GME costs	J			· ·		27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	0	0	0	28. 00
	through 27)		_	_			
	FACILITY OVERHEAD			<u>'</u>		•	
29. 00	Facility Costs	0	52, 891	52, 891	0	52, 891	29. 00
30.00	Administrative Costs	0	77, 199	77, 199	0	77, 199	30. 00
31.00	Total Facility Overhead (sum of lines 29 and	0	130, 090	130, 090	0	130, 090	31.00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	342, 852	169, 440	512, 292	0	512, 292	32. 00
	and 31)						

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1334	Period: Worksheet M-1 From 01/01/2018
	Component CCN: 15-8523	To 12/31/2018 Date/Time Prepared:

			component	CN: 15-8523	10 12/31/20	5/30/2019 11 5/30/2019	
					RHC I	Cost	. 32 aiii
		Adjustments	Net Expenses		10101	0031	
			for Allocation				
			(col. 5 + col.				
			6)				
		6.00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	146, 059				1.00
2.00	Physician Assistant	o	0				2. 00
3.00	Nurse Practitioner	o	103, 940				3. 00
4.00	Visiting Nurse	o	0				4. 00
5.00	Other Nurse	o	92, 853				5. 00
6.00	Clinical Psychologist	o	0				6. 00
7.00	Clinical Social Worker	o	0				7. 00
8.00	Laboratory Techni ci an	o	0				8. 00
9.00	Other Facility Health Care Staff Costs	o	0				9. 00
10.00	Subtotal (sum of lines 1 through 9)	o	342, 852				10.00
11. 00	Physician Services Under Agreement	o	0				11.00
12. 00	Physician Supervision Under Agreement	o	0				12.00
13. 00	Other Costs Under Agreement	o	0				13. 00
14.00	Subtotal (sum of lines 11 through 13)	o	o				14. 00
15.00	Medical Supplies	o	39, 350				15. 00
16.00	Transportation (Health Care Staff)	0	0				16. 00
17.00	Depreciation-Medical Equipment	O	0				17. 00
18.00	Professional Liability Insurance	O	0				18. 00
19.00	Other Health Care Costs	O	0				19. 00
20.00	Allowable GME Costs						20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	39, 350				21. 00
22. 00	Total Cost of Health Care Services (sum of	0	382, 202				22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0				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	0				28. 00
	through 27)						
	FACILITY OVERHEAD						
	Facility Costs	0	52, 891				29. 00
30. 00	Administrative Costs	0	77, 199				30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	0	130, 090				31. 00
	30)						1
32. 00	Total facility costs (sum of lines 22, 28	0	512, 292				32. 00
	and 31)	I	ı				1

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SCOTT MEMORIA SERVICES	Provi der Co		Peri od:	u of Form CMS-2 Worksheet M-2	
			Component (From 01/01/2018 To 12/31/2018	Date/Time Prep 5/30/2019 11:	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 80					1. 00
2.00	Physici an Assistant	0. 00	l .				2.00
3.00	Nurse Practitioner	1. 00			· ·		3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 80			5, 460	6, 067	4. 00
5.00	Visiting Nurse	0.00				0	5. 00
6. 00	Clinical Psychologist	0.00	l e			0	6. 00
7. 00	Clinical Social Worker	0.00	l e			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l e			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	1. 80	6, 067			6, 067	8. 00
9. 00	Physician Services Under Agreements		0			0	9. 00
	, <u>, , , , , , , , , , , , , , , , , , </u>	<u>'</u>		·			
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	7, line 22)			382, 202	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11. 00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			382, 202	12.00
13. 00	3.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						
14. 00	4.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						
15. 00							
16. 00	b.00 Total overhead (sum of lines 14 and 15)						16. 00
17. 00						0	17. 00
	Enter the amount from line 16					353, 421	18. 00
	Overhead applicable to hospital-based RHC/FQ					353, 421	19.00
20.00	Total allowable cost of hospital-based RHC/F	QHC services (s	sum of lines 10	and 19)		735, 623	20.00

	Financial Systems SCOTT MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1334	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI C		Component CCN: 15-8523	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/30/2019 11:	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		735, 623	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		35, 883	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			699, 740	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, l	ine 9)		6, 067 0	
6. 00	Total adjusted visits (line 4 plus line 5)	7)		6, 067	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			115. 34	7. 00
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate Period		
			1)	Peri od 2) 2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	0.00	83. 45	8. 00
9.00	Rate for Program covered visits (see instructions)		115. 34	115. 34	9. 00
10.00	CALCULATION OF SETTLEMENT	contractor records)	O	1 427	10.00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line		0	1, 437 165, 744	
12. 00	Program covered visits for mental health services (from contra	•	o	0	1
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 16. 00	Graduate Medical Education Pass Through Cost (see instructions Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	165, 744	15. 00 16. 00
16. 01	Total program charges (see instructions) (from contractor's real	,		291, 425	1
16. 02	Total program preventive charges (see instructions)(from provi	•		2, 384	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			1, 356	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0%) (Titles V and XIX see instructions.)	3 and 18) times .80)		115, 151	16. 04
16. 05	Total program cost (see instructions)		0	116, 507	16. 05
17. 00	Primary payer amounts			297	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		20, 449	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		53, 718	19. 00
20.00	records)			11/ 210	20.00
20. 00 21. 00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		116, 210 19, 030	1
22. 00	Total reimbursable Program cost (line 20 plus line 21)	,		135, 240	
23. 00	Allowable bad debts (see instructions)			0	
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
24. 00 25. 00	Allowable bad debts for dual eligible beneficiaries (see insti OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	24. 00 25. 00
	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	
25. 99	Demonstration payment adjustment amount before sequestration	,		0	1
26. 00	Net reimbursable amount (see instructions)			135, 240	
26. 01 26. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			2, 705	1
27. 00	Interim payments			0 68, 159	
28. 00	Tentative settlement (for contractor use only)			00, 137	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0			64, 376	29. 00
30. 00	Protested amounts (nonallowable cost report items) in accordance chapter I, §115.2	nce with CMS Pub. 15-II,		0	30. 00

Health Financial Systems	SCOTT MEMORIAL I	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1334	Peri od: From 01/01/2018	Worksheet M-4
VACCINE COST		Component CCN: 15-8523		
		Title XVIII	RHC I	Cost

		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		342, 852	342, 852	1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota	al health care staff time	0. 000681	0. 004915	2. 00
3.00	Pneumococcal and influenza vaccine health care staff cost (lir	ne 1 x line 2)	233	1, 685	3. 00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr	rom your records)	6, 958	9, 767	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	7, 191	11, 452	5. 00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksho	eet M-1, col. 7, line 22)	382, 202	382, 202	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)		353, 421	353, 421	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 018815	0. 029963	8. 00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	6, 650	10, 590	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	13, 841	22, 042	10. 00
11 00	lines 5 and 9)	(6	F.1	2/0	11 00
11.00	Total number of pneumococcal and influenza vaccine injections		51		11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10		271. 39		12.00
13. 00	Number of pneumococcal and influenza vaccine injections admini beneficiaries	stered to Program	39	141	13. 00
14. 00	Program cost of pneumococcal and influenza vaccine and its (th	neir) administration	10, 584	8, 446	14. 00
	(line 12 x line 13)				
15. 00	Total cost of pneumococcal and influenza vaccine and its (theil of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,	,		35, 883	15. 00
16. 00	Total Program cost of pneumococcal and influenza vaccine and i administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	ts (their)		19, 030	16. 00

Health Financial Systems	Financial Systems SCOTT MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-1			
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 15-1334 Component CCN: 15-8523	Peri od: From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 5/30/2019 11:32 am		

	Component Con. 13-0323	10 12/31/2010	5/30/2019 11: 3	
		RHC I	Cost	
		Pai	rt B	
		mm/dd/yyyy	Amount	
		1. 00	2, 00	
O Total interim payments paid to hospital-based RHC/FQHC		11.00	68, 159	1
OD Total interim payments paid to hospital-based RHC/FQHC OD Interim payments payable on individual bills, either submitted or to be submitted to			0	2
the contractor for services rendered in the cost reporting pe				_
"NONE" or enter a zero	0.1.04. 1.1.1.01.0, 11.1.1.0			
O List separately each retroactive lump sum adjustment amount by	based on subsequent			3
revision of the interim rate for the cost reporting period. A				
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider			•	
1			0	1 3
2			0	3
3			0	3
4			0	3
5				3
Provider to Program				,
0			0	: ا
1				
2				3
3				3
4				3
9 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98	8)			3
O Total interim payments (sum of lines 1, 2, and 3.99) (transfer	,		68, 159	2
27)	er to workshoot w o, Time		00, 107	
TO BE COMPLETED BY CONTRACTOR			•	
O List separately each tentative settlement payment after desk	review. Also show date o	f		١ و
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider		<u> </u>	•	
1			0	ļ 5
2			0	
3			0	5
Provider to Program		<u> </u>		
0			0	[
1			0	5
2			0	
9 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98	8)		0	
O Determined net settlement amount (balance due) based on the	cost report. (1)		1	1
1 SETTLEMENT TO PROVIDER	,		64, 376	1
2 SETTLEMENT TO PROGRAM			0	1
O Total Medicare program liability (see instructions)			132, 535	-
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1. 00	2. 00	