SULLI VAN COUNTY COMMUNI TY HOSPI TAL

In Lieu of Form CMS-2552-10

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 F AND SETTLEMEN	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION	Provider CCN: 15-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/30/2019 2:35 pm
PART I - COST	REPORT STATUS			
Provi der	 [X] Electronically filed cost report 		Date: 5/30/20	19 Time: 2:35 pm
use only	2. [] Manually submitted cost report			
	3. [0] If this is an amended report enter the number 4. [F] Medicare Utilization. Enter "F" for full or "I	of times the provider re _" for low.	esubmitted this co	ost report
Contractor use only	 5. [1] Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended (5) Amended (6) Date Received: (7) Contractor No. (8) [N] Initial Report for (9) [N] Final Report for 	11.C pr this Provider CCN 12.[
PART II - CER	FI FI CATI ON			
MI SREPRESENTA	TION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN T	HIS COST REPORT MAY BE P	UNISHABLE BY CRIM	IINAL, CIVIL AND
ADMI NI STRATI VE	ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.	FURTHERMORE, IF SERVICES	IDENTIFIED IN TH	IIS REPORT WERE

PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SULLIVAN COUNTY COMMUNITY HOSPITAL (15-1327) 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)	
(SI)	gnea)	

Officer or Administrator of Provider(s)

Title

Date

		Title XVIII					
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY		_				
1.00	Hospi tal	0	54, 986	563, 444	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	34, 371	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	89, 357	563, 444	0	0	200.00

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

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provio	der CCN: 1	5-1327	Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti 5/30/20	me Pre	epared:
	1.00	2.00		3.00		4	4.00			
~~	Hospital and Hospital Health Care Co	PO Box: 10								1 1 0
. 00	Street: 2200 NORTH SECTION STREET City: SULLIVAN	State: IN	Zin Cod	le: 47882-	Coup	ty: SULLIVAN				1.0
. 00	orty. Solervan	Component Name	CCN	CBSA	Provi der		Payme	ent Syst	em (P	2.0
			Number	Number	Туре	Certified		, 0, or		
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
~ ~	Hospital and Hospital-Based Componer		454007	15440		0 (/01 /0005				
. 00	Hospi tal	SULLIVAN COUNTY COMMUNITY HOSPITAL	151327	45460	1	06/01/2005	N	0	0	3.0
. 00	Subprovider - IPF	COMMONT IT HOSFITAL								4.0
. 00	Subprovider - IRF									5.0
. 00	Subprovider - (Other)									6.0
. 00	Swing Beds - SNF	SULLI VAN COUNTY	15Z327	45460		06/01/2005	N	0	N	7.0
		COMMUNITY HOSPITAL								
. 00	Swing Beds - NF									8.0
0. 00 0. 00	Hospital-Based SNF Hospital-Based NF									9.0
1.00	Hospital - Based OLTC									11.0
2.00	Hospi tal -Based HHA	SULLIVAN COUNTY HOME	157542	45460		07/23/2002	N	Р	N	12.0
2.00		HEALTH	107012	10100		017 207 2002		· ·		
3.00	Separately Certified ASC									13.0
4.00	Hospi tal -Based Hospi ce									14. (
5.00										15. (
5.00	Hospital - Based Health Clinic - FQHC									16.
7.00	Hospital-Based (CMHC) I Renal Dialysis									17.0
8.00 9.00										18.0
7.00	other					From:		Tc)·	17.0
						1.00		2.0		1
0 00										
	Cost Reporting Period (mm/dd/yyyy)					01/01/2	018	12/31	/2018	20.0
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					01/01/2	018	12/31	/2018	20. C 21. C
					1.00	9	018			1
	Type of Control (see instructions)				1.00		018	3.0		1
1.00	Type of Control (see instructions)	currently receiving pa	vments for	r		9	018			21.0
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1.00 2.00 2.01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "M 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 "M cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting 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.	estment, in accordance w or yes or "N" for no. Is (412.106(c)(2)(Pickle and or yes or "N" for no. iccompensated care paymer mn 1, "Y" for yes or "N eriod occurring prior to "for no for the portic er October 1. (see inst requires final uncompe port settlement? (see "for no, for the porti- ber 1. Enter in column 2 te cost reporting period ic reclassification fro ds for delineating stat folumn 1, "Y" for yes or g period prior to Octobe no for the porti of te er October 1. (see inst to lumn 1, "Y" for yes or g period prior to Octobe no for the portion of te er October 1. (see inst 100 but not more than 4 2.105)? Enter in column	i th 42 CFF this endment ts for thi october n of the or nof the or nsated can nstruction on of the , "Y" for on or afi m urban to istical ar "N" for r er 1. Ente he cost ructions) 99 beds (a 3, "Y" for	R is for 1. cost re ns) yes ter po reas no er	N N N	9 2.00 N N	018	3. (00	21.
1. 00 2. 00 2. 01 2. 02 2. 02 2. 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "M reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "M cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting 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.	estment, in accordance w or yes or "N" for no. Is (412.106(c)(2)(Pickle and or yes or "N" for no. iccompensated care paymer mn 1, "Y" for yes or "N priod occurring prior to " for no for the portic er October 1. (see inst requires final uncompe port settlement? (see i " for no, for the portic ter 1. Enter in column 2 te cost reporting period dic reclassification from ds for delineating stat tolumn 1, "Y" for yes or g period prior to Octoben no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column 24	i th 42 CFF this endment ts for thi "for no 1 October 7 n of the c ructions) nsated can nstruction on of the , "Y" for on or aff m urban to istical ar "N" for r er 1. Ente he cost ructions) 99 beds (a 3, "Y" for and/or 25	R is for 1. cost re ns) yes ter por reas no er	N N N	9 2.00 N N	018	3. (00	21. 22. 22. 22. 22. 22.
1.00 2.00 2.01 2.02	Type of Control (see instructions) Inpati ent PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section S hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir 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 Method below? In column 1, enter 1 if date if date of discharge. Is the method	estment, in accordance w ryes or "N" for no. Is (412.106(c)(2)(Pickle and oryes 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 inst requires final uncompe- port settlement? (see i "for no, for the porti- tier 1. Enter in column 2 the cost reporting perior ds for delineating stat olumn 1, "Y" for yes or g period prior to Octobe no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if cens of identifying the days	ith 42 CFF this endment ts for thi october n of the or ructions) nstruction on of the , "Y" for on or aff m urban to istical ar "N" for r er 1. Ente he cost ructions) 99 beds (a 3, "Y" for and/or 25 us days, of in this of	R for 1. cost re ns) yes ter preas no er as pr as pr 3 5 7 3	N N N	9 2.00 N N	018	3. (00	21. 22. 22. 22. 22. 22.
. 00 . 00 . 01 . 02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section S hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of the October 1. Did this hospital receive a geograph- rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir 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.	estment, in accordance w ryes or "N" for no. Is (412.106(c)(2)(Pickle and oryes or "N" for no. (compensated care paymer mm 1, "Y" for yes or "Neriod occurring prior to "for no for the portic er October 1. (see inst requires final uncompe port settlement? (see i "for no, for the porti- ter 1. Enter in column 2 le cost reporting perior dic reclassification from dis for delineating stat for the portion of the period prior to October no for the portion of the er October 1. (see inst folumn 1, "Y" for yes or g period prior to October no for the portion of the er October 1. (see inst 100 but not more than 4 2.105)? Enter in column edicaid days on lines 24 of admission, 2 if censo fidentifying the days method used in the prior	i th 42 CFF this endment ts for thi october n of the or ructions) nsated car nstruction on of the , "Y" for on or aff m urban to istical ar "N" for r er 1. Ente he cost ructions) 99 beds (a 3, "Y" for and/or 25 us days, of in this or r cost	R for 1. cost re ns) yes ter preas no er as pr as pr 3 5 7 3	N N N	9 2.00 N N	018	3. (00	21. 22. 22. 22. 22. 22.

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC			1/2018	Part I Date/T 5/30/2	ieet S-2 ime Pre 2019 2:3	epared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	iys Me	Other di cai d days	
1 00	If this provider is an LDDS bessited anten the	1.00	2.00	3.00	4.00	5.00	0	6.00	24.0
5. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid 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, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0		0		0		24.0
					Urban/R			f Geogr 00	· -
5.00	Enter your standard geographic classification (not wa	age) status	at the beg	inning of t		1	۷.	00	26.0
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	rural. age) status r "2" for ru	at the end Iral. If ap	l of the cos		1			27.0
5.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35.0
					Begi nr 1. (i ng: 00	_
5.00	Enter applicable beginning and ending dates of SCH st	tatus. Subso	ript line	36 for numb		10	Ζ.	00	36. (
. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		of period	ls MDH statu	s	0			37.0
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37. (
3. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. (
					Y/			/N	_
9.00	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 t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent requiremen	er in colum its in	n			<u>00</u> N	39. (
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Enter	"Y" for y					N	40.
						1. 00	XVIII) 2.00	_	-
	Prospective Payment System (PPS)-Capital	+ 6cm	anort! '	o ob '					
00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	IL FOR DISPI	oportionat	e snare in	accordance	N	N	N	45.
00	Is this facility eligible for additional payment exce					N	N	N	46.
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks1 Pt. III.			Ves or "N"		N N	N N	N N	47. 48.
00					no.	IN	IN		
00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of	t? Enter "	" for yes	or "N" for		N			56.
. 00 . 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N	t? Enter " approved G period durin yes or "N" th of this of (", complete	/" for yes IE programs ng which re for no in cost report Worksheet	or "N" for ? Enter "Y sidents in column 1. ing period?	" for yes approved If column 1 Enter "Y"	N			56. 57.
0. 00 0. 00 0. 00 0. 00 0. 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont	t? Enter " approved GM period durin yes or "N" th of this ((", complete , if applic pursement for	<pre>/" for yes // programs // no in for no in cost report e Worksheet able. or physicia</pre>	or "N" for ? Enter "Y ssidents in column 1. ing period? E-4. If co	" for yes approved If column 1 Enter "Y" Iumn 2 is	N			

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	TA	Provider CC	F	eriod: rom 01/01/2018 o 12/31/2018	Date/Time Pre	parec
			NAHE 413.85 Y/N	Worksheet A Line #	5/30/2019 2:3 Pass-Through Qual i fi cati on Cri teri on Code	
			1.00	2.00	3.00	
00 Are you claiming nursing and allied health education			N			60. (
any programs that meet the criteria under §413.85? (Y/N	ructions) IME	Direct GME	IME	Direct GME	
	1.00	2.00	2.00	4.00	F 00	-
00 Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	5.00	61.
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)						
01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.
instructions)						11
02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.
 and/or general surgery residents, which is used for determining compliance with the 75% test. (see 						61.
<pre>instructions) 04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the</pre>						61.
 current cost reporting period. (see instructions). 05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 						61.
 61.04 minus line 61.03). (see instructions) 06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 						61.
care or general surgery. (see this full tons)	Prog	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
 10 Of the FTEs in line 61.05, specify each new program 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. 20 Of the FTEs in line 61.05, specify each expanded and the program of FTE. 				0.00		
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 Ser				od for which	0.00	40
00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc01 Enter the number of FTE residents that rotated from a	tions)				0.00	
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	<u>ram. (se</u> er Settir	e <u>instructio</u> n ngs	ns)			
00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple					N	63.
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor	e June 3	30, 2010.	-	-	-	2.4
00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in	-primary all nonp non-pri	r care provider mary care	0.00	0.00	0. 000000	64

SPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	AIA Provider	Fr	eriod: com 01/01/2018	Worksheet S-2 Part I	
			To	12/31/2018	Date/Time Pre 5/30/2019 2:3	pared 5 pm
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs	FTEs in	$(col \cdot 3 + col \cdot$	
			Nonprovider Site	Hospi tal	4))	
-	1.00	2.00	3.00	4.00	5.00	1
00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)						
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der	Hospi tal	(201. 1 + 201. 2))	
			Si te			
			1.00	2.00	3.00	
Section 5504 of the ACA Current N beginning on or after July 1, 207		n Nonprovider Settir	ngsEffective fo	r cost reporti	ing periods	
	inweighted nen prime	rovider settings.				
FTEs that trained in your hospita (column 1 divided by (column 1 +		ry care resident 3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
FTEs that trained in your hospita (column 1 divided by (column 1 +	al. Enter in column : _column 2)). (see in:	ry care resident 3 the ratio of structions)	FTĔs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
FTEs that trained in your hospita (column 1 divided by (column 1 + 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	al. Enter in column a column 2)). (see in: Program Name	ry care resident 3 the ratio of structions) Program Code	FTËs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
FTEs that trained in your hospita (column 1 divided by (column 1 + 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	al. Enter in column a column 2)). (see in: Program Name	ry care resident 3 the ratio of structions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital 4.00 0.00	(col. 3 + col. 4)) 5.00 0.000000	_
FTEs that trained in your hospita (column 1 divided by (column 1 + 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	al. Enter in column : column 2)). (see in Program Name 1.00	ry care resident 3 the ratio of structions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00 0.000000	_
FTEs that trained in your hospita (column 1 divided by (column 1 + 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)	al. Enter in column <u>column 2)). (see in</u> Program Name <u>1.00</u> <u>255</u> ychiatric Facility (ry care resident 3 the ratio of structions) Program Code 2.00	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00 1.0	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	
FTEs that trained in your hospita (column 1 divided by (column 1 + 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)	Program Name 1.00 1.00 Program Name 1.00 1.	ry care resident 3 the ratio of structions) Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0.0000000 0.0000000 0.000000	70.
FTEs that trained in your hospita (column 1 divided by (column 1 + 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) Inpatient Psychiatric Facility PP 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF column 3: If column 2 is Y, indic	PS ychiatric Facility (the facility have an effore November 15, 2 umn 2: Did this fac R 412.424 (d)(1)(iii) cate which program yo y PPS	ry care resident 3 the ratio of structions) Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTĚs Nonprovi der Si te 3.00 0.00 intain an IPF subp sing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0 2.00 3.00 0 0 0 2.00 3.00	_

Health Financial Systems SULLI VAN COUNTY COMMUNI TY HOSPI TAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1327 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: То 12/31/2018 5/30/2019 2:35 pm 1.00 Long Term Care Hospital PPS 80.00 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Ν 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Ν 85 00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87 00 Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. ٧ XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν γ 90 00 ves or "N" for no in the applicable column. $|I\,s\,$ this hospital reimbursed for title V and/or XIX through the cost report either in 91 00 Ν γ 91 00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν Ν 94 00 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν Ν 96.00 applicable column 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97 00 0 00 0.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post 98.00 Υ Υ stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Υ 98.01 98.01 Υ C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation γ 98.02 v bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V. and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and Ν 98.04 Ν in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in 98.05 γ 98.05 column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? Y 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R Ν 107.00 training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 108.00 Υ CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Respi ratory Physi cal Occupati onal Speech 1 00 2 00 4 00 3 00 109.00 109.00 If this hospital qualifies as a CAH or a cost provider, are Ν Ν Ν Ν therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, 110.00 Ν complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e.

Heal th Financial Systems SULLIVAN COUNTY COMMUNITY HOSPITA			n Lieu	u of For		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC	N: 15-1327	Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti		
		10 12/31/	2010	5/30/20)19 2:3	35 pm
		1.00		2. (00	-
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	period? Enter enter the column 2.	N				111. 00
			1.00	2.00	3.00	
 Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in is yes, enter the method used (A, B, or E only) in column 2. If column 2 i 3 either "93" percent for short term hospital or "98" percent for long ter psychiatric, rehabilitation and long term hospitals providers) based on th Pub. 15-1, chapter 22, §2208.1. 114.00 Is this chapter 12, §2208.1. 	s "E", enter m care (incl me definition	in column udes	N		0	115.00
116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" 117.00 s this facility legally-required to carry malpractice insurance? Enter "Y no.		"N" for	N Y			116.00 117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 i claim-made. Enter 2 if the policy is occurrence.	f the policy	is	1			118.00
	Premi ums	Losse	5	Insur	ance	
	1.00	2.00		3. (
118.01 List amounts of malpractice premiums and paid losses:	111, 7	19	0		(0118.01
		1.00 N		2. (00	1
118.02 Are malpractice premiums and paid losses reported in a cost center other t Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)	ost centers vision in ACA for yes or ne Outpatient	N		N		118. 02 119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices	charged to	Y				121.00
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1903(Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.						122.00
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no. If	N				125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter the certif	ication date					126. 00
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.	cation date					127. 0
28.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.						128. 0
29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.		n				129.00
30.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2.						130.0
31.00 f this is a Medicare certified intestinal transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2.						131.00
 32.00 If this is a Medicare certified islet transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 33.00 If this is a Medicare certified other transplant center, enter the certifi 						132.00
in column 1 and termination date, if applicable, in column 2. 34.00 If this is an organ procurement organization (0P0), enter the OPO number i						134. 00
and termination date, if applicable, in column 2. All Providers						
140.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home are claimed, enter in column 2 the home office chain number. (see instruct	office costs	Y				140. 00

JSPITAL AND HUSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	COMMUNI TY HOSPI TA Provi der CC			In Lie /01/2018 2/31/2018	Worksheet S- Part I	2 epared:
1.00		. 00		·	3.00		
If this facility is part of a cha				name and	address	of the	
home office and enter the home of 11.00Name:	Contractor name and Contractor's Name:	contractor numbe		tor's Num	hor:		141.0
12.00 Street:	PO Box:		Contrac		IDEI.		141.0
13. 00 Ci ty:	State:		Zip Code	e:			143.0
			· · ·				
						1.00	
14.00 Are provider based physicians' co	sts included in Worksheet	: A?				Y	144. C
					1. 00	2.00	-
15.00 If costs for renal services are c	laimed on Wkst. A, line 7	4, are the costs	for		1.00	2.00	145.0
inpatient services only? Enter "Y	" for yes or "N" for no i	n column 1. If c	olumn 1 is				
no, does the dialysis facility in	clude Medicare utilizatio	on for this cost	reporti ng				
period? Enter "Y" for yes or "N"		auchy filed east	roport2		N		146 0
16.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no i				f	N		146. C
yes, enter the approval date (mm/		10 Z, Chapter 4	5, 37020) I	.			
						1.00	
17.00 Was there a change in the statist						N	147.0
18.00Was there a change in the order o 19.00Was there a change to the simplif				r no		N N	148.0
		Part A	Part B		tle V	Title XIX	147.0
		1.00	2.00		3.00	4.00	
Does this facility contain a prov	ider that qualifies for a	an exemption from	the applic			r of costs	
or charges? Enter "Y" for yes or	"N" for no for each compo			(See 42			
55.00Hospi tal		N	N		N	N	155.0
66.00 Subprovider - IPF 57.00 Subprovider - IRF		N	N N		N N	N N	156. (157. (
58. 00 SUBPROVIDER		IN	IN		IN	IN IN	157.0
59. 00 SNF		N	Ν		Ν	N	159.0
50.00 HOME HEALTH AGENCY		N	Ν		Ν	N	160. C
51.00 CMHC			N		Ν	N	161. C
						1.00	_
Mul ti campus						1.00	-
55.00 Is this hospital part of a Multica					SAc2	N	
	ampus hospital that has o	ne or more campu	ses in diff	erent CB9		I N	105 0
Enter "Y" for yes or "N" for no.	ampus hospital that has o	one or more campu	ses in diff	erent CBS	545 !	N	165.0
	Name	County	State Z	ip Code	CBSA	FTE/Campus	165.0
Enter "Y" for yes or "N" for no.		•				FTE/Campus 5.00	165.0
Enter "Y" for yes or "N" for no.	Name	County	State Z	ip Code	CBSA	FTE/Campus 5.00	_
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column	Name	County	State Z	ip Code	CBSA	FTE/Campus 5.00	_
Enter "Y" for yes or "N" for no.	Name	County	State Z	ip Code	CBSA	FTE/Campus 5.00	_
Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Name	County	State Z	ip Code	CBSA	FTE/Campus 5.00	_
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,	Name	County	State Z	ip Code	CBSA	FTE/Campus 5.00	_
Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	Name	County	State Z	ip Code	CBSA	FTE/Campus 5.00 0.0	_
Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	Name 0	County 1.00	State Z 2.00	i p Code 3. 00	CBSA	FTE/Campus 5.00	_
Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI	Name O T) incentive in the Ameri	County 1.00 can Recovery and	State Z 2.00	i p Code 3. 00	CBSA	FTE/Campus 5.00 0.0	0 166. (
Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	Name 0 T) incentive in the Ameri r under §1886(n)? Enter	County 1.00 can Recovery and "Y" for yes or "	State Z 2.00	ip Code 3.00	CBSA 4.00	FTE/Campus 5.00 0.0	 0 166. (167. (
Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 38.00 If this provider is a CAH (line 10 reasonable cost incurred for the line 10	Name 0 0 T) incentive in the Ameri r under §1886(n)? Enter D5 is "Y") and is a meani HIT assets (see instructi	County 1.00 can Recovery and "Y" for yes or " ngful user (line ons)	State Z 2.00 I Reinvestme N" for no. 167 is "Y"	nt Act	CBSA 4.00 the	FTE/Campus 5.00 0.0	0 166. (167. (0 168. (
Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 58.01 If this provider is a CAH and is b	Name 0 1) incentive in the Ameri r under §1886(n)? Enter 25 is "Y") and is a meani HIT assets (see instructi not a meaningful user, do	County 1.00 can Recovery and "Y" for yes or " ngful user (line ons) bes this provider	State Z 2.00 I Rei nvestme N" for no. 167 i s "Y" qual i fy fo	nt Act), enter na hards	CBSA 4.00 the	FTE/Campus 5.00 0.0	0 166. (167. (0 168. (
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Enter "Y" for yes or "N" for no. Enter "Y" for yes or "N" for each "State" Enter "State" Enter "Y" for yes or "N" for each "State" Enter "State	Name 0 1) incentive in the Ameri r under §1886(n)? Enter 25 is "Y") and is a meani HIT assets (see instructi not a meaningful user, do ? Enter "Y" for yes or "N user (line 167 is "Y") an	County 1.00 <u>can Recovery and</u> "Y" for yes or " ngful user (line ons) wes this provider " for no. (see i	State Z 2.00 I Reinvestme N" for no. 167 is "Y" qualify fo nstructions	ip Code <u>3.00</u> ant Act), enter r a hards "N"), er	CBSA 4.00 the shi p	FTE/Campus 5.00 0.0 1.00 Y	165. C 0 166. C 167. C 0 168. C 168. C 168. C
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Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the l 88.01 If this provider is a CAH and is in exception under §413.70(a)(6)(ii)' 59.00 If this provider is a meaningful transition factor. (see instruction)	Name 0 1 0 <tr td=""> 0</tr>	County 1.00 <u>can Recovery and</u> "Y" for yes or " ngful user (line ons) wes this provider " for no. (see i nd is not a CAH (State Z 2.00	nt Act), enter "N"), er Beg	CBSA 4.00 the ship nter the jinning 1.00	FTE/Campus 5.00 0.0 1.00 Y 0.0 Endi ng 2.00	0 166. (167. (0 168. (168. (168. (0 169. (
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Enter "Y" for yes or "N" for no. Enter "Y" for yes or "N" for each column for the lifeton of the second o	Name 0 1 0 0 1 0 1 1 0 1 1 0 1	County 1.00 <u>can Recovery and</u> "Y" for yes or " ngful user (line ons) les this provider " for no. (see i d is not a CAH (date for the re	State Z 2.00 1.00	ip Code <u>3.00</u> nt Act), enter r a hards "N"), er <u>Beg</u> 01/(CBSA 4.00 the ship nter the jinning 1.00	FTE/Campus 5.00 0.0 1.00 Y 0.0 Endi ng 2.00 12/31/2018 2.00	167. (0168. (0168. (168. (169. (170. (
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	Financial Sullivan County CO AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1327 F	Period:	u of Form CMS Worksheet S-	
				rom 01/01/2018 To 12/31/2018		epared:
	· · · ·			Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	esponses. Enter	all dates in t	he	
	COMPLETED BY ALL HOSPITALS					_
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
. 00	reporting period? If yes, enter the date of the change in c	olumn 2. (see	instructions)	IN IN		1.00
			Y/N	Date	V/I	
. 00	Has the provider terminated participation in the Medicare P	hoogram? If	1.00 N	2.00	3.00	2.0
. 00	yes, enter in column 2 the date of termination and in colum		IN IN			2.0
	voluntary or "I" for involuntary.					
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o		N			3.0
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members o	of the board				
	of directors through ownership, control, or family and othe	r similar				
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f		Y	A		4.0
	or "R" for Reviewed. Submit complete copy or enter date ava	ilable in				
	column 3. (see instructions) If no, see instructions.					
. 00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit rec		N			5.0
				Y/N	Legal Oper.	
				1.00	2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If yos is th	a providor ic	N		6.0
. 00	the legal operator of the program?	TT yes, is ti	le provider is	IN		0.00
. 00	Are costs claimed for Allied Health Programs? If "Y" see in	structions.		N		7.00
. 00	Were nursing school and/or allied health programs approved	and/or renewed	d during the	N		8.00
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	graduate medio	cal education	N		9.00
	program in the current cost report? If yes, see instruction					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
0.00	Was an approved Intern and Resident GME program initiated o	or renewed in 1	the current	N		10.0
1 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& R in an Anr	proved	N		11.0
1.00	Teaching Program on Worksheet A? If yes, see instructions.		51 OVCU	N.		11.0
					Y/N	
	Bad Debts				1.00	
2.00	Is the provider seeking reimbursement for bad debts? If yes	, see instruct	ti ons.		Y	12.0
3.00	If line 12 is yes, did the provider's bad debt collection p	olicy change d	during this cos	st reporting	Ν	13.0
1 00	period? If yes, submit copy.	nte waiwad2 lf	Ever coolinct	ructions	N	14.0
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ants warveu? II	yes, see mst	.i uc ti ons.	N	14.0
5.00	Did total beds available change from the prior cost reporti	ng period?lf	yes, see instr		Ν	15.00
			rt A	Par		_
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
	PS&R Data		2100	0100		
6. 00	Was the cost report prepared using the PS&R Report only?	Y	03/28/2019	Y	03/28/2019	16. 0
	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)					
7.00	Was the cost report prepared using the PS&R Report for	Y	03/28/2019	Y	03/28/2019	17.0
	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)					
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		18.0
	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.					
9.00	If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		19.00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

Health Financial Systems

SULLI VAN	COUNTY	COMMUNI TY	HOSPI TAL

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1327	Peri od:	Worksheet S	-2	
				From 01/01/2018 To 12/31/2018		repared:	
					5/30/2019 2		
			ption	Y/N	Y/N		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R)	1.00 N	3.00 N	20.00	
20.00	Report data for Other? Describe the other adjustments:			iv iv	14	20.00	
		Y/N	Date	Y/N	Date		
21 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.00	
	records? If yes, see instructions.						
					1.00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	FPT CHILDRENS H	Ο SPI ΤΔΙ S)		1.00	_	
	Capital Related Cost		0311174237				
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00	
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprais	als made duri	ng the cost	Ν	23.00	
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost rep	porting period?	N	24.00	
25.00	Have there been new capitalized leases entered into during instructions.	, the cost repor	ting period?	lf yes, see	N	25.00	
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	he cost reporti	ng period? I	f yes, see	N	26.00	
27.00	Has the provider's capitalization policy changed during th	ne cost reportin	g period?lf	yes, submit	N	27.00	
	copy.	·		-		_	
20 00	Interest Expense Were new Loans, mortgage agreements or letters of credit e	ntorod into dur	ing the cost	roporting	Y	28.00	
20.00	period? If yes, see instructions.		ring the cost	reporting	, i	20.00	
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		bt Service Re	eserve Fund)	Y	29.00	
30.00	Has existing debt been replaced prior to its scheduled mat instructions.		debt? If yes,	see	N	30.00	
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see	N	31.00	
	instructions. Purchased Services					_	
32.00	Have changes or new agreements occurred in patient care se	ervi ces furni she	d through co	ntractual	N	32.00	
	arrangements with suppliers of services? If yes, see instr						
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	plied pertainin	g to competi	tive bidding? If		33.00	
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facility under an a	arrangement with	provi der-bas	sed physi ci ans?	Y	34.00	
35 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	visting agreemen	ts with the u	arovi der-based	Y	35.00	
	physicians during the cost reporting period? If yes, see i				'	33.00	
				Y/N	Date		
	Home Office Costs			1.00	2.00		
36.00	Were home office costs claimed on the cost report?			N		36.00	
	If line 36 is yes, has a home office cost statement been p	prepared by the	home office?			37.00	
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of			38.00	
39 00	the provider? If yes, enter in column 2 the fiscal year er If line 36 is yes, did the provider render services to oth					39.00	
	see instructions.		5				
40.00	If line 36 is yes, did the provider render services to the instructions.	e home office?	lf yes, see			40.00	
	1.00 2.						
	Cost Report Preparer Contact Information			Z.			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	EI CHELMAN		NI CK		41.00	
	respectively.						
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP				42.00	
43.00	Enter the telephone number and email address of the cost	(317) 383-3781		NEI CHELMAN@BKD	. COM	43.00	
	report preparer in columns 1 and 2, respectively.					1	

Heal th	Financial Systems	SULLI VAN COUNTY (СОММ	UNI TY HOSPI TAL		In Lieu	u of Form CMS	-255	2-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provider CCN: 15-1327		eri od:	Worksheet S-	2	
					To			epar 35 p	red:
				3.00					
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the	title/position	DH	RECTOR				4	1.00
	held by the cost report preparer in colur	nns 1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the co	ost report						4	2.00
	preparer.								
43.00	Enter the telephone number and email add	ress of the cost						4	3.00
	report preparer in columns 1 and 2, respe	ecti vel y.							

SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-1327	Period: From 01/01/2018 To 12/31/2018		
		1				5/30/2019 2:3	5 pm
						I/P Days / O/P	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	<u>Visits / Trips</u> Title V	
	component	Line Number	NO. OF DEUS	Avai I abl e	CAIT HOUTS		
		1.00	2.00	3.00	4.00	5.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	21	7,60	41, 592. 00	0	1.
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
00	HMO and other (see instructions)						2.
00	HMO I PF Subprovi der						3.
00	HMO I RF Subprovider						4
00	Hospital Adults & Peds. Swing Bed SNF					0	
00 00	Hospital Adults & Peds. Swing Bed NF		0.1	7 /	41 500 00	0	
00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,60	41, 592. 00	0	7
00	INTENSIVE CARE UNIT	31.00	4	1, 40	4, 248. 00	0	8
00	CORONARY CARE UNIT	31.00	4	1, 40	4, 240. 00	0	9
00	BURN INTENSIVE CARE UNIT						10
00	SURGI CAL I NTENSI VE CARE UNI T						11
00	OTHER SPECIAL CARE (SPECIFY)						12
00	NURSERY	43.00				0	
00	Total (see instructions)	101 00	25	9, 12	45, 840. 00	-	
00	CAH visits			., .		0	
00	SUBPROVIDER - IPF						16
00	SUBPROVIDER - IRF						17
00	SUBPROVI DER						18
00	SKILLED NURSING FACILITY						19
00	NURSING FACILITY						20
00	OTHER LONG TERM CARE						21
00	HOME HEALTH AGENCY	101.00				0	22
00	AMBULATORY SURGICAL CENTER (D. P.)						23
00	HOSPICE						24
10	HOSPICE (non-distinct part)	30.00					24
00	CMHC - CMHC						25
00	RURAL HEALTH CLINIC						26
25	FEDERALLY QUALIFIED HEALTH CENTER	89.00	25			0	
00 00	Total (sum of lines 14-26)		25			0	27
00	Observation Bed Days Ambulance Trips					0	29
00	Employee discount days (see instruction)						30
00	Employee discount days (see first detroit)						31
00	Labor & delivery days (see instructions)		0		0		32
01	Total ancillary labor & delivery room		0		Ĭ		32
	outpatient days (see instructions)						52
. 00	LTCH non-covered days						33
	LTCH site neutral days and discharges						33

	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CC	JN: 15-1327	Peri From To	00: 1 01/01/2018 12/31/2018	Worksheet S-3 Part I Date/Time Pre 5/30/2019 2:3	pare
		I/P Days	/ O/P Visits / Trips		Full Time		qui val ents	
	Component	Title XVIII	Title XIX	Total All Patients		tal Interns Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1, 024	27	1, 73	33			1.
00	HMO and other (see instructions)	22	125					2.
00	HMO IPF Subprovider	0	0					3.
00	HMO IRF Subprovider	0	0					4.
00	Hospital Adults & Peds. Swing Bed SNF	444	0	44	44			5.
00	Hospital Adults & Peds. Swing Bed NF		56	Ę	56			6.
00	Total Adults and Peds. (exclude observation	1, 468	83	2, 23	33			7
	beds) (see instructions)							
0C	INTENSIVE CARE UNIT	109	8	17	77			8
00	CORONARY CARE UNI T							9
00	BURN INTENSIVE CARE UNIT							10
00	SURGICAL INTENSIVE CARE UNIT							11
. 00	OTHER SPECIAL CARE (SPECIFY)							12
00	NURSERY		60	25	56			13
00	Total (see instructions)	1, 577	151	2,66	56	0.00	223.60	14
00	CAH visits	0	0		0			15
00	SUBPROVIDER - IPF							16
00	SUBPROVIDER – IRF							17
00	SUBPROVI DER							18
00	SKILLED NURSING FACILITY							19
00	NURSING FACILITY							20
00	OTHER LONG TERM CARE							21
00	HOME HEALTH AGENCY	1, 954	108	2, 49	95	0.00	4.77	
00	AMBULATORY SURGICAL CENTER (D. P.)							23
00	HOSPI CE							24
10	HOSPICE (non-distinct part)				0			24
00	CMHC – CMHC							25
00	RURAL HEALTH CLINIC		-					26
25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	
00	Total (sum of lines 14-26)					0.00	228.37	
00	Observation Bed Days		173	1, 26	57			28
00	Ambul ance Trips	0						29
00	Employee discount days (see instruction)			Ę	50			30
. 00	Employee discount days - IRF		_		0			31
. 00	Labor & delivery days (see instructions)	0	0		17			32
. 01	Total ancillary labor & delivery room				0			32
	outpatient days (see instructions)	_						
. 00	LTCH non-covered days LTCH site neutral days and discharges	0						33

HOSPI ⁻	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Pre 5/30/2019 2:3	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 17.00 20.00 21.00 22.00 23.00 24.00 24.00 24.00 24.00 26.25 27.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0.00 0.00 0.00	0		57 16 8 0 0 0 57 16	653	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 23.00 24.00 24.00 24.00 25.00 24.00 26.00 27.00 20.00 27.00 20.0
28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days				0		28. 00 29. 00 30. 00 31. 00 32. 00 32. 00 33. 00

	Financial Systems SULI EALTH AGENCY STATISTICAL DATA	LI VAN COUNTY CO		AL CN: 15-1327	In Lie Period:	u of Form CMS-: Worksheet S-4	
HOME H	EALIH AGENCY STATISTICAL DATA			CN: 15-1327 CCN: 15-7542	From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
					Home Health	5/30/2019 2:3 PPS	o pili
					Agency I		1
					1.	00	-
0.00	County				SULLI VAN		0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	<u> </u>	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00 2.00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0 0.00	1, 390 84. 00		0 0 00 0.00		
2.00		0.00	04.00		ployees (Full Ti		2.00
		Enter the number		Staff	Contract	Total	
		your normal	WORK WEEK				
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	-					
3.00	Administrator and Assistant Administrator(s)		40.00			0.65 0.00	
4.00 5.00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.0		0.00	
6.00	Direct Nursing Service			3.		3. 62	
7.00 8.00	Nursing Supervisor Physical Therapy Service			0.0		0.00 0.33	
9.00	Physical Therapy Supervisor			0.0		0.00	
10.00	Occupational Therapy Service			0.1		0. 22	
11.00 12.00	Occupational Therapy Supervisor Speech Pathology Service			0.0		0. 00 0. 01	
13.00	Speech Pathology Supervisor			0.0	0. 00	0.00	13.00
14.00 15.00	Medical Social Service Medical Social Service Supervisor			0.0		0.02	14.00 15.00
16.00	Home Heal th Ai de			0.0		0.61	
17.00	Home Heal th Ai de Supervisor			0.0		0.00	1
18.00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.(0.00	0.00	18.00
19.00	Enter in column 1 the number of CBSAs where				2		19.00
	you provided services during the cost reporting period.						
20.00	List those CBSA code(s) in column 1 serviced			45460			20.00
	during this cost reporting period (line 20 contains the first code).						
20. 01				99915			20. 01
		Full Ep					
		Without Outliers	With Outliers	LUPA EPI SOde	s PEP Only Epi sodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
21.00	PPS ACTIVITY DATA Skilled Nursing Visits	560	30		17 23	630	21.00
22.00	Skilled Nursing Visit Charges	83, 865	4, 530		59 3, 473	94, 427	22.00
23.00 24.00	Physical Therapy Visits Physical Therapy Visit Charges	527 93, 775	C) 1,43	8 17 32 3, 043	552 98, 250	
25.00	Occupational Therapy Visits	192	C)	1 14	207	1
26.00	Occupational Therapy Visit Charges	34, 125	C	1	79 2, 506	36, 810	
27.00 28.00	Speech Pathol ogy Visits Speech Pathol ogy Visit Charges	6 1,035	C		0 0	6 1, 035	
29.00	Medical Social Service Visits	3	4	L .	0 1	8	29.00
30.00	Medical Social Service Visit Charges Home Health Aide Visits	603 482	804 15		0 201 1 53	1, 608 551	1
	Home Health Aide Visit Charges	402	1, 395		4, 929	50, 893	
31. 00 32. 00	nome near th Arde Visit charges				27 108	1, 954	33.00
31.00	Total visits (sum of lines 21, 23, 25, 27,	1, 770	49	' ·	100	1, 701	
31.00 32.00 33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1, 770	49 C		0 0	0	34.00
31. 00 32. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28,	1, 770 0 257, 879	49 C 6, 729		0 0	0	
31.00 32.00 33.00 34.00 35.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	0 257, 879	C		0 0 53 14, 152	0 283, 023	35.00
31.00 32.00 33.00 34.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0	C		0 0	0	35. 00 36. 00

Heal th	Financial Systems SULLIVAN COUNTY COMMUNI	ITY HOSPITA	L	In Lie	eu of Form CMS-2	2552-10
		Provider CC	N: 15-1327	Peri od:	Worksheet S-1	0
				From 01/01/2018 To 12/31/2018		narod
				10 12/31/2010	5/30/2019 2:3	5 pm
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ided by lin	e 202 colum	ו 8) ו 8)	0. 324914	1.00
	Medicaid (see instructions for each line)	4		·		
2.00	Net revenue from Medicaid				2, 305, 105	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplementa			ai d?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fro	om Medicaid			764, 241	5.00
6.00	Medicaid charges				8, 776, 065	6.00
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (1	lino 7 minu	c cum of li	ac 2 and E. if	2, 851, 466 0	7.00
6.00	<pre>c zero then enter zero)</pre>		S SUII OF TH	ies z aliu 5, TT	0	0.00
	Children's Health Insurance Program (CHIP) (see instructions for	r each line)			
9.00	Net revenue from stand-alone CHIP				0	9.00
10.00					0	
11.00				с н	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (lenter zero)	line 11 min	us line 9; i	f < zero then	0	12.00
	Other state or local government indigent care program (see instr	ructions fo	r each line)	1	I	
13.00	Net revenue from state or local indigent care program (Not inclu	uded on lin	es 2, 5 or 9	9)	2, 250, 799	13.00
14.00	Charges for patients covered under state or local indigent care	program (N	ot included	in lines 6 or	11, 080, 637	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line 14)		<i>.</i>		3, 600, 254	15.00
16.00	Difference between net revenue and costs for state or local indi	igent care	program (lii	ne 15 minus line	1, 349, 455	16.00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIF	P and state	/local indi	ent care program	ns (see	-
	instructions for each line)				13 (300	
17.00	Private grants, donations, or endowment income restricted to fu	nding chari	ty care		0	17.00
18.00	5 11 1				0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent c	are programs	s (sum of lines	1, 349, 455	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci	: 1 : + . /	112, 8	0 424 470	747, 278	20.00
20.00	(see instructions)	iiity	112, 8	634, 478	141,218	20.00
21.00	Cost of patients approved for charity care and uninsured discour	nts (see	36, 6	50 634, 478	671, 128	21.00
22.00	instructions) Payments received from patients for amounts previously written of	off as	1, 8	45 10, 376	12, 221	22.00
22.00	chari ty care		1, 0	10, 370	12, 221	22.00
23.00	Cost of charity care (line 21 minus line 22)		34, 8	624, 102	658, 907	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patient	t days bevo	nd a length	of stay limit	N 1.00	24.00
211.00	imposed on patients covered by Medicaid or other indigent care		na a rongen	or oray rimit		2
25.00	If line 24 is yes, enter the charges for patient days beyond the		care progra	n's length of	0	25.00
24 00	stay limit	tructions)			1 000 444	24 00
26.00	Total bad debt expense for the entire hospital complex (see ins: Medicare reimbursable bad debts for the entire hospital complex		uctions)		1, 829, 666 705, 032	
	Medicare allowable bad debts for the entire hospital complex (so				1, 084, 664	
	Non-Medicare bad debt expense (see instructions)				745,002	
29.00		ense (see i	nstructions`)	621, 694	
	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 280, 601	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus lin	ne 30)			2, 630, 056	31.00

CLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CC		eriod:	Worksheet A	
					rom 01/01/2018 o 12/31/2018	Date/Time Pre 5/30/2019 2:3	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00	GENERAL SERVICE COST CENTERS		732, 714	732, 714	87, 342	820, 056	1
00	00200 NEW CAP REL COSTS BEDG & TTXT		1, 040, 644			1, 057, 698	
)0	00400 EMPLOYEE BENEFITS DEPARTMENT	143, 324	151, 257			4, 016, 285	
)1	00590 I S/ACCOUNTI NG/MARKETI NG	624, 658	737,007			1, 177, 282	
)2	00591 BUSINESS OFFICE & ADMITTING	621, 717	1, 717, 047	2, 338, 764		2, 052, 744	
)3	00592 OTHER A&G	150, 009	1, 750, 216	1, 900, 225	-97, 589	1, 802, 636	5
00	00700 OPERATION OF PLANT	406, 484	866, 923	1, 273, 407	-127, 671	1, 145, 736	7
00	00800 LAUNDRY & LINEN SERVICE	43, 252	42, 538	85, 790	-24, 344	61, 446	8
00	00900 HOUSEKEEPI NG	297, 618	196, 346	493, 964	-150, 152	343, 812	9
00	01000 DI ETARY	337, 134	384, 231	721, 365	-154, 528	566, 837	10
00	01100 CAFETERI A	0	0	0	-	0	11
00	01300 NURSI NG ADMI NI STRATI ON	432, 622	147, 129			451, 111	
00	01400 CENTRAL SERVICES & SUPPLY	110, 825	48, 168			111, 517	
00	01500 PHARMACY	375, 414	1,005,449			1, 265, 931	
00	01600 MEDICAL RECORDS & LIBRARY	288, 704	131, 658			313, 835	
00	01900 NONPHYSI CLAN ANESTHETI STS	0	596, 150	596, 150	0	596, 150	19
00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 375, 802	487, 597	1, 863, 399	115, 817	1, 979, 216	30
00	03100 I NTENSI VE CARE UNI T	383, 552	487, 597 146, 508			414, 853	
00	04300 NURSERY	0	140, 500			83, 523	
00	ANCI LLARY SERVI CE COST CENTERS		0	0	03, 323	00, 020	
00	05000 OPERATI NG ROOM	688, 946	525, 919	1, 214, 865	-343, 756	871, 109	50
00	05200 DELIVERY ROOM & LABOR ROOM	606, 424	299, 055			68, 390	
00	05300 ANESTHESI OLOGY	0	10, 024			-1, 405	
00	05400 RADI OLOGY-DI AGNOSTI C	561, 958	523, 934	1, 085, 892		885, 868	
01	05401 ULTRASOUND	129, 911	51, 238	181, 149	-39, 583	141, 566	54
00	05600 RADI OI SOTOPE	0	140, 094	140, 094	-34, 756	105, 338	56
00	06000 LABORATORY	752, 312	1, 412, 366	2, 164, 678	-289, 583	1, 875, 095	60
00	06300 BLOOD STORING, PROCESSING & TRANS.	0	7, 669	7, 669	0	7, 669	63
00	06400 I NTRAVENOUS THERAPY	0	103, 313			96, 432	
00	06500 RESPI RATORY THERAPY	456, 277	242, 595			513, 623	
00	06600 PHYSI CAL THERAPY	718, 754	243, 185			749, 550	
00	06700 OCCUPATI ONAL THERAPY	132, 523	33, 088			133, 119	
00	06800 SPEECH PATHOLOGY	70, 969	20, 249			71, 738	
00	07000 ELECTROENCEPHALOGRAPHY 07001 CARDI OPULMONARY	0	3, 312			3, 312	
01 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	54, 330 0	17, 084 103, 140			55, 801 368, 598	
00	07200 I MPL. DEV. CHARGED TO PATIENT	0	103, 140			40, 414	
00	07300 DRUGS CHARGED TO PATIENTS	0	0			40, 414	
00	OUTPATIENT SERVICE COST CENTERS	0	0	0		0	1 / 3
00	09000 CLINIC	1, 664	39, 437	41, 101	-31	41, 070	90
	09001 JV CLINIC	166, 166	22, 223			167, 047	
02	09002 CLINIC - LAKESIDE	0	0	0	0	0	
03	09003 CLINIC - QUICKCARE	0	0	0	0	0	
	09100 EMERGENCY	756, 330	1, 063, 611	1, 819, 941	-259, 741	1, 560, 200	91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
00	04950 BEHAVI OR HEALTH	88, 392	361, 827	450, 219	-158, 873	291, 346	93
	OTHER REIMBURSABLE COST CENTERS						
. 00	10100 HOME HEALTH AGENCY	309, 612	146, 831	456, 443	-97, 702	358, 741	101
	SPECIAL PURPOSE COST CENTERS	11 005 (00)		24 427 450	07.000	24 445 200	1110
3. 00		11,085,683	15, 551, 776	26, 637, 459	27, 830	26, 665, 289	118
	NONREIMBURSABLE COST CENTERS	0	0	0			190
	19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	o	196, 891	196, 891		196, 891	
	19200 PHYSICIANS PRIVATE OFFICES	0	170, 071	170, 071			192
	19201 MS0 CEINICS	o	0				192
	07950 MEALS ON WHEELS	0	0	0			194
	07951 GUEST MEALS	0	0	0			194
	07951 00EST MERLS	79, 073	133, 655	212, 728	-16, 460	196, 268	
	07953 NONREI MBURSABLE - OTHER	40, 912	11, 583			41, 125	
				52, 170			

		MMUNITY HOSPITAL		In Lieu of Form CMS	6-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN	: 15-1327	Period: Worksheet A	
				From 01/01/2018 To 12/31/2018 Date/Time Pr	renared
				5/30/2019 2:	
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For Allocation			
	6.00	7.00			
GENERAL SERVICE COST CENTERS	1				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	-96, 814				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	-11,090				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-865, 229				4.00
5. 01 00590 I S/ACCOUNTI NG/MARKETI NG	-98, 456				5.01
5. 02 00591 BUSINESS OFFICE & ADMITTING	-1, 147, 659				5. 02
5. 03 00592 OTHER A&G	143, 658				5.03
7.00 00700 OPERATION OF PLANT	-9, 303				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	-5, 515				8.00
9.00 00900 HOUSEKEEPI NG	0				9.00
10. 00 01000 DI ETARY	0				10.00
11. 00 01100 CAFETERI A	-129, 443				11.00
13.00 01300 NURSING ADMINISTRATION	-1, 125				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	-12, 158				14.00
15.00 01500 PHARMACY	-37,588				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-9, 226				16.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	-596, 150	0			19.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS	0				30.00
31.00 03100 INTENSIVE CARE UNIT	0				31.00
43. 00 04300 NURSERY	0	83, 523			43.00
ANCI LLARY SERVICE COST CENTERS		074 400			
50. 00 05000 OPERATING ROOM	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	-38, 250				52.00
53. 00 05300 ANESTHESI OLOGY	0	-1, 405			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-1, 600				54.00
54. 01 05401 ULTRASOUND	0				54.01
56. 00 05600 RADI 0I SOTOPE 60. 00 06000 LABORATORY	0				56.00
					60.00 63.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	0	.,			64.00
65. 00 06500 RESPI RATORY THERAPY	0	96, 432			65.00
66. 00 06600 PHYSI CAL THERAPY	0	513, 623 749, 550			66.00
67. 00 06700 0CCUPATI ONAL THERAPY	0	133, 119			67.00
68. 00 06800 SPEECH PATHOLOGY	0				68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				70.00
70. 01 07001 CARDI OPULMONARY	0	0,012			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	187, 901				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0				73.00
OUTPATIENT SERVICE COST CENTERS		<u> </u>			/0.00
90. 00 09000 CLINIC	0	41,070			90.00
90. 01 09001 JV CLINIC	207, 897				90.01
90. 02 09002 CLINIC - LAKESIDE	409, 687				90.02
90. 03 09003 CLINIC - QUICKCARE	196, 375				90.03
91.00 09100 EMERGENCY	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93. 00 04950 BEHAVI OR HEALTH	6, 170	297, 516			93.00
OTHER REIMBURSABLE COST CENTERS	. · · ·				
101.00 10100 HOME HEALTH AGENCY	0	358, 741			101.00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-1, 907, 918	24, 757, 371			118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	196, 891			192.00
192. 01 19201 MS0 CLINICS	0	0			192.01
192. 03 19203 FPA	0	0			192.03
194.00 07950 MEALS ON WHEELS	0	0			194.00
194.0107951 GUEST MEALS	0	0			194.01
194. 02 07952 MARKETI NG	0	196, 268			194.02
194. 03 07953 NONREI MBURSABLE – OTHER	0	41, 125			194.03
200.00 TOTAL (SUM OF LINES 118 through 199)	-1, 907, 918	25, 191, 655			200.00

LASSIF	FICATIONS			Provider CCN: 15-	From 01/01/2018	
					To 12/31/2018 Date/Time 5/30/2019	e Prepared: 2:35 pm
	Cost Center	Increases Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	- ADVERTISING RECLASS					
	S/ACCOUNTI NG/MARKETI NG	5. 01 194. 02	0	6, 162 4, 527		1.0
0	<u>ARKETING</u>		0	<u>4, 527</u> 10, 689		2.0
	- DELIVERY ROOM RECLASS					
	DULTS & PEDIATRICS	30.00	520, 121	36, 418		1. (
	JRSERY		6 <u>1, 286</u> 581, 407	2 <u>2, 2</u> 37 58, 655		2.0
-	- EMPLOYEE BENEFITS RECLASS		301,407	30, 033		
EN	MPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 727, 525		1.0
		0.00 0.00	0 0	0		2. (
		0.00	0	0		4. (
		0.00	О	0		5. (
		0.00	0	0		6. (
		0.00 0.00	0	0		7. (
		0.00	0	0		9.
		0.00	0	0		10.
		0.00	0	0		11.
		0.00 0.00	0	0		12.
		0.00	0	0		14.
		0.00	О	0		15.
		0.00 0.00	0	0		16. 17.
0		0.00	0	0		17.
		0.00	Ō	Ō		19.
)		0.00	0	0		20.
		0.00 0.00	0	0		21.
		0.00	0	0		22.
		0.00	О	0		24.
		0.00	0	0		25.
))		0.00 0.00	0	0		26. 27.
5		0.00	0	0		28.
> L		0.00	•	<u>0</u>		29.
0	- OXYGEN RECLASS		0	3, 727, 525		
ME	EDI CAL SUPPLI ES CHARGED TO	71.00	0	33, 513		1. (
P/	ATI ENTS	+				
0 F	- MEDICAL SUPPLIES RECLASS		0	33, 513		
ME	EDI CAL SUPPLI ES CHARGED TO	71.00	0	231, 945		1. (
	ATI ENTS	70.00		10.111		
	MPL. DEV. CHARGED TO ATLENT	72.00	0	40, 414		2. (
1		0.00	о	0		3.
		0.00	0	0		4.
		0.00 0.00	0	0		5. 6.
		0.00	0	0		7.
		0.00	О	0		8.
		0.00	0	0		9.
0		0.00 0.00	0	0		10.
		0.00	Ő	Ő		12.
		0.00	0	0		13.
))		0.00	0	0		14. 15.
		0.00 0.00	0	0		16.
		0.00	o	0		17.
		0.00	0	0		18.
		0.00	0	0 272, 359		19. (
F	- BEHAVI OR HEALTH OVERHEAD		UU	212, 339		
NE	EW CAP REL COSTS-BLDG &	1.00	0	87, 342		1. (
	IXT	2 00		17 054		2
	EW CAP REL COSTS-MVBLE	2.00	0	17, 054		2.0
OF	PERATION_OF_PLANT	7.00	0	1 <u>1, 1</u> 26		3. C
	DTALS		0	115, 522		
JU Gr	rand Total: Increases		581, 407	4, 218, 263		500.0

	nancial Systems FICATIONS	50LL	IVAN COUNTY CON		CCN: 15-1327	Peri od:	u of Form CMS-255: Worksheet A-6
						From 01/01/2018 To 12/31/2018	Date/Time Prepar
		Decreases					5/30/2019 2:35 p
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	4	
	6.00	7.00	8.00	9.00	10.00		
	- ADVERTISING RECLASS	4.00	0	5, 821	1	b	1
	EHAVIOR HEALTH	93.00	0	4, 868			2
		<u></u>	0	<u>4, 6</u> 89			2
В	- DELIVERY ROOM RECLASS	1			.1		
D DE	LIVERY ROOM & LABOR ROOM	52.00	581, 407	58, 655	5 (D	1
		0.00	0	0	+	<u>)</u>	2
0			581, 407	58, 655	5		
	- EMPLOYEE BENEFITS RECLASS	E 01	0	100 545	-	b	
	S/ACCOUNTING/MARKETING JSINESS OFFICE & ADMITTING	5. 01 5. 02	0	190, 545 286, 020			
	THER A&G	5.02	0	97, 589			
	PERATION OF PLANT	7.00	o	138, 797			
	AUNDRY & LINEN SERVICE	8.00	0	24, 344			Į
	DUSEKEEPI NG	9.00	0	150, 152		b	
	ETARY	10.00	0	154, 528	3 (
	JRSING ADMINISTRATION	13.00	0	128, 640		D	1
	ENTRAL SERVICES & SUPPLY	14.00	0	47, 476		C	
	IARMACY	15.00	0	114, 279		2 2	10
	EDI CAL RECORDS & LI BRARY	16.00	0	106, 527			1
	DULTS & PEDIATRICS NTENSIVE CARE UNIT	30.00 31.00	0	438, 721 115, 205			12
	PERATING ROOM	50.00	0	195, 166			1.
	ELIVERY ROOM & LABOR ROOM	52.00	0	187, 633			1
	ADI OLOGY-DI AGNOSTI C	54.00	o	176, 630			1
	TRASOUND	54.01	0	36, 658			1
DO LA	ABORATORY	60.00	0	288, 296		b	1
00 RE	SPI RATORY THERAPY	65.00	0	140, 492	2 (D	1
	IYSI CAL THERAPY	66.00	0	202, 224		C	2
	CCUPATIONAL THERAPY	67.00	0	32, 249		D	2
	PEECH PATHOLOGY	68.00	0	19, 480			2
	ARDI OPULMONARY / CLI NI C	70. 01 90. 01	0	15, 597			2
	MERGENCY	90.01 91.00	0	17, 700 254, 050			2
	EHAVI OR HEALTH	93.00	0	38, 468			2
	OME HEALTH AGENCY	101.00	0	97, 702			2
	ONREIMBURSABLE - OTHER	194.03	0	11, 370		b	2
DO MA	ARKETING	194.02	0	20, 987	7(D	20
0			0	3, 727, 525	5		
	- OXYGEN RECLASS					1	
D RE	SPIRATORY_THERAPY		0	33,513		2	
0			0	33, 513	3		
	- MEDI CAL SUPPLI ES RECLASS	15.00	0	653			
	DULTS & PEDIATRICS	30.00	0	2, 001			
	ITENSIVE CARE UNIT	31.00	0	2,001			
	PERATING ROOM	50.00	0	148, 590			
D DE	LIVERY ROOM & LABOR ROOM	52.00	0	9, 394		b	
	IESTHESI OLOGY	53.00	0	11, 429		C	
	ADI OLOGY-DI AGNOSTI C	54.00	0	23, 394		D	
	TRASOUND	54.01	0	2, 925		C	
	ADI OI SOTOPE	56.00	0	34, 756		D	
	ABORATORY	60.00	0	1, 287			1
	ITRAVENOUS THERAPY ESPI RATORY THERAPY	64.00 65.00	0	6, 881			1
	IYSI CAL THERAPY	66.00	0	11, 244 10, 165			1
	CCUPATI ONAL THERAPY	67.00	0	243			1
	ARDI OPULMONARY	70.01	o	16			1
		90.00	Ō	31		b	1
	/ CLINIC	90.01	0	3, 642		p	1
DO EM	IERGENCY	91.00	0	5, 691	1 ()	1
00 <u>BE</u>	HAVIOR HEALTH	93.00	o	15	50	기	1
0			0	272, 359	9		
	- BEHAVI OR HEALTH OVERHEAD	22.25		4			
	HAVI OR HEALTH	93.00	0	115, 522		9	
		0.00	0	(-	7	
1 1		0.00	<u>v</u>	115, 522		4	
	DTALS	1	0				

Heal th Financia	S) ا	stems		
RECONCI LI ATI ON	OF (CAPI TAL	COSTS	CENTERS

		SULLIVAN COUNTY CO	MMUNITY HOSPIT.	AL		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO		Fro To	riod: om 01/01/2018 12/31/2018		pared:
				Acquisition	IS			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL AS			_				
1.00	Land	1, 032, 727	0		0	0	0	1.00
2.00	Land Improvements	812, 251	2, 279, 407		0	2, 279, 407	0	2.00
3.00	Buildings and Fixtures	22, 092, 048	0		0	0	7, 125, 543	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	1, 393, 180	5, 086, 572		0	5, 086, 572	0	5.00
6.00	Movable Equipment	18, 172, 060	1, 466, 776		0	1, 466, 776	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43, 502, 266	8, 832, 755		0	8, 832, 755	7, 125, 543	8.00
9.00	Reconciling Items	0	0		0	0	0	9,00
10.00	Total (line 8 minus line 9)	43, 502, 266	8, 832, 755		0	8, 832, 755	7, 125, 543	10.00
		Endi ng Bal ance			-	-,,	.,,	
			Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL AS	SSET BALANCES						
1.00	Land	1, 032, 727	0					1.00
2.00	Land Improvements	3, 091, 658	0					2.00
3.00	Buildings and Fixtures	14, 966, 505	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	6, 479, 752	0					5.00
6.00	Movable Equipment	19, 638, 836	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	45, 209, 478	0					8.00
9.00	Reconciling Items	0	0					9.00
	Total (line 8 minus line 9)	45, 209, 478	0					10.00

Health Financial Systems SL	ILLIVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lieu of Form CMS		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2018	Worksheet A-7 Part II	
			-	To 12/31/2018	Date/Time Pre 5/30/2019 2:3	
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Depreci ati on	Lease	Interest	Insurance (see instructions)	•	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WC	RKSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	574, 441	0	158, 27	3 0	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	957, 677	82, 967	(0 0	0	2.00
3.00 Total (sum of lines 1-2)	1, 532, 118	82, 967	158, 27	3 0	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
	Capi tal -Rel ate	of cols. 9				
	d Costs (see	through 14)				
	instructions)	-				
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	732, 714				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	1, 040, 644				2.00
3.00 Total (sum of lines 1-2)	0	1, 773, 358				3.00

ECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part III Date/Time Prep 5/30/2019 2:35	pared:	
	COM	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL					
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL CO							
.00 NEW CAP REL COSTS-BLDG & FIXT .00 NEW CAP REL COSTS-MVBLE EQUIP .00 Total (sum of lines 1-2)	25, 610, 177 19, 638, 836 45, 249, 013	0	25, 610, 17 19, 638, 83 45, 249, 01	6 0. 434017	0 0	1.0 2.0 3.0	
		TION OF OTHER O		SUMMARY O	F CAPITAL		
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL CO	OSTS CENTERS						
.00 NEW CAP REL COSTS-BLDG & FIXT .00 NEW CAP REL COSTS-MVBLE EQUIP .00 Total (sum of lines 1-2)	0	0		0 704, 735 0 966, 990 0 1, 671, 725	0 82, 967 82, 967	1.0 2.0 3.0	
	0	0	IMMARY OF CAPI		02, 707	3.0	
Cost Center Description		Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL CO							
.00 NEW CAP REL COSTS-BLDG & FIXT .00 NEW CAP REL COSTS-MVBLE EQUIP .00 Total (sum of lines 1-2)	18, 507 -3, 349 15, 158	0	(723, 242 1, 046, 608 1, 769, 850	1.0 2.0 3.0	

SULLIVAN COUNTY COMMUNITY HOSPITAL

	Financial Systems	SULLI	VAN COUNTY CO	MMUNI TY HOSPI TAL		eu of Form CMS-2	
DJUST	MENTS TO EXPENSES				Period: From 01/01/2018 To 12/31/2018		pared
				Expense Classification or To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-158, 273	NEW CAP REL COSTS-BLDG & FLXT	1.00	11	1. (
. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.
00	Investment income - other (chapter 2)		0		0.00	0	3.
00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.
00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.
00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.
00	Telephone services (pay stations excluded) (chapter 21)	А	-2, 516	OTHER A&G	5.03	0	7.
00	Television and radio service (chapter 21)	А	-1, 714	OPERATION OF PLANT	7.00	0	8.
00 . 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -634, 400		0.00	0	9. 10
. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11
00	Related organization transactions (chapter 10)	A-8-1	1, 483, 991			0	12
. 00 . 00	Laundry and linen service Cafeteria-employees and guests	В	0 -129 443	CAFETERI A	0.00 11.00		
. 00	Rental of quarters to employee and others		0		0.00		
. 00	Sale of medical and surgical supplies to other than patients	В	-235	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16
. 00	Sale of drugs to other than patients	В	-37, 588	PHARMACY	15.00	0	17
00	Sale of medical records and abstracts	В	-9, 226	MEDICAL RECORDS & LIBRARY	16.00	0	18
00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19
	Vending machines Income from imposition of	В	0	OTHER A&G	5.03 0.00		20 21
. 00	interest, finance or penalty charges (chapter 21) Interest expense on Medicare		0		0.00	0	22
	overpayments and borrowings to repay Medicare overpayments		-				
. 00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPI RATORY THERAPY	65.00		23
. 00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSI CAL THERAPY	66.00		24
. 00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25
00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26
00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE	2.00	0	27
00	Non-physician Anesthetist		0	NONPHYSI CI AN ANESTHETI STS	19.00		28
. 00 . 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00		29 30
. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30
. 00	instructions) Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31

	Financial Systems	SULL	IVAN COUNTY CO	MMUNITY HOSPITAL		u of Form CMS-2	
ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/30/2019 2:3	pared: 5 nm
				Expense Classification or	Worksheet A		
				To/From Which the Amount is			
					,		
					T		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
	1	1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for	A		NEW CAP REL COSTS-MVBLE	2.00	9	32.00
	Depreciation and Interest			EQUI P			
	PHYSICIAN RECRUITMENT	A		OTHER A&G	5.03		00.00
33.01	FLOWERS & PLANTS	A		OTHER A&G	5.03		00.0.
33.02	LOBBYING EXPENSES	A		OTHER A&G	5.03		33. 02
	MISC INCOME	В		OTHER A&G	5.03		00.00
33.04	EDUCATION REVENUE	В	-1, 125	NURSING ADMINISTRATION	13.00	0	
33.05	DOMESTIC HEALTHCARE CLAIMS	В		EMPLOYEE BENEFITS DEPARTMEN			33.05
33.06	HOSPITAL ASSESSMENT FEE	A	-1, 147, 659	BUSINESS OFFICE & ADMITTING	5.02	0	33.06
33.07	SURETY BONDS	В	-585	OTHER A&G	5.03	0	
33.08	MI SC I NCOME	В	-1, 600	RADI OLOGY-DI AGNOSTI C	54.00	0	33.08
33.09	BOND ISSUANCE COST	A		NEW CAP REL COSTS-BLDG &	1.00	11	33.09
				FLXT			
33.10	BEHAVIORAL HEALTH - START-UP	A	5, 581	BEHAVIOR HEALTH	93.00	0	33.10
	COSTS						
33. 11	BEHAVIORAL HEALTH - START-UP	A	589	BEHAVIOR HEALTH	93.00	0	33. 11
	COSTS						
50.00	TOTAL (sum of lines 1 thru 49)		-1, 907, 918				50.00
	(Transfer to Worksheet A,						
	Column 6 line 200)			1	1		1

(c) um 6, line 200.)
 (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.
 (2) Additional ediustrates are the med on the part of t

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	SULLI VAN COUNTY C	OMMUNITY HOSPITAL		In Lie	eu of Form CMS-	2552-10
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN:		Period:	Worksheet A-8	-1
OFFI CE	COSTS				From 01/01/2018 To 12/31/2018		nored.
					. 12/31/2018	5/30/2019 2:3	
	Line No.	Cost Center	Expense Ite	ems	Amount of	Amount	
					Allowable Cost	Included in	
						Wks. A, column	
						5	
	1.00	2.00	3.00		4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH	RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:						
1.00		NEW CAP REL COSTS-MVBLE EQUI			0	3, 349	1.00
2.00		EMPLOYEE BENEFITS DEPARTMENT			0	3, 823	2.00
3.00			FITNESS CENTER - F		0	10, 925	3.00
4.00		OTHER A&G	FITNESS CENTER - A		0	7,605	4.00
4.01			FITNESS CENTER - M		0	7, 109	4.01
4.02			FITNESS CENTER - M	ATERIALS M	0	1, 938	4.02
4.03		OTHER A&G	MSO CLINICS		0	103, 463	4.03
4.04		I S/ACCOUNTI NG/MARKETI NG	MSO CLINICS		0	87, 531	4.04
4.05		LAUNDRY & LINEN SERVICE	MSO CLINICS		0	5, 515	4.05
4.06			MSO CLINICS		0	480	4.06
4.07		CENTRAL SERVICES & SUPPLY	MSO CLINICS		0	10, 220	4.07
4.08		OTHER A&G	MSO CLINICS		242, 932	0	4.08
4.09		NEW CAP REL COSTS-BLDG & FIX			42, 952	0	4.09
4.10			MSO CLINICS		3, 759	0	4.10
4.11			MSO CLINICS		235, 148	0	4.11
4.12			MSO CLINICS		155, 578	0	4.12
4.13		CLINIC – LAKESIDE	MSO CLINICS		245, 542	0	4.13
4.14		CLINIC – LAKESIDE	MSO CLINICS		164, 145	0	4.14
4.15			MSO CLINICS		62, 208	0	4.15
4.16			MSO CLINICS		32, 558	0	4.16
4.17	90. 03	CLINIC – QUICKCARE	MSO CLINICS		108, 316	0	4.17
4.18	90. 03	CLINIC – QUICKCARE	MSO CLINICS		88, 059	0	4.18
4.19			MSO CLINICS		64, 359	0	4.19
4.20		JV CLINIC	JV PAIN MANAGEMENT	CLINIC	0	115, 635	4.20
4.21		JV CLINIC	JV PAIN MANAGEMENT	CLINIC	0	14, 512	4.21
4.22	90. 01	JV CLINIC	JV PAIN MANAGEMENT		338, 044	0	4.22
4.23	4.00	EMPLOYEE BENEFITS DEPARTMENT	JV PAIN MANAGEMENT	CLINIC	72, 496	0	4.23
5.00	0		0		1, 856, 096	372, 105	5.00

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

1103 1101	been posted to norresheet n,				or this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	i i
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
	B INTERPELATIONSHIP TO PELAT	TED OPCANIZATION(S) AND/OP HO		·		

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.

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

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

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

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

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

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

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

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

Hool	+h	Ei nonci ol	Systems
неаг	τn	FI nanci ai	Systems

. . с **г** ONC 0550 40

Heal th	Financial Syste	ems		SULLI VAN COUNT	Y COMMU	NITY HOSPI	TAL			In Li	eu of Form	CMS-2	2552-10
STATEME	ENT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ONS AND	HOME	Provi der	CCN: 1	15-1327	Peri		Worksheet	: A-8	-1
OFFI CE	COSTS								From			D	
									То	12/31/2018	3 Date/Time 5/30/2019) 2·3	pared: 5 nm
	Net	Wkst. A-7 Ref.									1 37 307 2017	2.5	<u>5 pii</u>
	Adjustments												
	(col. 4 minus												
	col. 5)*												
	6.00	7.00									-		
	A. COSTS INCUR	RED AND ADJUST	MENTS RE	QUIRED AS A RESULT	OF TRAM	ISACTI ONS	WITH	RELATED C	RGANI	ZATI ONS OR	CLAI MED		
	HOME OFFICE COS												
1.00	-3, 349	11											1.00
2.00	-3, 823	0											2.00
3.00	-10, 925	0											3.00
4.00	-7,605	0											4.00
4 01	-7 109	0											4 01

4.01	-7, 109	0		4.01
4.02	-1, 938	0		4.02
4.03	-103, 463	0		4.03
4.04	-87, 531	0		4.04
4.05	-5, 515	0		4.05
4.06	-480	0		4.06
4.07	-10, 220	0		4.07
4.08	242, 932	0		4.08
4.09	42, 952	9		4.09
4.10	3, 759	9		4.10
4.11	235, 148	0		4.11
4.12	155, 578	0		4.12
4.13	245, 542	0		4.13
4.14	164, 145	0		4.14
4.15	62, 208	0		4.15
4.16	32, 558	0		4.16
4.17	108, 316	0		4.17
4.18	88, 059	0		4. 18
4.19	64, 359	0		4.19
4.20	-115, 635	0		4.20
4.21	-14, 512	0		4. 21
4.22	338, 044	0		4. 22
4.23	72, 496	0		4.23
5.00	1, 483, 991			5.00
* The	amounts on line	s = 1 - 4 (and subs	cripts as appropriate) are transferred in detail to Worksheet A column 6 lines as	

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	t been posted to norkaneet A,	condining i and/or 2, the amount arrowable should be marcated in condining of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	Type of Busiliess		
	(00		
	6.00		
	B INTERRELATIONSHIP TO RELAT	TED 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 coimburgement under title VV/III

i er ilibui	Sement under title XVIII.		
6.00	FI TNESS CENTER	6.	5.00
7.00	FITNESS CENTER	7.	7.00
8.00	FITNESS CENTER	8.	3.00
9.00	FITNESS CENTER	9.	9.00
10.00	FITNESS CENTER	10.	0. 00
10.01	FITNESS CENTER	10.	0. 01
10. 02	FITNESS CENTER	10.). 02
10.03	JV PAIN CLINIC	10.	0. 03
100.00		100.	0. 00

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

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

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

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

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

Health Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT

SULLIVAN COUNTY COMMUNITY HOSPITAL

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

Heal th	Financial Syste	ems SU	LLIVAN COUNTY C	OMMUNITY HOSPI	TAL	In Li	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (Peri od:	Worksheet A-8	3-2
						From 01/01/2018		
						To 12/31/2018		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	5/30/2019 2:3 Physi ci an/Prov	
	WKSL. A LINE #	I denti fi er	Remuneration	Component	Component	RUE AIIOUITE	ider Component	
		ruentirrei	Reliuner at rom	Component	component		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		NONPHYSICIAN ANESTHETISTS	<u> </u>					1 00
1.00							-	1.00
2.00		DELIVERY ROOM & LABOR ROOM	38, 250			-		2.00
3.00		LABORATORY	26, 000				0	3.00
4.00	0.00		0	0	(0	4.00
5.00	0.00		0	0	(0 0	0	5.00
6.00	0.00		0	0	(0 0	0	6.00
7.00	0.00		0	0	(0 0	0	7.00
8.00	0.00		0	0	(0 0	0	8.00
9.00	0.00		0	0	(0 0	0	9.00
10.00	0.00		0	0	0	ol o	0	10.00
200.00			660, 400	634, 400	26,000		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er		Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	19.00	NONPHYSICIAN ANESTHETISTS	0	0	(0 0		1.00
2.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	ol o	0	2.00
3.00		LABORATORY	0	0			0	3,00
4.00	0, 00		0	0	(0	0	4.00
5.00	0.00		0	0	(0	5.00
6.00	0.00		0	0			0	6.00
7.00	0.00		0	0	(0	7.00
8.00	0.00		0	0			0	8.00
9.00	0.00			0			0	
10.00	0.00		0			۰ ۱	0	10.00
200.00	0.00		0	0		°	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSL. A LINE #	I denti fi er			Di sal l owance	Aujustillent		
		Identifier	Component	Limit	Disarrowance			
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	18.00	-	
1.00		NONPHYSICIAN ANESTHETISTS	15.00		17.00			1.00
2.00		DELIVERY ROOM & LABOR ROOM		-				2.00
2.00		LABORATORY					1	2.00
3.00 4.00	0.00		0			°		3.00 4.00
			0	-		°		
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					9.00
10.00	0.00		0	0				10.00
200.00			0	0	(634,400		200.00

SULLI VAN COUNTY COMMUNI TY HOSPI TAL Provi der CCN: 15-1327

In Lieu of Form CMS-2552-10 Period: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

				T,	o 12/31/2018		
			CAPI TAL REL	ATED COSTS		5/30/2019 2:3	5 pm
	Cost Center Description	Net Expenses	NEW BLDG & FLXT	NEW MVBLE EQUI P	EMPLOYEE	Subtotal	
		for Cost Allocation	FIAI	EQUIP	BENEFI TS DEPARTMENT		
		(from Wkst A			DEFRICTMENT		
		col. 7)					
		0	1.00	2.00	4.00	4A	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	723, 242	723, 242				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	1, 046, 608	720,212	1, 046, 608			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 151, 056	2, 658				4.00
5.01	00590 I S/ACCOUNTI NG/MARKETI NG	1, 078, 826	13, 757	21, 687		1, 282, 883	5.01
5.02	00591 BUSINESS OFFICE & ADMITTING 00592 OTHER A&G	905, 085	36, 594			1, 167, 187	5.02
5.03 7.00	00700 OPERATION OF PLANT	1, 946, 294 1, 136, 433	31, 964 60, 398	50, 390 95, 216		2, 069, 140 1, 401, 768	5.03 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	55, 931	4, 038			78, 010	•
9.00	00900 HOUSEKEEPI NG	343, 812	2, 085			429, 519	•
10.00	01000 DI ETARY	566, 837	16, 505			700, 363	
11.00		-129, 443	12,037	18, 975		-98, 431	
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	449, 986 99, 359	14, 020 11, 804	22, 102 18, 608		602, 885 159, 686	
15.00	01500 PHARMACY	1, 228, 343	8, 584			1, 351, 794	
16.00	01600 MEDICAL RECORDS & LIBRARY	304, 609	7, 915			402, 931	
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 070 01/	01 150	140 710	F11 7/0	0 705 051	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 979, 216 414, 853	91, 159 17, 855			2, 725, 851 564, 386	30.00 31.00
43.00	04300 NURSERY	83, 523	1, 183			103, 114	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	871, 109	75, 129			1, 250, 642	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	30, 140	3, 130			44, 958	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	-1, 405 884, 268	2, 479 45, 207			4, 982 1, 152, 431	
54.01	05401 ULTRASOUND	141, 566	1, 410			180, 265	
56.00	05600 RADI OI SOTOPE	105, 338	2, 037	3, 211		110, 586	
60.00	06000 LABORATORY	1, 875, 095	16, 505			2, 120, 689	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	7,669	759			9,624	1
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	96, 432 513, 623	2, 455 9, 528			102, 757 661, 333	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	749, 550	26, 952			1, 013, 004	•
67.00	06700 OCCUPATI ONAL THERAPY	133, 119	1, 010			171, 492	•
68.00	06800 SPEECH PATHOLOGY	71, 738	872			93, 142	•
70. 00 70. 01	07000 ELECTROENCEPHALOGRAPHY 07001 CARDI OPULMONARY	3, 312	992 6, 929			5,867	
70.01	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	55, 801 556, 499	0, 929	10, 924 0		88, 319 556, 499	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	40, 414	0	0	-	40, 414	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS	44.070		0.770		44.050	
90. 00 90. 01	09000 CLINIC 09001 JV CLINIC	41,070	1, 762			46, 059 546-367	
	09002 CLINIC - LAKESIDE	374, 944 409, 687	19, 492 26, 881	30, 728 42, 377		546, 367 545, 224	
90.03	09003 CLINIC - QUICKCARE	196, 375	19, 778			276, 571	
91.00	09100 EMERGENCY	1, 560, 200	38, 457	60, 627	204, 155	1, 863, 439	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	007 54/	10.054		00.050	0	
93.00	04950 BEHAVI OR HEALTH OTHER REIMBURSABLE COST CENTERS	297, 516	18, 954	29, 880	23, 859	370, 209	93.00
101.00	10100 HOME HEALTH AGENCY	358, 741	5, 669	8, 937	83, 573	456, 920	101.00
	SPECIAL PURPOSE COST CENTERS		-,			,	
118.00		24, 757, 371	658, 943	1, 038, 802	3, 125, 518	24, 652, 879	118.00
100.00	NONREI MBURSABLE COST CENTERS		0.707	5 070		0.757	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 196, 891	3, 787	5, 970 0		9, 757 196, 891	190.00
	19201 MSO CLINICS	190, 891	0	0			192.00
	19203 FPA	0	0	0	0		192.03
	07950 MEALS ON WHEELS	0	0	0	-		194.00
	07951 GUEST MEALS	0	0	0	-		194.01
	07952 MARKETING 07953 NONREIMBURSABLE – OTHER	196, 268 41, 125	1, 165 59, 347	1, 836	21, 344 11, 043	220, 613 111, 515	
200.00		41,125	57, 547	0	11, 043		200.00
201.00			0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	25, 191, 655	723, 242	1, 046, 608	3, 157, 905	25, 191, 655	202.00

Heal th	Fi nanci al	Systems	
COCT A			CEE

Heal th	Financial Systems SUL	LIVAN COUNTY COM	MUNITY HOSPITA	AL	In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1327 P F T	eriod: rom 01/01/2018 o 12/31/2018	Worksheet B Part I Date/Time Pre 5/30/2019 2:3	epared:
	Cost Center Description	I S/ACCOUNTI NG/ MARKETI NG	Subtotal	BUSINESS OFFICE & ADMITTING	Subtotal	OTHER A&G	
		5.01	5A. 01	5. 02	5A. 02	5.03	-
	GENERAL SERVICE COST CENTERS	0.01	0/11/01	0102	0/11/02	0100	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590 I S/ACCOUNTI NG/MARKETI NG	1, 282, 883					5. 01
5.02	00591 BUSINESS OFFICE & ADMITTING	63, 209	1, 230, 396	1, 230, 396			5.02
5.02	00592 OTHER A&G	112,054	2, 181, 194	115, 381	2, 296, 575	2, 296, 575	
7.00	00700 OPERATION OF PLANT	75, 913	1, 477, 681	78, 166			
8.00	00800 LAUNDRY & LINEN SERVICE	4, 225	82, 235	4, 350			
9.00	00900 HOUSEKEEPING	23, 261	452, 780	23, 951		47, 615	
10.00	01000 DI ETARY	37, 928	738, 291	39, 054			
11.00	01100 CAFETERI A	37, 720	-98, 431	37,034		040	
13.00	01300 NURSI NG ADMI NI STRATI ON						
		32, 649	635, 534	33, 618		66, 834	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	8, 648	168, 334	8, 905		17, 702 149, 856	
		73, 206	1, 425, 000	75, 380			
16.00	01600 MEDI CAL RECORDS & LI BRARY	21, 821	424, 752	22, 469		44, 668	
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	147 (10	2 072 470	151 005	2 025 4/5	202 101	1 20 00
30.00	03000 ADULTS & PEDIATRICS	147,619	2,873,470				
31.00	03100 INTENSIVE CARE UNIT	30, 564	594, 950	31, 472			
43.00		5, 584	108, 698	5, 750	114, 448	11, 431	43.00
F0 00	ANCI LLARY SERVICE COST CENTERS	(7.700	4 040 074	(0.700	4 000 440	100 (10	50.00
50.00	05000 OPERATI NG ROOM	67, 729	1, 318, 371	69, 739			
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 435	47, 393	2, 507			
53.00	05300 ANESTHESI OLOGY	270	5, 252	278			
54.00	05400 RADI OLOGY-DI AGNOSTI C	62, 410	1, 214, 841	64, 263			
54.01	05401 ULTRASOUND	9, 762	190, 027	10, 052			
56.00	05600 RADI OI SOTOPE	5, 989	116, 575	6, 167		12, 259	
60.00	06000 LABORATORY	114, 846	2, 235, 535	118, 255			
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	521	10, 145	537	10, 682	1, 067	
64.00	06400 I NTRAVENOUS THERAPY	5, 565	108, 322	5, 730		11, 391	
65.00	06500 RESPI RATORY THERAPY	35, 814	697, 147	36, 878	734, 025	73, 314	
66.00	06600 PHYSI CAL THERAPY	54, 859	1, 067, 863	56, 488	1, 124, 351	112, 299	66.00
67.00	06700 OCCUPATI ONAL THERAPY	9, 287	180, 779	9, 563	190, 342	19, 011	67.00
68.00	06800 SPEECH PATHOLOGY	5,044	98, 186	5, 194	103, 380	10, 325	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	318	6, 185	327	6, 512	650	70.00
70.01	07001 CARDI OPULMONARY	4, 783	93, 102	4, 925	98, 027	9, 791	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	30, 137	586, 636	31, 032	617, 668	61, 692	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2, 189	42, 603	2, 254	44, 857	4, 480	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	2, 494	48, 553	2, 568	51, 121	5, 106	90.00
90. 01		29, 589	575, 956	30, 467			90.01
90. 02	09002 CLINIC - LAKESIDE	29, 527	574, 751	30, 403	605, 154	60, 442	90.02
	09003 CLINIC - QUICKCARE	14, 978	291, 549	15, 422			90.03
91.00	09100 EMERGENCY	100, 915	1, 964, 354	103, 910	2, 068, 264	206, 576	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
93.00	04950 BEHAVI OR HEALTH	20, 049	390, 258	20, 644	410, 902	41, 040	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	24, 745	481, 665	0	481, 665	48, 108	101.00
	SPECIAL PURPOSE COST CENTERS	· · · · ·					
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 270, 936	24, 640, 932	1, 218, 094	24, 628, 630	2, 240, 340	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 757	0	9, 757	975	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	196, 891	0			192.00
	19201 MSO CLINICS	0	0	0			192.01
	19203 FPA	0	0	0	0		192.03
	07950 MEALS ON WHEELS	0	0	0	=		194.00
	07951 GUEST MEALS	0	0	0	-		194.01
	07952 MARKETI NG	11, 947	232, 560				194.02
	07953 NONREI MBURSABLE - OTHER	0	111, 515	12, 302			194.02
200.00			0	0	0		200.00
200.00		0	0	0	-	n	200.00
201.00		1, 282, 883	25, 191, 655		-		202 00
_02.00		., 202, 000	20, 171, 000	., 200, 070	20, 171, 000	2,270,070	

Heal th	Financial Systems SULI	LIVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1327 Pe Fr To	riod: om 01/01/2018 12/31/2018	Worksheet B Part I Date/Time Pre	
						5/30/2019 2:3	35 pm
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00590 I S/ACCOUNTI NG/MARKETI NG						4.00 5.01
5.01	00591 BUSINESS OFFICE & ADMITTING						5.01
5.03	00592 OTHER A&G						5.03
7.00	00700 OPERATION OF PLANT	1, 711, 243					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	13, 474	108, 707				8.00
9.00	00900 HOUSEKEEPI NG	6, 956	0				9.00
10.00	01000 DI ETARY	55,072	496		926, 330	447 202	10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	40, 163 46, 780	443 0		513, 601 0	467, 282 22, 041	
14.00	01400 CENTRAL SERVICES & SUPPLY	39, 385	0		0	9, 846	1
15.00	01500 PHARMACY	28, 642	0		0	20, 383	
16.00	01600 MEDI CAL RECORDS & LI BRARY	26, 410	0		0	20, 866	
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	204 177	24.745	07 100	204 420	100 (15	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	304, 177 59, 576	24, 745 591		204, 428 13, 364	108, 615 20, 383	1
43.00	04300 NURSERY	3,946	1, 709		13, 304	3, 247	
	ANCI LLARY SERVICE COST CENTERS		.,			-1	
50.00	05000 OPERATI NG ROOM	250, 682	12, 425		15, 377	35, 583	
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 444	3, 196		0	1, 347	
53.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	8, 272	0		0	0	
54.00 54.01	05400 RADI OLOGY - DI AGNOSTI C 05401 ULTRASOUND	150, 844 4, 704	5, 348 0		0 0	32, 267 6, 322	1
56.00	05600 RADI OI SOTOPE	6, 797	0		0	0, 322	1
60.00	06000 LABORATORY	55, 072	348		0	57, 417	
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	2, 531	0	725	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	8, 192	0		0	0	1
65.00		31, 791	654		0	25, 496	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	89, 932 3, 368	38, 985 0		0	34, 962 5, 113	
68.00	06800 SPEECH PATHOLOGY	2,910	0		0	3, 317	
70.00	07000 ELECTROENCEPHALOGRAPHY	3, 309	0		0	0	1
70. 01	07001 CARDI OPULMONARY	23, 121	0	6, 624	0	2, 798	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	-	0	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	-	0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73.00
90.00	09000 CLINIC	5,880	0	1, 684	0	276	90.00
90.01	09001 JV CLINIC	65, 037	1, 403	18, 632	0	0	90.01
90.02	09002 CLINIC - LAKESIDE	89, 693	0		0	0	
	09003 CLINIC - QUICKCARE	65, 994	0	.0, ,00	0	0	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	128, 321	18, 364	36, 761	0	44, 669	91.00 92.00
93.00	04950 BEHAVI OR HEALTH	63, 244	0	18, 118	o	7, 013	93.00
	OTHER REIMBURSABLE COST CENTERS			, ····,	- 1	• • •	
101.00	0 10100 HOME HEALTH AGENCY	0	0	5, 419	0	0	101.00
	SPECIAL PURPOSE COST CENTERS		400 707	105 0/0	7.4. 770		
118.00	NONREI MBURSABLE COST CENTERS	1, 694, 719			746, 770	461, 961	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12, 637	0		0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0		192.00 192.01
	19203 FPA	0	0	-	0		192.03
	07950 MEALS ON WHEELS	0	0	0	179, 560		194.00
194.01	07951 GUEST MEALS	0	0	0	0		194.01
	207952 MARKETING	3, 887	0		0		194.02
	3 07953 NONREI MBURSABLE - OTHER	0	0	41, 506	0	1, 866	194.03
200.00 201.00			^		_	<u>^</u>	200. 00 201. 00
201.00		1, 711, 243	108, 707	531, 302	926, 330	467, 282	
	· · · · · · · · · · · · · · · · · · ·			, 55., 552	. 20, 000	, 202	1

IST AL	LOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1327	Period: From 01/01/2018	Worksheet B Part I	
					To 12/31/2018	Date/Time Pre 5/30/2019 2:3	eparec 15 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	NONPHYSI CI AN ANESTHETI STS	
		13.00	14.00	15.00	16.00	19.00	
	GENERAL SERVICE COST CENTERS						1 1
	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1. 2.
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
	00590 I S/ACCOUNTI NG/MARKETI NG						5.
	DOS90 TSTACCOUNTING MARKETING DO591 BUSINESS OFFICE & ADMITTING						5. 5.
	DOS97 DOSTNESS OFFICE & ADMITTING						5.
	DO700 OPERATION OF PLANT						7.
	DOBOO LAUNDRY & LINEN SERVICE						8.
	DO900 HOUSEKEEPING						9.
	DI ETARY						10.
	D1100 CAFETERI A						11.
. 00	01300 NURSING ADMINISTRATION	818, 208					13.
	01400 CENTRAL SERVICES & SUPPLY	0	255, 455				14.
	D1500 PHARMACY	0	3, 754	1, 711, 22	20		15.
	D1600 MEDICAL RECORDS & LIBRARY	0	0		0 546, 731		16.
	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	0	19.
	NPATIENT ROUTINE SERVICE COST CENTERS	220 722	4, 605		0 44 200	0	1 20
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	339, 722 63, 753	4, 605 910		0 44, 299 0 3, 162	0 0	
	04300 NURSERY	10, 199	318		0 1, 666	0	
	ANCI LLARY SERVI CE COST CENTERS	10, 177	510		1,000	0	43.
	D5000 OPERATI NG ROOM	88, 400	15, 038		0 37, 432	0	50.
	D5200 DELIVERY ROOM & LABOR ROOM	4, 167	595		0 379	0	
	05300 ANESTHESI OLOGY	0	0		6,054	0	
00	05400 RADI OLOGY-DI AGNOSTI C	0	4, 841		0 96, 925	0	54.
01	05401 ULTRASOUND	0	0		0 20, 082	0	54.
	D5600 RADI OI SOTOPE	0	0		0 3, 743	0	
	D6000 LABORATORY	0	29, 970		0 106, 080	0	
	D6300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 3, 705	0	
	06400 I NTRAVENOUS THERAPY	17, 379	0		0 9,605	0	
	06500 RESPI RATORY THERAPY	0	11, 201		0 17, 198	0	
	06600 PHYSI CAL THERAPY	0	0		0 18, 540	0	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	56 66		0 3, 228 0 799	0	
	07000 ELECTROENCEPHALOGRAPHY	0	00		0 267	0	
	07001 CARDI OPULMONARY	8, 733	0		0 2,850	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0,700	164, 609		0 43, 236	0	
	07200 I MPL. DEV. CHARGED TO PATIENT	0	11, 949		0 2,664	0	
. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1, 711, 22		0	
(DUTPATIENT SERVICE COST CENTERS						
1	09000 CLI NI C	0	0		0 818	0	
		81, 474	0		0 10, 215	0	
	09002 CLINIC - LAKESIDE	0	555		0 6, 162	0	
	09003 CLINIC – QUICKCARE 09100 EMERGENCY	139, 735	3, 885 2, 409		0 4, 020 0 70, 542	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	139, 735	2,409		70, 342	0	91.
	04950 BEHAVIOR HEALTH	0	0		0 5, 463	0	
	OTHER REIMBURSABLE COST CENTERS	<u> </u>	-1		-, -,,		
1.00	10100 HOME HEALTH AGENCY	64, 646	426		0 2,853	0	101.
-	SPECIAL PURPOSE COST CENTERS						
. 00	SUBTOTALS (SUM OF LINES 1 through 117)	818, 208	255, 187	1, 711, 22	20 546, 731	0	118.
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	^	190.
	19200 PHYSICIANS' PRIVATE OFFICES	0	268		0 0		190. 192.
	19200 PHISICIANS PRIVATE OFFICES	0	200				192.
	19203 FPA	0	0		0 0		192.
	D7950 MEALS ON WHEELS	0	0		0 0		194.
	07951 GUEST MEALS	Ő	o		0 0		194.
	07952 MARKETI NG	0	0		0 0		194.
	07953 NONREI MBURSABLE - OTHER	0	О		0 0	0	194.
0. 00	Cross Foot Adjustments					0	200.
1 00	Negative Cost Centers	0	0	1, 711, 22	0 0 20 546, 731		201. 202.
1.00 2.00	TOTAL (sum lines 118 through 201)	818, 208	255, 455				

OST ALLOCATION	Systems SULL - GENERAL SERVICE COSTS		Provider C		Peri od:	eu of Form CMS-255 Worksheet B
					From 01/01/2018 To 12/31/2018	
						5/30/2019 2:35 p
Cos	t Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	ERVICE COST CENTERS		1	1	Ĩ	
	CAP REL COSTS-BLDG & FIXT					
	CAP REL COSTS-MVBLE EQUIP LOYEE BENEFITS DEPARTMENT					
	ACCOUNTI NG/MARKETI NG					
	INESS OFFICE & ADMITTING					
03 00592 OTH						
00 00700 OPE	RATION OF PLANT					· · ·
00 00800 LAU	NDRY & LINEN SERVICE					
00 00900 HOU						
. 00 01000 DI E						10
. 00 01100 CAF						1
						1:
	TRAL SERVICES & SUPPLY					1.
. 00 01500 PHA . 00 01600 MED	I CAL RECORDS & LI BRARY					1
	PHYSICIAN ANESTHETISTS					1
	ROUTI NE SERVI CE COST CENTERS					
	LTS & PEDIATRICS	4, 445, 385	0	4, 445, 3	385	30
. 00 03100 I NT	ENSIVE CARE UNIT	867, 794				3
. 00 04300 NUR		148, 095	0	148, (095	4
	SERVICE COST CENTERS	0.050.50		0.050		
	RATING ROOM	2,053,504				50
	IVERY ROOM & LABOR ROOM	78,004				5.
	STHESI OLOGY I OLOGY-DI AGNOSTI C	22, 778 1, 740, 298				5
01 05400 KAD		252, 519				5
00 05600 RAD		147, 488				5
00 06000 LAB		2, 853, 548		2, 853, 5		61
	OD STORING, PROCESSING & TRANS.	18, 710		18,		6
. 00 06400 I NT	RAVENOUS THERAPY	162, 966		162, 9	966	6
	PI RATORY THERAPY	902, 786				6
	SI CAL THERAPY	1, 444, 832				6
	UPATIONAL THERAPY ECH PATHOLOGY	222,083		222, (6
	CTROENCEPHALOGRAPHY	121, 631 11, 686		121, 0		61
	DI OPULMONARY	151, 944		151, 9		70
	I CAL SUPPLIES CHARGED TO PATIENTS	887, 205		887, 2		7
	L. DEV. CHARGED TO PATIENT	63, 950				7
	GS CHARGED TO PATIENTS	1, 735, 964				7
OUTPATI EN	T SERVICE COST CENTERS					
00 09000 CLI		64, 885				90
01 09001 JV		843, 753		843,		90
	NIC - LAKESIDE NIC - QUICKCARE	787, 701 430, 436		787, 1		90
00 09100 EME		2, 715, 641		2, 715, 6		9
	ERVATION BEDS (NON-DISTINCT PART)	2,713,04	0	2,710,0		9:
	AVIOR HEALTH	545, 780	0	545,	780	9
	MBURSABLE COST CENTERS			1		
	E HEALTH AGENCY	603, 117	0	603, 1	117	10
	URPOSE COST CENTERS		-			
	TOTALS (SUM OF LINES 1 through 117)	24, 324, 483	0	24, 324, 4	183	11;
	RSABLE COST CENTERS T, FLOWER, COFFEE SHOP & CANTEEN	26, 989	0	26, 9	289	19
	SICIANS' PRIVATE OFFICES	216, 824		216, 8		19:
2.01 19201 MSO		210,02-	0 0	2,0,0	0	19:
2. 03 19203 FPA		(o o		0	19:
4. 00 07950 MEA	LS ON WHEELS	179, 560	0	179, 5	560	19-
4. 01 07951 GUE		C	0		0	19
4. 02 07952 MAR		277, 774		277, 1		19-
	REIMBURSABLE - OTHER	166, 025		166, (19
	ss Foot Adjustments	0	-		0	200
	ative Cost Centers AL (sum lines 118 through 201)	(25, 191, 655	0			20 20
2.00 TOT	A ISUM LINES LIX THROUGH 2011	75 101 655		1 75 191 /		1201

SULLIVAN COUNTY COMMUNITY HOSPITAL

Heal th	Financial Systems SULL	IVAN COUNTY COM	MMUNITY HOSPITA	AL	In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	F	eriod: rom 01/01/2018 o 12/31/2018	Worksheet B Part II Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		5/30/2019 2:3	5 pm
				AILD COSTS			
	Cost Center Description	Directly Assigned New Capital	NEW BLDG & FLXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs				DELYNCIMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	,					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 658	4, 191		6, 849	4.00
5.01	00590 I S/ACCOUNTI NG/MARKETI NG	0	13, 757	21, 687	35, 444	365	5.01
5.02	00591 BUSINESS OFFICE & ADMITTING	0	36, 594	57, 689	94, 283	364	5.02
5.03	00592 OTHER A&G	0	31, 964	50, 390	82, 354	88	5.03
7.00	00700 OPERATION OF PLANT	0	60, 398	95, 216	155, 614	238	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	4, 038	6, 366	10, 404	25	8.00
9.00	00900 HOUSEKEEPI NG	0	2, 085	3, 287	5, 372	174	9.00
10.00	01000 DI ETARY	0	16, 505	26, 019	42, 524	197	10.00
11.00	01100 CAFETERI A	0	12, 037	18, 975	31, 012	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	14, 020	22, 102	36, 122	253	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	11, 804	18, 608	30, 412	65	14.00
15.00	01500 PHARMACY	0	8, 584	13, 532	22, 116	220	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	7, 915	12, 478		169	16.00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	91, 159	143, 713	234, 872	1, 113	30.00
31.00	03100 INTENSIVE CARE UNIT	0	17, 855	28, 147	46, 002	224	31.00
43.00	04300 NURSERY	0	1, 183	1, 865	3, 048	36	43.00
	ANCI LLARY SERVICE COST CENTERS				· · · ·		
50.00	05000 OPERATING ROOM	0	75, 129	118, 438	193, 567	403	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	3, 130	4, 935		15	52.00
53.00	05300 ANESTHESI OLOGY	0	2, 479	3, 908		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	45, 207	71, 268		329	
54.01	05401 ULTRASOUND	0	1, 410	2, 222		76	1
56.00	05600 RADI OI SOTOPE	0	2,037	3, 211		0	56.00
60.00	06000 LABORATORY	0	16, 505	26, 019		440	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	759	1, 196		0	1
64.00	06400 I NTRAVENOUS THERAPY	0	2, 455	3, 870		0	64.00
65.00	06500 RESPI RATORY THERAPY	0	9, 528	15, 020		267	65.00
66.00	06600 PHYSI CAL THERAPY	0	26, 952	42, 490		420	1
67.00	06700 OCCUPATI ONAL THERAPY	0	1,010	1, 591		78	67.00
68.00	06800 SPEECH PATHOLOGY	0	872				68.00
		0	872 992	1, 375		42	1
70.00		0		1, 563		0	70.00
70.01	07001 CARDI OPULMONARY	0	6, 929	10, 924		32	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0		0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
00.00	OUTPATIENT SERVICE COST CENTERS		4 7/0	0.770	4 5 4 0		00.00
	09000 CLINIC	0	1, 762	2, 778		1	90.00
90.01	09001 JV CLINIC	0	19, 492	30, 728		263	
90. 02	09002 CLINIC - LAKESIDE	0	26, 881	42, 377		144	
90.03	09003 CLINIC - QUICKCARE	0	19, 778			63	
91.00	09100 EMERGENCY	0	38, 457	60, 627	99, 084	442	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04950 BEHAVI OR HEALTH	0	18, 954	29, 880	48, 834	52	93.00
	OTHER REIMBURSABLE COST CENTERS	,					
101.00	10100 HOME HEALTH AGENCY	0	5, 669	8, 937	14, 606	181	101.00
	SPECIAL PURPOSE COST CENTERS	,					
118.00		0	658, 943	1, 038, 802	1, 697, 745	6, 779	118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 787	5, 970	9, 757	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
	19201 MSO CLINICS	0	0	0	0		192.01
192.03	19203 FPA	0	0	0	0	0	192. 03
	07950 MEALS ON WHEELS	0	0	0	0		194.00
	07951 GUEST MEALS	0	0	0	0		194.01
	07952 MARKETI NG	0	1, 165	1, 836	3, 001		194.02
	07953 NONREI MBURSABLE – OTHER	0	59, 347	., 230	59, 347		194.03
200.00			0,,017	Ű	0,017	21	200.00
201.00			0	n	0	Ω	201.00
201.00		0	723, 242	1, 046, 608	1, 769, 850		202.00
202.00		, oj	,20,272	., 010, 000	., , , , , , , , , , , , , , , , , , ,	0, 047	

Cost Center Description S/ACCOUNTING OFFER AGC OPHER AGC OPHER AGC OPHER AGC OPHER AGC DEFENSION LAURDY & LINEN SERVICE 100 00100 NBN CAP REL COSTS -BLOC & AFIAT 5.02 5.03 7.00 8.00 1.00 00100 NBN CAP REL COSTS -BLOC & AFIAT 5.02 5.03 7.00 8.00 1.00 00000 ENLOYEE BEREFITS DEPARTMENT 25.800 9.411 5.42 7.00 8.00 1.00 00000 ENLOYEE BEREFITS DEPARTMENT 25.800 9.411 5.42 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.01 7.01 7.01 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02 7.01 7.02<		Financial Systems SULI TION OF CAPITAL RELATED COSTS	LIVAN COUNTY CON	Provider CC	N: 15-1327 P	eriod: rom 01/01/2018		pared:
CHERNAL SERVICE COST CATERS 0.00 DOTOON INF CAP REL COSTS-RIDG & FLT 0.00 DOTOON INF CAP REL COSTS-RIDG & FLT 0.00 DOTOON INF CAP REL COSTS-WARE TEQUEP 5.01 DOSYOI IS/ACCOUNT WC/MARCT INF 5.00 DOSYOI IS/ACCOUNT WC/MARCT INF <t< th=""><th></th><th>Cost Center Description</th><th></th><th>OFFICE &</th><th>OTHER A&G</th><th></th><th>LAUNDRY &</th><th></th></t<>		Cost Center Description		OFFICE &	OTHER A&G		LAUNDRY &	
1.00 DOTOO NEW CAP REL COSTS-RUED & FLAT 4.00 DOROO EUPLOYCE BENEFITS UPFARTMENT 35,809 5.02 DOSSY IRESINESS OFFICE & ADMITTING 35,809 5.02 DOSSY IRESINESS OFFICE & ADMITTING 35,809 5.02 DOSSY IRESINESS OFFICE & ADMITTING 1,745 9,6,411 0.00000 DEMONDANCETING 1,745 9,6,412 0.00000 DEMONDANCETING 1,755 9,6,411 0.00000 DEMONDANCETING 1,055 3,600 0.00000 DEMONDANCETING 0 0 0 0.00000 DEMONDER TATION 1,059 3,060 3,199 5,487 13.00 DISCONDERFERIN 0 0 0 0 0 10.00 DISCONDERFERIN 0 0 0 0 0 0 10.00 DISCONDERFERIN 0 0 0 0 0 0 10.00 DISCONDERFERIN STATION 912 2,634 0 0 0 0 0 0			5.01	5.02	5.03	7.00	8.00	
2.00 002001 NEW CAP REL COSTS-MURLE COUTY 0 5.01 005901 IS-ACCOUNT NOUVARKET INO 35.809 0 5.01 005901 IS-ACCOUNT NOUVARKET INO 3.129 0.412 0.412 5.01 005901 IS-ACCOUNT NOUVARKET INO 3.129 0.412 0.412 5.02 00591 IS-ACCOUNT NOUVARKET INO 3.129 0.412 0.413 5.00 005001 CAUNDERY AL LINES NOT ICC 1.12 1.120 0.012 0.432 0.432 0.432 5.00 005000 HUISEKEEPING 6.49 1.877 1.902 0.432 0.446 1.02 10.00 CHARTING NA INSTRATION 912 2.634 7.754 4.461 0 11.00 DIADO CARTINAL SERVICES & LINBRAY 2.04 6.69 7.761 3.024 0								
4.00 DOUDD (DEPLOYCE BLEFT IS DEPARTMENT)								1.00
5.01 COUSTON IT MACAGARKET IN G 32, 800								2.00
5.02 00057] EUSINESS DEFICE & ADMINITING 1,765 99,412 7.00 00700 QPERATING OF PLANT 2,1179 6,125 6,602 170,498 7.00 00700 QPERATING OF PLANT 2,1179 6,125 6,602 170,498 9.00 000000 HUJSKEEPING 6,649 1,877 1,962 6,633 0,587 9.00 000000 HUJSKEEPING 6,649 1,677 1,962 6,633 0,0 11.00 01000 CHETER AMONIN STRATION 9,0 2,764 4,000 51 11.00 01500 PHARMACY 2,044 5,007 6,174 2,654 0 10.00 01500 PHARMACY 2,044 5,007 6,174 2,654 0			25,000					4.00
5.03 00522 OTHER AGG 3,127 9,041 94,041 94,042 8.00 00800 LAUNDRY & LINEN SERVICE 118 341 3356 1,342 12,586 9.00 00900 OTHER AGG 4649 1,077 1,962 643 0 10.00 01000 DETRAY 1,059 3,060 3,199 5,487 577 11.00 01000 CHETRAY 0 0 0 0 4,002 51 13.00 01300 NIRSI IG AUMINISTARTION 0 0 0 0 3,924 0 15.00 01500 PHRDALC CENTRAL SERVICES A SUPPLY 2,414 660 7,758 3,924 0 15.00 01500 PHRDALT SEDITION SETHETISTS 0 0 0 0 0 0 15.00 01500 PHRDALTS & FEDITATRI CS COST CENTERS - - - - - - 0 <t< td=""><td></td><td></td><td></td><td>04 412</td><td></td><td></td><td></td><td>5.01</td></t<>				04 412				5.01
7.00 DOTOD OPERATION OF PLANT 2,119 6,125 6.402 170,498 9.00 DOBODO HUJSEKEPING 1,342 1,346 1,342 1,2566 9.00 DOBODO HUJSEKEPING 1,049 1,847 1,962 693 0.0 10.00 DITODO LETARY 1,059 3,066 3,199 5,487 577 10.00 DITODO LETARY 2,434 5,649 7,273 4,661 0 10.00 DITODO MUSTREEPING 2,244 5,649 6,727 3,224 0 10.00 DITODO MUSTREEPING 2,641 5,649 6,727 3,224 0 10.00 DITODO MUSTREEPING 1,170 1,1909 1,2,444 30.038 2,850 10.00 DISOD MULTS & PEDIATINICS 4,112 11,909 12,444 30.038 2,860 10.00 DISODO MURTS SERVICE COST CENTERS - - - 7,71 30 188 20.00 DISODO MUSTSKEY EKWICE COST CENTERS - 1,441 370					04 612			5.02 5.03
8.00 00000 LAUNDEY & LINEN SERVICE 118 341 356 1,342 12.566 0.00 00000 LOUGEXEEPIN 1,059 3,060 3,199 5,487 57 110 00 1000 DEFTARY 1,962 4,001 1578 10 N 912 2,634 2,754 4,661 00 140 01400 CHARLS FERVICE & SUPPLY 241 696 729 3,924 00 15 00 10100 DETARY SERVICE 5 SUPPLY 2,241 696 7,79 4,661 00 15 00 10100 DEAS SECURINGS & LIBARY 2,2.644 5,907 6,174 2,854 00 15 00 10100 DEAS SECURINGS & LIBARY 2,2.64 5,907 6,174 2,854 00 10 00 1000 DEAS SECURINES & LIBARY 2,0.64 5,907 6,174 2,854 00 10 00 1000 DEAS SECURINES & LIBARY 2,0.64 5,907 6,174 2,854 00 10 00 3000 AUNTS & PENDASTHET ISTS 0 0 0 0 10 00 3000 AUNTS & PENDASTHET ISTS 0 0 0 10 00 3000 DEAS SECURINES & LIBARY 2,0.64 5,907 6,174 2,854 00 10 00 3000 DEAS SECURINES & LIBARY 2,0.64 5,907 6,174 2,958 6,86 31 00 03000 DEAS SECURINES & LIBARY 2,0.64 5,971 2,4.947 6,0.258 0,938 6,86 31 00 03000 DEAS SECURINES 0,0.0 0 0 00 0000 DESTAINS & PENDASTHET ISTS 0 1 0 0 0 00 05000 DESTAINS & PENDASTHET ISTS 0,0 1,0.0 0,0.0 0,0.0 0 00 0000 DESTAINS & PENDASTHET ISTS 0,0 1,0.0 0,0.0						170 498		7.00
9 00 00000 HUUSEKEEPING 649 1.877 1.962 693 0 10 00 01000 DETARY 0.0000 1000 544 0 11 00 01100 CAFETERIA 0 10 00 01000 DETARY 0.000 155 0 11 00 01100 CAFETERIA 0 10 00 000 HURSING ADMINISTRATION 912 2.634 2.754 4.661 0 11 00 01100 CAFETERIA 2.854 0 10 00 01000 CAFETERIA 2.854 0 10 00 01000 CAFETERIA 2.854 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								8.00
10.00 D1000 D12000 D12000 D12000 D12000 D12000 A427 S75 13.00 D1300 NURSING ADMINISTRATION 912 2, 634 2, 754 4, 661 0 14.00 D1300 NURSING ADMINISTRATION 912 2, 634 2, 754 4, 661 0 15.00 D1500 PHARMACY 2, 044 5, 907 6, 174 2, 854 0 10.00 D3000 ADMINTS KERVECOST CENTERS 0<								9.00
11.00 0.1100 CAFETERIA 0 0 0 0.0 4.002 51 13.00 01300 DERSING ADMINISTRATION 912 2.634 2.754 4.661 0 14.00 OLADRESING ADMINISTRATION 912 2.634 0.729 3.924 0 15.00 01500 MEDICAL RECORDS & LIBRARY 609 1.761 1.840 2.631 0							-	10.00
13.00 01300 NURSI NG ADMI NI STRATI ON 912 2,634 2,754 4,661 0 15.00 01500 PHARMACY 2,044 5,907 6,174 2,854 0 10.00 01500 PHARMACY 2,044 5,907 1,1840 2,631 0 10.00 01500 PHARTARCY 609 1,771 1,1840 2,631 0 11.00 013001 AULETS & LEBRARY 609 1,771 1,1840 2,631 0 10.00 03000 AULETS & PEDIATRICS 4,112 11,909 12,444 30,308 2,865 30.01 03000 AULETS & PEDIATRICS 4,112 11,909 12,444 30,308 2,865 30.01 05000 OPERATINA SERVICE COST CENTERS 5,264 15,29 14,437 302 30.01 05000 OPERATINA ROUM 6,86 1,801 5,264 15,29 469 16,90 30.01 05000 OPERATINA ROUM 1,801 1,827 7,86 6,264 16,90 6,60 6,60 6,600 6,600	1							11.00
14 00 [01400] CENTRAL SERVICES & SUPPLY 2.41 6498 729 3.924 0 15.00 1500 PHARMACY 2.044 5.907 6.174 2.854 0 16.00 10400 PEDICAL RECORDS & LIBRARY 609 1.761 1.840 2.631 0 <td< td=""><td></td><td></td><td>-</td><td>-</td><td>-</td><td></td><td></td><td>13.00</td></td<>			-	-	-			13.00
15.00 0 01500 PHARNACY 2,044 5,907 6,174 2,884 0 19.00 01900 00000PHYSICIAN ANESTHETISTS 0							-	14.00
16.00 01600 MEDICAL RECORDS & LIBRARY 609 1.761 1.840 2.631 0 INPATLENT ROUTINE SERVICE COST CENTERS 0							0	15.00
01 01 01 0 <td>16.00</td> <td>01600 MEDI CAL RECORDS & LI BRARY</td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>16.00</td>	16.00	01600 MEDI CAL RECORDS & LI BRARY					0	16.00
30.00 03000 ADULTS & PEDIATRICS 4, 112 11, 909 12, 444 30, 308 2, 865 43.00 04300 NURESSIVE CARE UNIT 853 2, 466 2, 578 5, 936 668 43.00 04300 NURSSIVE CAST CENTERS 156 451 471 393 198 ANCILLARY SERVICE COST CENTERS 1, 891 5, 465 5, 712 24, 976 1, 433 50.00 05300 ANESTHESI DLOGY 88 205 1, 041 370 52.00 05300 ANESTHESI DLOGY 1, 742 5, 036 5, 264 15, 029 619 54.01 05400 RADIOLASITAR 157 483 505 677 0 54.00 05600 RADIOLABRATORY 3, 206 9, 266 9, 666 5, 477 40 469 816 0 60.00 060000 NITRAVENOUS THERAPY 1, 232 449 449 422 0 66.00 6660 9460 73 336 0 0 0 0 0 0 0 0 0 0							0	19.00
31.00 03100 NTENSI VE CARE UNIT 853 2.466 2.578 5.936 666 ANCILLARY SERVICE COST CENTERS	Ī	INPATIENT ROUTINE SERVICE COST CENTERS						1
43.00 04300 NURSERY 156 451 471 393 198 ANCILLARY SERVICE COST CENTERS	30.00	03000 ADULTS & PEDIATRICS	4, 112	11, 909	12, 444	30, 308	2, 865	30.00
ANCILLARY SERVICE COST CENTERS	31.00	03100 INTENSIVE CARE UNIT	853	2, 466	2, 578	5, 936	68	31.00
50.00 05000 DELVICEY ROW & LABOR ROM 1.891 5.465 5.712 24,976 1.433 52.00 05200 DELVICEY ROW & LABOR ROM 66 196 205 1.041 370 52.00 05300 ANESTHESI OLOGY 8 22 23 824 0 64.00 DEADOR LABORSTIC 1.742 5.036 5.264 15.029 619 64.00 DEADOR LABORSTORY 3.206 9.266 9.686 5.487 400 0.6300 BLOOD LABORATORY 3.206 9.266 9.686 5.487 40 0.6300 BLOOD INTRAVENDIS THERAPY 1.532 4.42 4.44 252 0 0.6400 RADOR THERAPY 1.000 2.890 3.021 3.167 76 0.6500 RESPI RATORY THERAPY 1.532 4.426 4.627 8.960 4.515 0.70.00 CELORATIONAL THERAPY 1.434 386 403 2.304 00 070.00 DOVOD OLELOCK TAROLORAPHY	43.00	04300 NURSERY	156	451	471	393	198	43.00
52:00 05200 DEL/VERY ROM & LABOR ROM 66 196 205 1,041 370 53:00 05300 RADIOLOGY 8 22 23 824 00 54:00 05400 RADIOLOGY-DIAGNOSTIC 1,742 5,036 5,264 15,029 619 54:00 05600 RADIOLOGY-DIAGNOSTIC 1,742 5,036 5,264 15,029 619 56:00 05600 RADIOLSOTOPE 167 483 505 6777 0 00:000 LABORATORY 3,206 9,266 9,686 5,487 40 00:000 DEADO STRING, PROCESSING & TRANS. 15 42 44 252 0 06:400 INTRAVENUS THERAPY 1,532 4,426 4,627 8,960 4,515 00:600 OCCUPATIONAL THERAPY 1,532 4,426 4,627 8,960 4,515 00:00 OCOUC CLEATTONAL THERAPY 1,532 4,426 4,627 8,930 0 0 00:0		ANCILLARY SERVICE COST CENTERS					-	
53:00 05300 ANESTHESI OLOGY B 2.2 2.3 8.24 0 05:00 DKADIOLOCY-DIAGNOSTIC 1.742 5.036 5.26.4 15.029 619 56:00 DS600 RADIOLSOTOPE 1.67 483 505 677 0 00 DS600 LABORATORY 3.206 9.266 9.686 5.487 40 0.0 DS000 LABORATORY 1.53 4.49 44 252 0 0.6300 BLODU STORING, PROCESSI NG & TRANS. 1.5 4.49 4.69 816 0 0.600 DRODU HTRAVENDUS THERAPY 1.000 2.890 3.021 3.167 76 0.0 D6500 RESPI RATORY THERAPY 1.000 2.890 3.021 3.167 76 0.0 D6000 DCUPATIONAL THERAPY 1.532 4.426 4.627 8.960 4.515 0.0 DO0 DCOUD DCOUD DCOUD 7.330 0 0 0.00 0			1, 891	5, 465	5, 712	24, 976	1, 439	50.00
64:00 05400 RADIOLOGY-DLACNOSTIC 1,742 5,036 5,264 15,029 619 64:01 05600 RADIOLOGY-DLACNOSTIC 273 788 823 469 0 65:00 05600 RADIOLOSTOPE 167 483 505 677 0 06:00 DAGOD LABORATORY 3,206 9,266 9,686 5,487 40 06:00 DOSCOR ESPIRATORY THERAPY 155 449 469 816 0 06:00 DECON CESPIRATORY THERAPY 1,532 4,426 4,627 8,960 4,515 06:00 OCCUPATIONAL THERAPY 1,532 4,426 4,627 8,960 4,515 00:00 OCCUPATIONAL THERAPY 1,532 4,426 4,627 8,960 4,515 00:00 OCCUPATIONAL THERAPY 1,532 4,426 4,627 8,960 4,515 00:00 OCUPATIONARY 9 26 277 330 0 0 0100 OTOO IMAL DEV. CHARGED TO PA								52.00
54.01 05401 ULTRASQUND 273 788 823 469 0 65.00 05600 RADI OLSOTOPE 167 483 505 677 0 63.00 06300 LABORATORY 3.206 9,266 9,686 5,487 40 63.00 06300 INTRAVENDUS THERAPY 155 449 469 816 0 64.00 06400 INTRAVENDUS THERAPY 1,532 4,426 4,627 8,960 4,515 65.00 06000 PHYSI CAL.THERAPY 1,532 4,426 4,627 8,960 4,515 67.00 06700 OCUPATI ONAL THERAPY 1,532 4,426 4,627 8,960 4,515 67.00 06700 OCUPATI ONAL THERAPY 141 407 425 290 0 0 07001 CARD OPULIONARY 134 386 403 2,304 0 0 07001 MEDI CAL SURGED TO PATI ENTS 841 2,432 2,542 0			-		23		-	53.00
56. 00 05600 ND10 ISOTOPE 167 483 505 677 0 60. 00 06000 LABDRATORY 3,206 9,266 9,686 5,487 40 63. 00 06300 INTRAVENOUS THERAPY 155 442 444 252 0 66. 00 06600 RESPI RATORY THERAPY 1,532 44,44 469 816 0 66. 00 0COU OCCUPATIONAL THERAPY 1,532 4,426 4,627 8,960 4,515 67. 00 0COU OCCUPATIONAL THERAPY 141 407 425 290 0 68. 00 0ELECTROENCEPHALOGRAPHY 9 26 27 330 0 0 70. 0 07001 CARDI OPULMONARY 134 386 403 2,304 0	1							54.00
60:00 06000 LABORATORY 3, 206 9, 266 9, 666 5, 487 40 63:00 06300 BLOOD STORING, PRCESSING & TRANS. 15 42 44 252 0 64:00 06400 INTRAVENUS THERAPY 155 449 469 816 0 66:00 06500 PHYSI CAL THERAPY 1, 532 4, 426 4, 627 8, 960 4, 515 67:00 06700 OCUPATI ONAL THERAPY 1, 532 4, 426 4, 627 8, 960 4, 515 60:00 66800 SPECE THATOLOGY 141 407 425 290 0 0 0 00 00 00 0							-	54.01
63:00 663:00 BLOOD STORING, PROCESSING & TRANS. 15 42 44 252 0 64:00 06400 INTRAVENOUS THERAPY 155 449 469 816 0 66:00 06500 RESPIRATORY THERAPY 1,000 2,890 3,021 3,167 76 66:00 00 0000 0000 0000 00000 0000 4,425 290 0 70:00 00000 00000 00000 00000 7330 0 0 71:00 07000 LECTROENCEPHALLOGRAPHY 9 26 27 330 0 71:00 07000 LARDICAL SUPPLIES CHARGED TO PATIENTS 8441 2,432 2,542 0 0 0 71:00 07000 IMULAL SUPPLIES CHARGED TO PATIENTS 8441 2,432 2,542 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>-</td><td>56.00</td></t<>							-	56.00
64.00 06400 INTRAVENOUS THERAPY 155 449 460 816 0 65.00 06500 RESPIRATORY THERAPY 1,000 2,890 3,021 3,167 76 66.00 06600 PHYSI CAL THERAPY 1,532 4,426 4,627 8,960 4,515 67.00 0C000 SPECEL PATHOLOCY 141 407 425 290 0 00 0000 SPECEL PATHOLOCRY 134 386 403 2,304 0 01 07010 CARDIO PULINONARY 134 386 403 2,304 0 01.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 841 2,432 2,542 0								60.00
65.00 06500 RESPIRATORY THERAPY 1,000 2,890 3,021 3,167 76 66.00 06600 PHYSICAL THERAPY 1,532 4,426 4,627 8,960 4,515 66.00 06600 PHYSICAL THERAPY 259 749 733 336 0 68.00 06800 SPEECH PATHOLOCY 141 407 425 290 0 70.01 OCUPATIONAL THERAPY 9 26 27 330 0 70.01 ORDIO PLECTRORCEPHALOCRAPHY 9 26 27 330 0 71.00 07001 IMPL CAL SUPPLIES CHARGED TO PATIENTS 841 2,432 2,542 0								63.00
66.00 06600 PHYSICAL THERAPY 1,532 4,426 4,627 8,960 4,515 67.00 06700 OCCUPATI ONAL THERAPY 259 749 783 336 0 68.00 06800 SPEECH PATHOLOGY 141 407 425 290 0 070.00 CLECTROENCEPHALOGRAPHY 9 26 27 330 0 070.01 CADIO (ARDI OPULMONARY 134 386 403 2,304 0 071.00 INEDI CAL SUPPLIES CHARGED TO PATIENTS 841 2,432 2,542 0 0 0 070.00 O7200 JRUGS CHARGED TO PATIENTS 841 2,432 2,542 0 0 0 070.00 07000 DRUGS CHARGED TO PATIENTS 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>64.00</td>								64.00
67.00 06700 0CCUPATIONAL THERAPY 259 749 783 336 0 68.00 06800 SPECH PATHOLOGY 141 407 425 290 0 00.00 07000 ELECTROENCEPHALOGRAPHY 9 26 27 330 0 070.01 ORADI OPULMONARY 134 386 403 2,304 0 071.00 OT200 IMPL. DEV. CHARGED TO PATIENTS 841 2,432 2,542 0 0 0.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0								65.00
668.00 06800 SPECH PATHOLOGY 141 407 425 290 0 70.00 07000 ELECTROENCEPHALOGRAPHY 9 26 27 330 00 70.00 O7001 CARDI OPULMONARY 134 386 403 2,304 00 71.00 OT100 NEDICAL SUPPLIES CHARGED TO PATIENTS 841 2,432 2,542 0 00 72.00 OT300 DRUGS CHARGED TO PATIENTS 0								66.00
70.00 070.00 ELECTROENCEPHALOGRAPHY 9 26 27 330 0 70.01 070.01 CARDI OPULMONARY 134 386 403 2, 304 0 70.01 ORDI OPULMONARY 134 386 403 2, 304 0 71.00 07100 MPL. BUY, CHARGED TO PATIENTS 841 2, 432 2, 542 0 0 70.00 073.00 DRUGS CHARGED TO PATIENTS 0							-	67.00
70.01 07001 CARDI OPULMONARY 134 386 403 2, 304 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 841 2, 432 2, 542 0 0 72.00 70.00 DEV. CHARGED TO PATI ENTS 61 177 185 0							-	68.00 70.00
71.00 071.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 841 2, 432 2, 542 0 0 72.00 07200 INPL. DEV. CHARGED TO PATI ENT 61 177 185 0 0 0 00 0000 DRUGS CHARGED TO PATI ENTS 0	1		1				-	70.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 61 177 185 0 0 007300 DRUGS CHARGED TO PATIENTS 0							-	71.00
73.00 DRUGS CHARGED TO O O O O OUTPATE ENT SERVICE COST CENTERS						-	-	72.00
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 70 201 210 586 0 90.01 09000 LINIC 826 2,387 2,495 6,480 162 90.02 09002 CLINIC LAKESIDE 824 2,382 2,490 8,936 0 90.03 09003 CLINIC - QUICKCARE 418 1,208 1,263 6,575 0 91.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 2,818 8,142 8,511 12,785 2,126 92.00 09200 BERVATION BEDS (NON-DISTINCT PART) 560 1,618 1,691 6,301 0 93.00 04950 BEHAVIOR HEALTH 6691 0 1,982 0 0 93.00 1000 HOME HEALTH AGENCY 691 0 1,982 0 0 91.00 INDREI MBURSABLE COST CENTERS 0 0 0 91.00 19200 ISTALS (SUM OF LINES 1 through 117) 35,475 95,448 92,295 168,852 12,586 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>73.00</td>								73.00
90. 00 09000 CLINIC 70 201 210 586 00 90. 01 09001 JV CLINIC 826 2, 387 2, 495 6, 480 162 90. 02 09002 CLINIC - LAKESIDE 824 2, 382 2, 490 8, 936 00 90. 03 09003 CLINIC - QUICKCARE 418 1, 208 1, 263 6, 575 0 91. 00 09100 EMERGENCY 2, 818 8, 142 8, 511 12, 785 2, 126 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 93. 00 04950 BEHAVIOR HEALTH 560 1, 618 1, 691 6, 301 0 04950 BEHAVIOR HEALTH 560 1, 618 1, 691 6, 301 0 01100 HOME HEALTH AGENCY 691 0 1, 982 0 0 0100 HOME HEALTH AGENCY 691 0 1, 982 0 0 00 0 0 0 0 0 0 0 0 0 1, 982 0 0 0 0 192. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 7 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 40 1, 259 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 810 0 192. 01 19201 MSO CLINICS 0 0 0 0 0 0 192. 03 19203 FPA 0 0 0 0 0 0 192. 03 19203 FPA 0 0 0 0 0 194. 00 07950 MEALS ON WHEELS 0 0 0 0 0 194. 00 07950 MEALS ON WHEELS 0 0 0 0 194. 00 07950 MEALS ON WHEELS 0 0 0 0 194. 00 07950 MAELS ON WHEELS 0 0 0 194. 00 07951 GUEST MEALS 0 194. 00 07951 MARETING 334 964 1, 008 387 0 194. 00 07952 MARKETING 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			ч Ч	9	0	0	0	/ 5. 00
90.01 09001 JV CLINIC 826 2,387 2,495 6,480 162 90.02 09002 CLINIC - LAKESIDE 824 2,382 2,490 8,936 0 90.03 09003 CLINIC - OUICKCARE 418 1,203 1,263 6,575 0 91.00 09200 DSERVATION BEDS (NON-DISTINCT PART) 2,818 8,142 8,511 12,785 2,126 92.00 09200 DSERVATION BEDS (NON-DISTINCT PART) 560 1,618 1,691 6,301 0 93.00 04950 BEHAVIOR HEALTH GOTHER 691 0 1,982 0 0 93.00 04950 BEHAVIOR HEALTH AGENCY 691 0 1,982 0 0 93.00 100 IMBURSABLE COST CENTERS 5 12,586 12,586 12,586 12,586 12,586 12,586 12,586 12,586 12,586 12,586 12,586 12,586 12,586 12,59 0 0 0 12,259			70	201	210	586	0	90.00
90. 02 09002 CLINIC - LAKESIDE 824 2, 382 2, 490 8, 936 0 90. 03 09003 CLINIC - QUICKCARE 418 1, 208 1, 263 6, 575 0 91. 00 09003 CLINIC - QUICKCARE 418 1, 208 1, 263 6, 575 0 91. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 2, 818 8, 142 8, 511 12, 785 2, 126 93. 00 04950 BEHAVIOR HEALTH 560 1, 618 1, 691 6, 301 0 010100 HOME HEALTH AGENCY 691 0 1, 982 0 0 93.00 04950 BEHAVI OR HEALTH AGENCY 691 0 1, 982 0 0 93.00 ID100 HOME HEALTH AGENCY 691 0 1, 982 0 0 93.00 SUBTOTALS (SUM OF LINES 1 through 117) 35, 475 95, 448 92, 295 168, 852 12, 586 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>90.01</td></td<>								90.01
90.03 09003 CLINIC - QUICKCARE 418 1,208 1,263 6,575 0 91.00 09100 EMERGENCY 2,818 8,142 8,511 12,785 2,126 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 560 1,618 1,691 6,301 0 93.00 04950 BEHAVIOR HEALTH 560 1,618 1,982 0 0 93.00 04950 BEHAVIOR HEALTH AGENCY 691 0 1,982 0 0 93.00 10100 HOME HEALTH AGENCY 691 0 1,982 0 0 0 93.00 SUBTOTALS (SUM OF LINES 1 through 117) 35,475 95,448 92,295 168,852 12,586 NONREI MBURSABLE COST CENTERS 0								90.02
91.00 09100 EMERGENCY 2,818 8,142 8,511 12,785 2,126 92.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART) 560 1,618 1,691 6,301 0 93.00 04950 BEHAVI OR HEALTH 560 1,618 1,691 6,301 0 0HER REIMBURSABLE COST CENTERS 500 1,982 0 0 0 111.00 HOME HEALTH AGENCY 691 0 1,982 0 0 SPECI AL PURPOSE COST CENTERS 500 1,982 0 0 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 35,475 95,448 92,295 168,852 12,586 1090.0 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 192.01 19203 FPA 0 0 0 0 0 0 0 0								90.03
93.00 04950 BEHAVI OR HEALTH 560 1, 618 1, 691 6, 301 0 OTHER REI MBURSABLE COST CENTERS 0 1, 982 0 0 SPECIAL PURPOSE COST CENTERS 560 1, 618 1, 691 6, 301 0 SPECIAL PURPOSE COST CENTERS 0 0 1, 982 0 0 I18.00 SUBTOTALS (SUM OF LINES 1 through 117) 35, 475 95, 448 92, 295 168, 852 12, 586 NONREL MBURSABLE COST CENTERS 0 0 40 1, 259 0 192.00 19200 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 192.01 19201 MSO CLINICS 0 </td <td>91.00</td> <td>09100 EMERGENCY</td> <td>2, 818</td> <td></td> <td></td> <td></td> <td></td> <td>91.00</td>	91.00	09100 EMERGENCY	2, 818					91.00
OTHER REI MBURSABLE COST CENTERS 101.00 HOME HEALTH AGENCY 691 0 1,982 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 35,475 95,448 92,295 168,852 12,586 NONREI MBURSABLE COST CENTERS 190.00 197, FLOWER, COFFEE SHOP & CANTEEN 0 0 40 1,259 0 192.00 192.00 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 192.00 192.00 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 192.01 NSO CLI NI CS 0	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101.00 HOME HEALTH AGENCY 691 0 1,982 0 0 0 SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS NONREL MBURSABLE COST CENTERS NONREL MBURSABLE COST CENTERS 101.00 0 117.00 35,475 95,448 92,295 168,852 12,586 NONREL MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 40 1,259 0 192.00 192.00 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 0 0 0 192.01 NSO CLI NI CS 0<	93.00	04950 BEHAVI OR HEALTH	560	1, 618	1, 691	6, 301	0	93.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 35,475 95,448 92,295 168,852 12,586 NONREI MBURSABLE COST CENTERS 0 0 40 1,259 0 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 810 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.01 19201 MSO CLI NI CS 0		OTHER REIMBURSABLE COST CENTERS					-	
SUBTOTALS (SUM OF LINES 1 through 117) 35,475 95,448 92,295 168,852 12,586 NONREI MBURSABLE COST CENTERS Interview Interview <t< td=""><td></td><td></td><td>691</td><td>0</td><td>1, 982</td><td>0</td><td>0</td><td>101.00</td></t<>			691	0	1, 982	0	0	101.00
NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 40 1,259 0 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 810 0 0 192.01 19201 MSO CLINICS 0	- F							
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 40 1,259 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0	+		35, 475	95, 448	92, 295	168, 852	12, 586	118.00
192.00 19200 PHYSICLANS' PRIVATE OFFICES 0 0 810 0 0 192.01 MSO CLINICS 0								
192.01 MSO CLINICS 0 0 0 0 192.03 19203 FPA 0 0 0 0 194.00 07950 MEALS ON WHEELS 0 0 0 0 0 194.02 07951 GUEST MEALS 0 0 0 0 0 0 0 194.02 07952 MARKETING 334 964 1,008 387 0 194.03 07953 NONREI MBURSABLE - OTHER 0 0 459 0 0 200.00 Cross Foot Adjustments 0 0 0 0 0 0			-	0				190.00
192.03 192.03 FPA 0 0 0 0 194.00 07950 MEALS ON WHEELS 0 0 0 0 0 194.01 07951 GUEST MEALS 0<								192.00
194.00 07950 MEALS ON WHEELS 0 <td></td> <td></td> <td>-</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>192.01</td>			-		0	0		192.01
194.01 07951 GUEST MEALS 0 0 0 0 0 194.02 07952 MARKETING 334 964 1,008 387 0 194.03 07953 NONREI MBURSABLE - OTHER 0 0 459 0 0 200.00 Cross Foot Adjustments 0 0 459 0 0					0	0		192.03
194. 02 07952 MARKETING 334 964 1,008 387 0 194. 03 07953 NONREI MBURSABLE - OTHER 0 0 459 0 0 200. 00 Cross Foot Adjustments 0 0 459 0 0			0	-	0	0		194.00
194.03 07953 NONREI MBURSABLE - OTHER 0 0 459 0 0 200.00 Cross Foot Adjustments			0	-	0	0		194.01
200.00 Cross Foot Adjustments						387		194.02
			0	0	459	0	0	194.03
					~	~	_	200.00
			25 000	04 410	04 410	170 400		201.00

Health Financial Systems SUL	LIVAN COUNTY COM	MUNITY HOSPITA	AL	In Lie	eu of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	F	eriod: rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared:
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	5/30/2019 2: 3 CENTRAL SERVI CES & SUPPLY	<u>5 pm</u>
	9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 01 00590 I S/ACCOUNTI NG/MARKETI NG						5.01
5. 02 00591 BUSINESS OFFICE & ADMITTING						5.02
5. 03 00592 OTHER A&G						5.03
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPI NG	10, 727	55 000				9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA	319 232	55, 902 30, 995	51, 912			10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	232	30, 445	2, 449			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	228	0	1, 094		37, 391	14.00
15. 00 01500 PHARMACY	166	0	2, 264		549	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	153	0	2, 318		0	16.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	C	0	0	19.00
30. 00 03000 ADULTS & PEDIATRICS	1, 759	12, 337	12, 067	20, 784	674	30.00
31. 00 03100 NTENSI VE CARE UNI T	345	806	2, 264			
43. 00 04300 NURSERY	23	0	361		47	43.00
ANCI LLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATI NG ROOM	1, 450	928	3, 953			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	60	0	150		87	52.00
53. 00 05300 ANESTHESI OLOGY	48	0	2 505	-	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	872 27	0	3, 585 702		709	54.00 54.01
56. 00 05600 RADI 0I SOTOPE	39	0	/02	0	0	56.00
60. 00 06000 LABORATORY	319	0	6, 379	0	4, 387	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	15	0	C	0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	47	0	C	.,	0	64.00
65. 00 06500 RESPIRATORY THERAPY	184	0	2, 832		1, 639	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	520 19	0	3, 884 568		0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	17	0	368		10	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	19	0	C	0	0	70.00
70. 01 07001 CARDI OPULMONARY	134	0	311	534	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	24, 094	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	-	1, 749	
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	73.00
90. 00 09000 CLINIC	34	0	31	0	0	90.00
90. 01 09001 JV CLINIC	376	0	C	4, 984		
90. 02 09002 CLINIC - LAKESIDE	519	0	C		81	
90. 03 09003 CLINIC - QUICKCARE	382	0	0	0		90.03
91.00 09100 EMERGENCY	742	0	4, 962	8, 549	353	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93.00 04950 BEHAVIOR HEALTH	366	0	779	0	0	92.00 93.00
OTHER REIMBURSABLE COST CENTERS	500	V	,,,,	0	0	75.00
101.00 10100 HOME HEALTH AGENCY	109	0	C	3, 955	62	101.00
SPECIAL PURPOSE COST CENTERS	1					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	9, 794	45, 066	51, 321	50, 056	37, 352	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	·		0	190.00
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	73	0	C	0		190.00
192. 01 19201 MS0 CLINICS	0	0	C	-		192.00
192. 03 19203 FPA	0	0	C	-		192.03
194.00 07950 MEALS ON WHEELS	0	10, 836	C	0		194.00
194.01 07951 GUEST MEALS	0	0	C	0		194.01
194. 02 07952 MARKETI NG	22	0	384			194.02
194.03 07953 NONREI MBURSABLE - OTHER 200.00 Cross Foot Adjustments	838	0	207	0	0	194. 03 200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0	14, 380	0	n	200.00
202.00 TOTAL (sum lines 118 through 201)	10, 727	55, 902	66, 292			202.00

Heal th	Fi nanci	al Syste	ems
411004	TLON OF	OADL TAL	

Health Financial Systems	SULLIVAN COUNTY COM	MUNITY HOSPIT	AL	In Lie	eu of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		eriod: ^om 01/01/2018	Worksheet B Part II	
			To		Date/Time Pre	
Cost Center Description	PHARMACY	MEDI CAL	NONPHYSI CI AN	Subtotal	5/30/2019 2:3	5 pm
		RECORDS &	ANESTHETI STS	oub to ta.	Residents Cost	
		LI BRARY			& Post	
					Stepdown Adjustments	
	15.00	16.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS			1		1	1 4 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00590 I S/ACCOUNTI NG/MARKETI NG						5.01
5. 02 00591 BUSINESS OFFICE & ADMITTING						5. 02
5. 03 00592 OTHER A&G						5.03
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY						13.00 14.00
15. 00 01500 PHARMACY	42, 294					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	29, 874	Ļ			16.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		2.420	1	247 //4		1 20 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	0	2, 420 173		347, 664 65, 748		
43. 00 04300 NURSERY	0	91		5, 899		
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	2, 045		249, 438		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	21		10, 533		
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	331 5, 296		7, 643 154, 956		
54. 01 05401 ULTRASOUND	0	1, 097		7, 887		
56. 00 05600 RADI OI SOTOPE	0	205		7, 324		56.00
60. 00 06000 LABORATORY	0	5, 796		87, 530		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 I NTRAVENOUS THERAPY	0	202 525		2, 525 9, 849		
65. 00 06500 RESPIRATORY THERAPY	0	940		40, 564		1
66. 00 06600 PHYSI CAL THERAPY	0	1, 013		99, 339		
67.00 06700 OCCUPATI ONAL THERAPY	0	176		5, 577		
	0	44		3, 991		
70. 00 07000 ELECTROENCEPHALOGRAPHY 70. 01 07001 CARDI OPULMONARY	0	15 156		2, 981 22, 247		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	VTS 0	2, 362		32, 271		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	146		2, 318		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	42, 294	1, 352		43, 646	0	73.00
	0	45		5 710	0	
90. 00 09000 CLINIC 90. 01 09001 JV CLINIC	0	45 558		5, 718 68, 751		
90. 02 09002 CLINIC - LAKESIDE	0	337		84, 971		
90. 03 09003 CLINIC - QUICKCARE	0	220		61, 656		
91.00 09100 EMERGENCY	0	3, 854	-	152, 368		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR 93.00 04950 BEHAVIOR HEALTH	0	298		60, 499	0	
OTHER REIMBURSABLE COST CENTERS		270		00,477	0	93.00
101.00 10100 HOME HEALTH AGENCY	0	156		21, 742	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through NONREI MBURSABLE COST CENTERS	117) 42,294	29, 874	. 0	1, 665, 635	0	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTER	EN O	C		11, 129	0	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		849		192.00
192. 01 19201 MSO CLI NI CS	0	0		0		192.01
192. 03 19203 FPA	0	0		0		192.03
194.00 07950 MEALS ON WHEELS 194.01 07951 GUEST MEALS	0	0		10, 836		194.00 194.01
194. 02 07952 MARKETI NG	0	0		6, 146		194.01
194. 03 07953 NONREI MBURSABLE - OTHER	0	C		60, 875		194.03
200.00 Cross Foot Adjustments			0	0		200. 00
201.00 Negative Cost Centers	0	0	0	14,380		201.00
202.00 TOTAL (sum lines 118 through 201)	42, 294	29, 874	0	1, 769, 850	1 0	202.00

In Lieu of Form CMS-2552-10 Worksheet B

ALLOCA	ITON OF CAPITAL RELATED COSTS		Provider CCN: 15-1327	Period: Worksheet B From 01/01/2018 Part II	nononod.
	Cost Costos Description	T-+-1		To 12/31/2018 Date/Time Pr 5/30/2019 2:	
	Cost Center Description	Total 26.00			
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590 I S/ACCOUNTI NG/MARKETI NG				5.01
5.02 5.03	00591 BUSINESS OFFICE & ADMITTING 00592 OTHER A&G				5.02 5.03
7.00	00392 OTHER A&G 00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPING				9.00
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERI A				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00	01500 PHARMACY				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY				16.00
	01900 NONPHYSI CLAN ANESTHETI STS				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS	I			
30.00	03000 ADULTS & PEDI ATRI CS	347,664			30.00
31.00	03100 I NTENSI VE CARE UNI T	65, 748			31.00
43.00	04300 NURSERY	5, 899			43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	249, 438			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 533			52.00
53.00	05300 ANESTHESI OLOGY	7,643			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	154, 956			54.00
54.01	05401 ULTRASOUND	7,887			54.01
56.00	05600 RADI OI SOTOPE	7, 324			56.00
60.00	06000 LABORATORY	87, 530			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2, 525			63.00
64.00	06400 I NTRAVENOUS THERAPY	9, 849			64.00
65.00	06500 RESPI RATORY THERAPY	40, 564			65.00
66.00	06600 PHYSI CAL THERAPY	99, 339			66.00
67.00	06700 OCCUPATI ONAL THERAPY	5, 577			67.00
68.00	06800 SPEECH PATHOLOGY	3, 991			68.00
70.00		2, 981			70.00
	07001 CARDI OPULMONARY	22, 247			70.01
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	32, 271			71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	2, 318			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	43, 646			73.00
90.00	09000 CLINIC	5, 718			90.00
90.00 90.01	09001 JV CLINIC	68, 751			90.00
	09002 CLINIC - LAKESIDE	84, 971			90.01
90.02	09003 CLINIC - QUICKCARE	61, 656			90.02
	09100 EMERGENCY	152, 368			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	102,000			92.00
	04950 BEHAVI OR HEALTH	60, 499			93.00
	OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY	21, 742			101.00
	SPECIAL PURPOSE COST CENTERS	,			
118.00		1, 665, 635			118.00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 129			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	849			192.00
	19201 MSO CLINICS	0			192.01
	19203 FPA	0			192.03
194.00	07950 MEALS ON WHEELS	10, 836			194.00
194.01	07951 GUEST MEALS	0			194.01
	07952 MARKETI NG	6, 146			194. 02
	07953 NONREI MBURSABLE – OTHER	60, 875			194. 03
200.00	Cross Foot Adjustments	0			200.00
201.00	5	14, 380			201.00
202.00	TOTAL (sum lines 118 through 201)	1, 769, 850			202.00
					-

SULLI VAN COUNTY COMMUNITY HOSPITAL

		IVAN COUNTY COM	MUNITY HOSPITA	AL	In Lie	u of Form CMS-	2552
OST ALI	LOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
					From 01/01/2018 To 12/31/2018	Date/Time Pre	pare
						5/30/2019 2:3	
		CAPI TAL REL	ATED COSTS				
	Cost Conton Description	NEW BLDG &			Reconciliation		
	Cost Center Description		NEW MVBLE	EMPLOYEE	Reconciliation		
		FLXT	EQUI P	BENEFITS		MARKETING	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A. 01	5. 01	
	SENERAL SERVICE COST CENTERS	101.075			1		
	00100 NEW CAP REL COSTS-BLDG & FIXT	121, 075					1
	00200 NEW CAP REL COSTS-MVBLE EQUIP		111, 140				2
	00400 EMPLOYEE BENEFITS DEPARTMENT	445	445	11, 699, 057			4
01 0	00590 I S/ACCOUNTI NG/MARKETI NG	2, 303	2, 303	624, 658	3 -1, 282, 883	23, 689, 040	5
	DO591 BUSINESS OFFICE & ADMITTING	6, 126	6, 126	621, 717	0	1, 167, 187	5
03 0	00592 OTHER A&G	5, 351	5, 351	150, 009	9 0	2, 069, 140	5
00 0	00700 OPERATION OF PLANT	10, 111	10, 111	406, 484	1 0	1, 401, 768	7
o lo	00800 LAUNDRY & LINEN SERVICE	676	676	43, 252	2 0	78, 010	8
	00900 HOUSEKEEPING	349	349	297, 618		429, 519	
	D1000 DI ETARY	2, 763	2, 763	337, 134		700, 363	
	01100 CAFETERI A	2,015	2,015	337, 13-		00,009	
		2, 013					
	01300 NURSI NG ADMI NI STRATI ON		2, 347	432, 622		602, 885	
	01400 CENTRAL SERVICES & SUPPLY	1,976	1, 976	110, 825		159, 686	
	D1500 PHARMACY	1, 437	1, 437	375, 414		1, 351, 794	
	01600 MEDICAL RECORDS & LIBRARY	1, 325	1, 325	288, 704		402, 931	
	01900 NONPHYSICIAN ANESTHETISTS	0	0	(0 0	0	19
	NPATIENT ROUTINE SERVICE COST CENTERS	тт			-1		
	03000 ADULTS & PEDI ATRI CS	15, 261	15, 261	1, 895, 923		2, 725, 851	
	03100 INTENSIVE CARE UNIT	2, 989	2, 989	383, 552		564, 386	
00 0	04300 NURSERY	198	198	61, 286	6 O	103, 114	43
	NCILLARY SERVICE COST CENTERS						
00 0	D5000 OPERATING ROOM	12, 577	12, 577	688, 946	5 O	1, 250, 642	50
00 0	D5200 DELIVERY ROOM & LABOR ROOM	524	524	25, 017	0	44, 958	52
00 0	05300 ANESTHESI OLOGY	415	415	(0 0	4, 982	53
00 0	05400 RADI OLOGY-DI AGNOSTI C	7, 568	7, 568	561, 958	3 0	1, 152, 431	54
	05401 ULTRASOUND	236	236	129, 911		180, 265	
	05600 RADI OI SOTOPE	341	341	127,711		110, 586	
				750 010	-		
	06000 LABORATORY	2, 763	2, 763	752, 312		2, 120, 689	
	06300 BLOOD STORING, PROCESSING & TRANS.	127	127	(9, 624	
	06400 I NTRAVENOUS THERAPY	411	411	(-	102, 757	
	06500 RESPI RATORY THERAPY	1, 595	1, 595	456, 277		661, 333	
	06600 PHYSI CAL THERAPY	4, 512	4, 512	718, 754	1 0	1, 013, 004	66
. 00 0	06700 OCCUPATI ONAL THERAPY	169	169	132, 523	3 0	171, 492	67
00 0	06800 SPEECH PATHOLOGY	146	146	70, 969	9 0	93, 142	68
00 0	07000 ELECTROENCEPHALOGRAPHY	166	166	(0 0	5, 867	70
01 0	07001 CARDI OPULMONARY	1, 160	1, 160	54, 330	0 0	88, 319	70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	. (556, 499	
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(40, 414	
	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	
	DUTPATIENT SERVICE COST CENTERS		0	,		0	1 ^`
	09000 CLINIC	295	295	1, 664	1 0	46, 059	90
	09001 JV CLINIC	3, 263	3, 263	449, 021		546, 367	
	09002 CLINIC - LAKESIDE						
		4,500	4, 500	245, 542		545, 224	
		3, 311	3, 311	108, 316		276, 571	
00 0	09100 EMERGENCY	6, 438	6, 438	756, 330	0 0	1, 863, 439	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			<u>.</u>			92
	04950 BEHAVI OR HEALTH	3, 173	3, 173	88, 392	2 0	370, 209	93
	THER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	949	949	309, 612	2 0	456, 920	101
	SPECIAL PURPOSE COST CENTERS						
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	110, 311	110, 311	11, 579, 072	2 -1, 184, 452	23, 468, 427	118
	IONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	634	634	(190
2.001	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(- 196, 891	0	192
	19201 MSO CLINICS	0	0	(0 0	0	192
	19203 FPA	0	o	(192
	07950 MEALS ON WHEELS	0	0	(194
	07951 GUEST MEALS	0	0	() (194
	07951 GUEST MEALS 07952 MARKETING	195	195	79, 073		220, 613	
	07953 NONREI MBURSABLE - OTHER	9, 935	0	40, 912	2 –111, 515	0	194
0.00	Cross Foot Adjustments						200
1.00	Negative Cost Centers						201
2.00	Cost to be allocated (per Wkst. B,	723, 242	1, 046, 608	3, 157, 905	ō l	1, 282, 883	202
	Part I)						
3.00	Unit cost multiplier (Wkst. B, Part I)	5. 973504	9. 417024	0. 269928	3	0. 054155	203
4.00	Cost to be allocated (per Wkst. B,			6, 849	9	35, 809	204
4. UU							

Health Financial Systems SULL	IVAN COUNTY COM	MUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2018	Worksheet B-1	
				To 12/31/2018	Date/Time Pre 5/30/2019 2:3	pared: 5 pm
	CAPI TAL REL	ATED COSTS				
Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	I S/ACCOUNTI NG/ MARKETI NG (ACCUM. COST)	
	1.00	2.00	4.00	5A. 01	5. 01	
205.00 Unit cost multiplier (Wkst. B, Part			0. 00058	5	0. 001512	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST A	Financial Systems SUL LLOCATION - STATISTICAL BASIS	LIVAN COUNTY CON	MUNITY HOSPIT	CN: 15-1327 Pe	In Lie eriod: rom 01/01/2018	u of Form CMS-2 Worksheet B-1	
				To		Date/Time Pre	
	Cost Center Description	Reconciliation	BUSINESS	Reconci I i ati on	OTHER A&G	5/30/2019 2:3 OPERATION OF	
			OFFICE & ADMITTING		(ACCUM. COST)	PLANT (SQUARE	
			(ACCUM.		0031)	FEET)	
			COST)	54.00	5.00		
	GENERAL SERVICE COST CENTERS	5A. 02	5.02	5A. 03	5.03	7.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 5.02	00590 I S/ACCOUNTI NG/MARKETI NG 00591 BUSI NESS OFFI CE & ADMI TTI NG	-1, 230, 396	23, 259, 862				5.01
5.03	00592 OTHER A&G	0	2, 181, 194		22, 993, 511		5.03
7.00	00700 OPERATION OF PLANT	0	1, 477, 681		1, 555, 847	85, 855	
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	82, 235		86, 585	676 349	
9.00 10.00	01000 DI ETARY	0	452, 780 738, 291		476, 731 777, 345	2, 763	
11.00	01100 CAFETERI A	98, 431	0		0	2,015	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	635, 534		669, 152	2, 347	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	168, 334		177, 239	1,976	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1, 425, 000 424, 752		1, 500, 380 447, 221	1, 437 1, 325	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	2,873,470		3, 025, 465		
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0	594, 950 108, 698		626, 422 114, 448	2, 989 198	
45.00	ANCI LLARY SERVICE COST CENTERS		100,070	, <u> </u>	114, 440	170	45.00
50.00	05000 OPERATI NG ROOM	0	1, 318, 371		1, 388, 110		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	47, 393		49, 900		
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	5, 252 1, 214, 841		5, 530 1, 279, 104	415 7, 568	
54.00	05401 ULTRASOUND	0	190, 027		200, 079	236	
56.00	05600 RADI OI SOTOPE	0	116, 575		122, 742	341	56.00
60.00	06000 LABORATORY	0	2, 235, 535		2, 353, 790		
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0	10, 145 108, 322		10, 682 114, 052	127 411	
65.00	06500 RESPI RATORY THERAPY	0	697, 147		734, 025	1, 595	
66.00	06600 PHYSI CAL THERAPY	0	1,067,863		1, 124, 351	4, 512	
67.00	06700 OCCUPATI ONAL THERAPY	0	180, 779		190, 342	169	1
68.00 70.00	06800 SPEECH PATHOLOGY 07000 ELECTROENCEPHALOGRAPHY	0	98, 186 6, 185		103, 380 6, 512	146	
70.00	07001 CARDI OPULMONARY	0	93, 102		98, 027	1, 160	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	586, 636		617, 668		
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	42, 603		44, 857	0	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73.00
90.00	09000 CLINIC	0	48, 553	3 0	51, 121	295	90.00
90.01	09001 JV CLINIC	0	575, 956		606, 423	3, 263	90.01
	09002 CLINIC - LAKESIDE	0	574, 751		605, 154		
90. 03 91. 00	09003 CLINIC - QUICKCARE 09100 EMERGENCY	0	291, 549 1, 964, 354		306, 971 2, 068, 264		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 704, 334	0	2,000,204	0,430	92.00
93.00	04950 BEHAVI OR HEALTH	0	390, 258	3 0	410, 902	3, 173	93.00
101 00	OTHER REIMBURSABLE COST CENTERS	404 (15			404 (15		101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	-481, 665	0	0 0	481, 665	0	101.00
118.00		-1, 613, 630	23, 027, 302	-2, 198, 144	22, 430, 486	85, 026	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-9, 757	0		9, 757		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 MSO CLI NI CS	-196, 891	0		196, 891 0		192.00 192.01
	19203 FPA	0	0		0		192.03
	07950 MEALS ON WHEELS	0	0		0		194.00
	07951 GUEST MEALS	0	0	0	0		194.01
	07952 MARKETI NG 07953 NONREI MBURSABLE – OTHER	-111, 515	232, 560		244, 862 111, 515		194.02 194.03
200.00		-111,010	0	, 0	111, 515	0	200.00
	Negative Cost Centers					l	201.00
201.00	Cost to be allocated (per Wkst. B,		1, 230, 396		2, 296, 575	1, 711, 243	202.00
				1			1
201.00 202.00	Part I)		0 05000	2	0 000070	10 021700	202 00
201.00	Part I) Unit cost multiplier (Wkst. B, Part I)		0. 052898 96, 412		0. 099879 94, 612		
201.00 202.00 203.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)		0. 052898 96, 412 0. 004145			170, 498	204.00

Health Financial Systems SULI	LIVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-1327	Peri od:	Worksheet B-1		
				From 01/01/2018 To 12/31/2018		narod.	
				10 12/31/2016	5/30/2019 2:3		
Cost Center Description	Reconciliation	BUSI NESS	Reconciliatio	on OTHER A&G	OPERATION OF		
		OFFICE &		(ACCUM.	PLANT		
		ADMI TTI NG		COST)	(SQUARE		
		(ACCUM.			FEET)		
		COST)					
	5A. 02	5.02	5A. 03	5.03	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)							

COST A	Financial Systems SULL LLOCATION - STATISTICAL BASIS	_IVAN COUNTY CO	Provider C	CN: 15-1327 P	eri od:	u of Form CMS-: Worksheet B-1	
					rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	5/30/2019 2:3 NURSI NG ADMI NI STRATI ON (DI RECT	
		8.00	9.00	10.00	11.00	NRSING HRS) 13.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	10.00	11.00	13.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 19.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00590 I S/ACCOUNTI NG/MARKETI NG 00591 BUSINESS OFFICE & ADMITTING 00592 OTHER A&G 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LI BRARY 01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	10, 306 0 47 42 0 0 0 0 0 0 0	93, 048 2, 763 2, 015 2, 347 1, 976 1, 437 1, 325 0	48, 313 26, 787 C C C C C C C C	13, 526 638 285 590 604	157, 487 0 0 0 0	14.00 15.00 16.00
30.00	03000 ADULTS & PEDIATRICS	2,346	15, 261			65, 389	
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	56 162	2, 989 198			12, 271 1, 963	
50.00	ANCILLARY SERVICE COST CENTERS	i	40.577		1 000		
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	1, 178 303	12, 577 524	802 C		17, 015 802	
53.00	05300 ANESTHESI OLOGY	0	415		0	0	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	507	7, 568 236			0	
56.00	05600 RADI OI SOTOPE	0	341	c c		0	
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	33	2, 763 127			0	60.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	0	411	c c	-	3, 345	
65.00	06500 RESPIRATORY THERAPY	62	1, 595			0	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	3, 696 0	4, 512 169			0	
68.00	06800 SPEECH PATHOLOGY	0	146	C	96	0	68.00
70. 00 70. 01	07000 ELECTROENCEPHALOGRAPHY 07001 CARDI OPULMONARY	0	166 1, 160		-	0 1, 681	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	c c	-	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0			0	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0		0	0	73.00
90.00	09000 CLI NI C	0				0	
90. 01 90. 02	09001 JV CLINIC 09002 CLINIC - LAKESIDE	133	3, 263 4, 500		-	15, 682 0	1
90. 03	09003 CLINIC – QUICKCARE	0	3, 311	c	0	0	90.03
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 741	6, 438	C	1, 293	26, 896	91.00 92.00
	04950 BEHAVI OR HEALTH	0	3, 173	C	203	0	
404 00	OTHER REIMBURSABLE COST CENTERS		0.40			10,440	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	949	C	0	12, 443	101.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	10, 306	84, 950	38, 948	13, 372	157, 487	118.00
100 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	634	C	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		-		192.00
	19201 MS0 CLINICS	0	0	-	-		192.01
	19203 FPA 07950 MEALS ON WHEELS	0		0 9, 365	-		192.03 194.00
194.01	07951 GUEST MEALS	0	0	C	0	0	194.01
	07952 MARKETING 07953 NONREIMBURSABLE - OTHER	0	195 7, 269		100 54		194.02 194.03
200.00			7,207		54	0	200.00
201.00	0	100 707	F21 202	00/ 000	447.000	010, 200	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	108, 707	531, 302	926, 330	467, 282	818, 208	202.00
203.00 204.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	10. 547933 12, 586				5. 195400 50, 056	203. 00 204. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part II)	1. 221230	0. 115285	1. 157080	3. 837942	0. 317842	205. 00

Health Financial Systems SULL	IVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-1327	Period:	Worksheet B-1		
				From 01/01/2018 To 12/31/2018			
Cost Center Description	LAUNDRY &	HOUSEKEEPING	DIETARY	CAFETERI A	NURSI NG		
	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(FTE'S)	ADMI NI STRATI ON		
	LAUNDRY)		02.0020)		(DI RECT		
					NRSING HRS)		
	8.00	9.00	10.00	11.00	13.00		
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)			l				

COST A	Financial Systems SULL NLLOCATION - STATISTICAL BASIS		Provider CC	N: 15-1327 F	Period:	u of Form CMS-2552- Worksheet B-1
					rom 01/01/2018 o 12/31/2018	Date/Time Prepared
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14. 00	PHARMACY (COSTED REQUI S.) 15. 00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME) 19.00	5/30/2019 2:35 pm
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT					1.0
2.00 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00	00200 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00590 I S/ACCOUNTI NG/MARKETI NG 00591 BUSI NESS OFFI CE & ADMI TTI NG 00592 OTHER A&G 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01900 NONPHYSI CI AN ANESTHETI STS	863, 985 12, 695 0 0	100 0 0	74, 864, 369 C		2. (4. 5. (5. (5. (7. 8. (9. (10. (11. 13. (14. (15. (16. 19. (19. (
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	15, 575	0	6, 065, 847	0	30. (
31. 00	03100 I NTENSI VE CARE UNI T	3, 079	0	433, 007	0	31. (
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1,077	0	228, 096	0 0	43. (
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	50, 859 2, 011	0 0	5, 125, 535 51, 847		50. 0 52. 0
52.00 53.00	05300 ANESTHESI OLOGY	2,011	0	829, 024		53. (
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	16, 372 0	0	13, 271, 947 2, 749, 778		54. (54. (
56.00	05600 RADI OI SOTOPE	0	0	512, 534		54.0
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	101, 361	0	14, 526, 207 507, 363		60. 0 63. 0
64. 00	06400 I NTRAVENOUS THERAPY	0	0	1, 315, 162	0	64. (
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	37, 883 0	0	2, 354, 964 2, 538, 696		65. (66. (
67.00	06700 OCCUPATI ONAL THERAPY	191	0	441, 957	0	67. (
68.00 70.00	06800 SPEECH PATHOLOGY 07000 ELECTROENCEPHALOGRAPHY	224	0	109, 463 36, 530		68. (70. (
70. 01	07001 CARDI OPULMONARY	0	0	390, 204	0	70. (
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	556, 734 40, 414	0	5, 920, 355 364, 793		71. (
73.00	07300 DRUGS CHARGED TO PATIENTS	0	100	3, 388, 200		73. (
90.00	OUTPATIENT SERVICE COST CENTERS	o	0	112, 021	0	90.0
90. 01	09001 JV CLINIC	0	0	1, 398, 678	8 O	90. (
	09002 CLINIC - LAKESIDE 09003 CLINIC - QUICKCARE	1, 878 13, 138	0 O	843, 698 550, 516		90. (90. (
91.00	09100 EMERGENCY	8, 146	О	9, 659, 318		91. (
92.00 93.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04950 BEHAVIOR HEALTH	О	0	748, 014	0	92. (
	OTHER REIMBURSABLE COST CENTERS			200 (15		101
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 441	0	390, 615	0	101. (
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	863, 078	100	74, 864, 369	0	118. (
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	190. (
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 MSO CLI NI CS	907	0	(192. 192.
	19203 FPA	0	0	0	0	192.
	07950 MEALS ON WHEELS 07951 GUEST MEALS	0	0	0	0	194. 194.
94.02	07952 MARKETI NG	0	0	(0	194.
94.03 200.00	07953 NONREIMBURSABLE - OTHER Cross Foot Adjustments	0	0	C	0	194. 200.
201.00	Negative Cost Centers					201.
202.00	Cost to be allocated (per Wkst. B, Part I)	255, 455	1, 711, 220	546, 731	0	202.
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 295671	17, 112. 200000	0.007303		203. (
204.00	Cost to be allocated (per Wkst. B, Part II)	37, 391	42, 294	29, 874	0	204. (
					1	205. (

Health Financia	al Systems S	ULLIVAN COUNTY CO	MMUNITY HOSPIT	u of Form CMS-	2552-10		
COST ALLOCATION - STATISTICAL BASIS			Provider C	CN: 15-1327	Period:	Worksheet B-1	
					From 01/01/2018 To 12/31/2018		epared:
						5/30/2019 2:3	<u>35 pm</u>
Co	st Center Description	CENTRAL	PHARMACY	MEDI CAL	NONPHYSI CI AN		
		SERVICES &	(COSTED	RECORDS &	ANESTHET I STS		
		SUPPLY	REQUIS.)	LI BRARY	(ASSI GNED		
		(COSTED		(GROSS	TIME)		
		REQUIS.)		CHARGES)			
		14.00	15.00	16.00	19.00		
206.00 NA	HE adjustment amount to be allocate	ed					206.00
(p	er Wkst. B-2)						
207.00 NA	HE unit cost multiplier (Wkst. D,						207.00
Pa	rts III and IV)						
							207.00

SULLI VAN COUNTY COMMUNI TY HOSPI TAL

Cost Center Description Total Cost (From Wst. B, 26) Total Cost (Prom Wst. B, 26) Total Costs (Prom Wst. B, 26) Total Costs (Prom Wst. B, 26) Total Costs (Prom Wst. B, 26) Total Costs (Prom Wst. B, 20) Total Costs (Prom Wst. B, 20) <thtpst (Prom</thtpst 	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/30/2019 2:3	
Cost Center Description Total Cost (from Wist, B) Part I, col. Total Costs (adj. Total Costs (bisal lowance) Total Costs Disal lowance Total Costs Disal lowance 30.00 04000 ADULTS & PEDIATRICS 10.00 4.00 5.00 3.00 4.00 5.00 31.00 04000 ADULTS & PEDIATRICS 10.00 4.45, 385 4.445, 385 4.445, 385 0 <t< td=""><td></td><td></td><td>Title</td><td>XVIII</td><td>Hospi tal</td><td>Cost</td><td></td></t<>			Title	XVIII	Hospi tal	Cost	
Impart ENT ROUTINE SERVICE COST CENTERS Ádj. Di sal I owance 0.00 03000 ADULTS & PEDIATRICS 4.445,385 0 0 30.00 30.00 03000 ADULTS & PEDIATRICS 4.445,385 0 0 31.00 43.00 04300 NURSERY 148,095 4.445,385 0 0 31.00 50.00 05000 PERATING COST CENTERS 148,095 0 0 31.00 50.00 05000 PELVERY NOM & LABOR ROOM 2,053,504 2,053,504 0 52.00 52.00 05000 PELVERY NOM & LABOR ROOM 22,0778 22,778 0 53.00 54.00 05400 RADI LOSY NOM & LABOR ROOM 252.519 0 54.01 54.01 56.00 06000 RADI OSTOPE 147,488 147,488 0 05.00 66.00 06000 RADI OSTOPE 147,488 18.710 0 63.00 66.00 06000 RESPI RATHERAPY 162.966 192.2766 0 64.00 67.00 064.00 070.04 1244.832 1444.832 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
INPATIENT RUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 30.00 03000 AULTS & PEDIATRICS 4.445,385 4.445,385 0 0 30.00 31.00 03000 INTESIVE CARE UNIT 867,794 867,794 0 0 31.00 AND 04300 NURSERV 148,095 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 148,095 0 0 50.00 55.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00	Cost Center Description	(from Wkst. B, Part I, col.		Total Costs		Total Costs	
INPATIENT ROUTINE SERVICE COST CENTERS Image: Control of Contender of Contreal of Control of Control of Control of Control of			2.00	2.00	4.00	E 00	
30.00 03000 AULTS & PEDIATRICS 4.445,385 4.445,385 0 0 0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0	INDATIENT DOUTINE SEDVICE COST CENTEDS	1.00	2.00	3.00	4.00	5.00	
31.00 03100 INTENSIVE CABE UNIT 867,794 0 0 31.00 43.00 04300 NURENERY 148,095 0 0 43.00 50.00 05000 0PENATI NG ROOM 2,053,504 0 0 0 50.00 52.00 50.00 0 52.00 50.00 0 53.00 0 53.00 0 53.00 0 53.00 0 53.00 0 53.00 0 53.00 0 53.00 0 53.00 0 53.00 0 53.00 0 54.01 54.01 54.01 54.01 54.01 54.01 54.01 55.00 0 56.00 56.00 56.00 56.00 56.00 56.00 56.00 60.00 66.00		1 115 385		1 115 3	85 0	0	30.00
43.00 043.00 043.00 148.095 0 43.00 ANCLLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS 50.00 Obsool OPERATING ROOM 2,053,504 0 0 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 78,004 78,004 0 0 52.00 53.00 Obsool OPERATING ROOM 22,778 0 53.00 0 53.00 0 53.00 0 53.00 0 54.01 53.00 0 54.01 54.01 0.54.01 0.54.01 0.54.01 0 54.01 0.54.01 0.56.00 0.500 0.570PE 147.488 147.488 0 0 56.00 60.00 60.00 0.6000 LABORATORY 2.853.548 2.853.548 0 60.00 66.00 64.00 66							
50.00 OF DOD (DERATING ROOM) 2,053,504 2,053,504 0 0 50.00 52.00 D52.00 DELIVERY ROOM & LABOR ROOM 78,004 78,004 0 0 52.00 53.00 D5300 ANESTHESI OLOGY 22,778 0 0 53.00 53.00 53.00 54.01 0 54.01 0 54.01 0 54.01 0 54.01 0 54.01 0 54.01 0 54.01 0 54.01 0 54.01 0 54.01 0 54.01 0 54.01 0 54.01 0 54.01 0 54.01 0 54.01 0 56.00 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 70.00 70.00 66.00 70.00 67.00 68.00 70.00 67.00 <		140,093		140,0	75 0	0	45.00
52.00 D5200 DELI VERY PROM & LABOR ROOM 78,004 78,004 0 52.00 53.00 05300 ANESTHESI OLOGY 22,778 0 0 53.00 54.00 D5400 RADI OLOGY - DI AGNOSTI C 1,740,298 1,740,298 0 54.00 54.01 D5401 ULTRASOUND 252,519 0 54.00 0 56.00 50.00 D6500 RADI OLOGY - DI AGNOSTI C 1,740,298 0 0 56.00 60.00 D6500 RADI OLOGY - DI AGNOSTI C 1,744,298 0 0 56.00 60.00 D6500 RADI OLOGY - DI AGNOSTI C 1,744,298 0 0 56.00 60.00 D6300 BLOD STORI NG, PROCESSI NG & TRANS. 18,710 18,710 0 63.00 64.00 D6500 RESPI RATORY THERAPY 1,448,832 0 0 65.00 66.00 D6700 DCCUPATI ONAL THERAPY 121,631 0 66.00 67.00 70.00 CCUPATI ONAL THERAPY 121,631 0 66.00 0 70.00 70.00		2 053 504		2 053 5	0	0	50.00
53.00 05300 ANESTHESI OLOGY 22,778 22,778 0 0 53.00 54.00 05400 RADI OLOGY 1,740,298 1,740,298 0 54.00 54.01 05400 RADI OLOGY 1,740,298 1,740,298 0 54.00 55.00 05600 RADI OLOGY 147,488 147,488 0 56.00 60.00 06300 BABORATORY 2,853,548 0 0 60.00 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 18,710 18,710 0 63.00 64.00 06400 INTRAVENOUS THERAPY 162,966 162,966 0 64.00 65.00 0500 RESPIRATORY THERAPY 124,031 0 124,031 0 65.00 66.00 06600 PHYSI CAL THERAPY 1,444,832 0 1,740,298 0 66.00 67.00 06700 0CUCUPATI ONAL THERAPY 222,083 0 222,083 0 66.00 70.00 07000 ELECTROENCEPHALOGRAPHY 11,686 11,686 0 70.00						-	
54.00 05400 RADI OLOGY-DI AGNOSTI C 1,740,298 1,740,298 0 54.00 54.01 05401 ULTRASOUND 252,519 252,519 0 54.01 56.00 05600 RADI OLOGY-DI AGNOSTI C 1,740,298 0 0 54.01 56.00 05600 RADI OLSTOPE 147,488 147,488 0 0 63.00 60.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 18,710 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 162,966 162,766 0 65.00 65.00 06500 RESPI RATORY THERAPY 902,786 902,786 0 65.00 64.00 06700 OCCUPATI ONAL THERAPY 121,631 0 121,631 0 68.00 70.00 OTOOD ELECTROENCEPHALOGRAPHY 11,686 11,686 0 70.00 70.01 71.00 OTOOL ELECTROENCEPHALOGRAPHY 151,944 151,944 0 70.01 70.01 71.00 OTOOL ELECTROENCEPHALOGRAPHY 151,944 1,735,964 0 70.01 70.01 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>							•
54.01 05401 ULTRASOUND 252,519 0 0 54.01 56.00 05600 RADIOI SOTOPE 147,488 0 0 56.00 60.00 06000 LABORATORY 22,853,548 2,853,548 0 0 60.00 63.00 06300 BLOD STORING, PROCESSING & TRANS. 18,710 18,710 0 64.00 64.00 05500 RESPIRATORY THERAPY 162,966 902,786 0 0 65.00 06500 RESPIRATORY THERAPY 1,448,832 0 147,483 0 66.00 66.00 06600 PHYSI CAL THERAPY 1,448,832 0 0 66.00 0 0600 SPEECH PATHOLOGY 121,631 0 121,631 0 68.00 70.00 07000 CLEDTRANCEPHALOGRAPHY 151,944 0 0 70.00 70.						-	
56.00 05600 RADI 0I SOTOPE 147,488 147,488 0 56.00 60.00 06000 LABORATORY 2,853,548 2,853,548 0 60.00 63.00 06000 TRANS. 18,710 18,710 0 60.00 64.00 06400 INTRAVENOUS THERAPY 162,966 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 902,786 0 902,786 0 66.00 60.00 06700 OCCUPATI ONAL THERAPY 1,444,832 0 1,444,832 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 121,631 0 121,631 0 68.00 70.00 OTOOD ELECTROPICEPHALOGRAPHY 111,486 115,944 0 0 70.00 70.00 TOROLECTROPICEPHALOGRAPHY 151,944 151,944 0 0 70.00 70.00 0 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00							•
60.00 06000 LABORATORY 2, 853, 548 2, 853, 548 0 0 60.00 63.00 06300 BLODD STORING, PROCESSING & TRANS. 18, 710 0 0 63.00 64.00 04001 INTRAVENOUS THERAPY 162, 966 0 0 64.00 06500 RESPI RATORY THERAPY 902, 786 0 0 65.00 06500 RESPI RATORY THERAPY 1, 444, 832 0 1, 444, 832 0 66.00 67.00 06700 0CUPATIONAL THERAPY 222, 083 0 222, 083 0 67.00 068.00 SPEECH PATHOLOGY 121, 631 0 121, 631 0 68.00 07.00 DELECTROENCEPHALOGRAPHY 151, 944 151, 944 0 70.00 70.00 07000 REDICAL SUPPLIES CHARGED TO PATIENTS 887, 205 887, 205 0 0 71.00 73.00 DRUGS CHARGED TO PATIENTS 1, 735, 964 0 0 73.00 0 90.00 0 73.00 0 90.01 0 90.01 0 90.01 90.02 9000							
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 18,710 18,710 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 162,966 162,966 0 0 64.00 65.00 OS600 RESPIRATORY THERAPY 0902,786 0 0 65.00 0 0 64.00 66.00 06600 PHYSI CAL THERAPY 0,902,786 0 0 66.00 0 66.00 0 66.00 0 66.00 0 66.00 0 67.00 66.00 0 0 67.00 66.00 0 67.00 68.00 0 0 67.00 68.00 0 0 68.00 0 70.00 68.00 0 70.00 68.00 0 70.00 0 68.00 0 70.00 68.00 0 70.00 68.00 0 70.00 68.00 0 70.00 70.00 70.00 70.00 70.01 70.01 70.00 70.01 70.00 70.00 70.00 70.00 70.00 72.00 72.00 72.00 72.00 7						0	•
64.00 06400 INTRAVENOUS THERAPY 162,966 162,966 0 64.00 65.00 06500 RESPIRATORY THERAPY 902,786 0 902,786 0 65.00 66.00 06700 0CCUPATIONAL THERAPY 1,444,832 0 1,444,832 0 66.00 67.00 06700 0CCUPATIONAL THERAPY 222,083 0 222,083 0 67.00 68.00 06800 SPEECH PATHOLOGY 121,631 0 121,631 0 68.00 70.00 CECTROENCEPHALOGRAPHY 11,1686 11,686 0 70.01 71.00 07000 ELECTROENCEPHALOGRAPHY 151,944 0 70.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 887,205 887,205 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,735,964 1,735,964 0 73.00 0010 09000 CLINIC 64,885 64,885 0 90.01 90.01 90.00 09000 CLINIC 2,715,641 2,715,641 0 90.02							
65.00 06500 RESPIRATORY THERAPY 902,786 0 902,786 0 65.00 66.00 06600 PHYSI CAL THERAPY 1,444,832 0 1,444,832 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 222,083 0 222,083 0 66.00 68.00 06800 SPEECH PATHOLOGY 121,631 0 121,631 0 68.00 70.00 07000 ELECTROENCEPHALOGRAPHY 11,686 11,686 0 0 70.00 70.01 CARDI OPULMONARY 151,944 151,944 0 0 70.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 887,205 887,205 0 0 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 1,735,964 0 0 73.00 73.00 O7300 DRUGS CHARAED TO PATI ENTS 843,753 843,753 0 0 90.01 990.02 CLI NI C 843,753 0 90.02 90.01 90.02 <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td>						0	
66.00 06600 PHYSI CAL THERAPY 1,444,832 0 1,444,832 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 222,083 0 222,083 0 67.00 68.00 06800 SPEECH PATHOLOGY 121,631 0 121,631 0 68.00 70.00 OTODO ELECTROENCEPHALOGRAPHY 11,686 0 0 70.00 70.01 O7010 CARDI OPULMONARY 151,944 151,944 0 0 70.01 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 887,205 887,205 0 0 71.00 72.00 IMPL. DEV. CHARGED TO PATI ENTS 1,735,964 0 0 0 73.00 0 73.00 0 73.00 0 73.00 0 0 73.00 0 90.01 90001 JV CLI NI C 843,753 843,753 0 0 90.01 90.02 90.02 001 CLI NI C 843,753 843,753 0 0 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.0			0				•
67.00 06700 0CCUPATI ONAL THERAPY 222,083 0 222,083 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 121,631 0 121,631 0 68.00 70.00 07000 ELECTROENCEPHALOGRAPHY 11,686 11,686 0 0 70.00 70.01 CARDI OPULMONARY 151,944 151,944 0 0 70.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 887,205 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 63,950 63,950 0 0 72.00 73.00 073000 DRUGS CHARGED TO PATIENTS 1,735,964 1,735,964 0 0 73.00 00.00 O9000 CLI NI C 843,753 843,753 0 0 90.01 90.01 90.00 90.01 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.02 90.03 90.03 0 90.03 90.03 0 90.03 90.03 90.03 90.03 91.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td>			0			0	
68.00 06800 SPEECH PATHOLOGY 121,631 0 121,631 0 68.00 70.00 07000 ELECTROENCEPHALOGRAPHY 11,686 11,686 0 0 70.00 70.01 07001 CARDIOPULMONARY 151,944 151,944 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 887,205 887,205 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 887,205 63,950 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,735,964 1,735,964 0 73.00 01000 09000 CLINIC 64,885 64,885 0 0 90.02 90.02 90.02 90.03 90.03 90.03 90.03 90.03 90.03			0			0	
70.00 07000 ELECTROENCEPHALOGRAPHY 11,686 0 0 70.00 70.01 07001 CARDI OPULMONARY 151,944 151,944 0 0 70.01 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 887,205 887,205 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 887,205 63,950 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1,735,964 1,735,964 0 0 73.00 001741 ENT SERVICE COST CENTERS 1,735,964 1,735,964 0 0 90.01 90.01 90.01 90.02 90.02 90.01 90.02 90.01 90.02 90.01 9			0			-	•
70. 01 07001 CARDI OPULMONARY 151, 944 151, 944 0 0 70. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 887, 205 887, 205 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 63, 950 0 0 72. 00 0 0 72. 00 0 0 72. 00 0 0 72. 00 0 0 72. 00 0 0 0 72. 00 0 0 0 72. 00 0 0 72. 00 0 0 0 72. 00 0 0 0 72. 00 0 0 0 72. 00 0 0 0 73. 00 0 0 0 73. 00 0			0			0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 887, 205 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 63, 950 63, 950 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1, 735, 964 1, 735, 964 0 0 73.00 00100 CLINIC COST CENTERS 64, 885 64, 885 0 90.00 90.00 09000 CLINIC 64, 885 0 90.00 90.01 90.01 09001 JV CLINIC 843, 753 843, 753 0 90.02 90.02 09002 CLINIC - LAKESI DE 787, 701 787, 701 0 90.02 90.03 09003 CLINIC - QUICKCARE 430, 436 430, 436 0 90.03 91.00 09100 EMERGENCY 2, 715, 641 0 0 92.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 1, 631, 301 1, 631, 301 0 92.00 92.00 04950 BEHAVI OR HEALTH 545, 780 0 0 93.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>•</td>						-	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 63,950 63,950 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,735,964 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0						-	
73.00 DRUGS CHARGED TO PATIENTS 1,735,964 1,735,964 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 0 <						-	
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 64,885 0 0 90.00 90.01 09001 JV CLINIC 843,753 843,753 0 0 90.01 90.02 09002 CLINIC LAKESIDE 787,701 0 0 90.02 90.03 09003 CLINIC - QUICKCARE 430,436 430,436 0 0 90.03 91.00 09100 EMERGENCY 2,715,641 0 0 91.00 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 93.00 0 0 92.00 92.955,784 0 25,955,784 0 020.00 200.00 200.00 200.00 200.00 200.00 201.00 0 201.00 0 201.00 0 25,955							•
90.00 09000 CLINIC 64,885 64,885 0 0 90.00 90.01 09001 JV CLINIC 843,753 843,753 0 0 90.01 90.02 09002 CLINIC - LAKESIDE 787,701 787,701 0 0 90.02 90.03 09003 CLINIC - QUICKCARE 430,436 430,436 0 0 90.03 91.00 09100 EMERGENCY 2,715,641 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,631,301 1,631,301 0 92.00 93.00 04950 BEHAVIOR HEALTH 545,780 545,780 0 0 93.00 011.00 HOME HEALTH AGENCY 603,117 603,117 0 0 101.00 200.00 Subtotal (see instructions) 25,955,784 0 25,955,784 0 200.00 201.00		1,700,701		1,100,1			1 101 00
90.01 09001 JV CLINIC 843,753 0 0 90.01 90.02 09002 CLINIC - LAKESIDE 787,701 787,701 0 0 90.02 90.03 09003 CLINIC - QUICKCARE 430,436 430,436 0 0 90.03 91.00 09100 EMERGENCY 2,715,641 2,715,641 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,631,301 1,631,301 0 92.00 93.00 04950 BEHAVIOR HEALTH 545,780 545,780 0 0 93.00 011.00 HOME HEALTH AGENCY 603,117 603,117 0 0 101.00 200.00 Subtotal (see instructions) 25,955,784 0 25,955,784 0 200.00 201.00		64, 885		64.8	85 0	0	90.00
90.02 09002 CLINIC - LAKESIDE 787,701 0 0 90.02 90.03 09003 CLINIC - QUICKCARE 430,436 430,436 0 0 90.03 91.00 09100 EMERGENCY 2,715,641 2,715,641 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,631,301 1,631,301 0 92.00 93.00 04950 BEHAVIOR HEALTH 545,780 0 0 93.00 0THER REI MBURSABLE COST CENTERS 0 0 91.00 0 92.00 00,117 0 0 92.00 02.00 0 0 92.00 0 0 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 93.00 92.00 93.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>90.01</td>						0	90.01
90.03 09003 CLINIC - QUICKCARE 430,436 430,436 0 0 90.03 91.00 09100 EMERGENCY 2,715,641 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,631,301 1,631,301 0 92.00 93.00 04950 BEHAVIOR HEALTH 545,780 0 0 93.00 0THER REIMBURSABLE COST CENTERS 0 0 0 101.00 0 101.00 0 101.00 0 25,955,784 0 0 0 200.00 201.00 Subtotal (see instructions) 25,955,784 0 25,955,784 0 0 200.00 201.00 201.00 1,631,301 0 201.00 0 201.00 1,631,301 0 201.00 0 201.00 0 201.00 1,631,301 0 201.00 0 201.00 0 201.00 1,631,301 0 201.00						0	
91.00 09100 EMERGENCY 2,715,641 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,631,301 1,631,301 0 92.00 93.00 04950 BEHAVIOR HEALTH 545,780 0 0 93.00 0THER REIMBURSABLE COST CENTERS 0 0 93.00 0 0 93.00 101.00 HOME HEALTH AGENCY 603,117 0 0 0 0 101.00 200.00 Subtotal (see instructions) 25,955,784 0 0 0 200.00 201.00 1,631,301 0 0 201.00						0	90.03
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 1, 631, 301 1, 631, 301 0 92. 00 93. 00 93. 00 04950 BEHAVI OR HEALTH 0 94. 00 93. 00						0	
93.00 04950 BEHAVI OR HEALTH 545, 780 0 0 93.00 0THER REI MBURSABLE COST CENTERS 0 0 93.00 101.00 10100 HOME HEALTH AGENCY 603, 117 603, 117 0 101.00 200.00 Subtotal (see instructions) 25, 955, 784 0 25, 955, 784 0 200.00 201.00 Less Observation Beds 1, 631, 301 1, 631, 301 0 201.00							
OTHER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 603, 117 0 101.00 200.00 Subtotal (see instructions) 25, 955, 784 0 25, 955, 784 0 200.00 201.00 Less Observation Beds 1, 631, 301 0 201.00						0	
200.00 Subtotal (see instructions) 25, 955, 784 0 25, 955, 784 0 200.00 201.00 Less Observation Beds 1, 631, 301 1, 631, 301 0 201.00							
200.00 Subtotal (see instructions) 25, 955, 784 0 25, 955, 784 0 200.00 201.00 Less Observation Beds 1, 631, 301 1, 631, 301 0 201.00		603, 117		603, 1	17	0	101.00
201.00 Less Observation Beds 1, 631, 301 1, 631, 301 0 201.00	200.00 Subtotal (see instructions)		0			0	200.00
	201.00 Less Observation Beds			1, 631, 3	01	0	201.00
202.00 10TAI (see instructions) 24,324,483 0 24,324,483 0 0 202.00	202.00 Total (see instructions)	24, 324, 483	0	24, 324, 4	83 0	0	202.00

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

	LIVAN COUNTY CO	MMUNITY HOSPIT	AL .	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/30/2019 2:3	
		Title	× XVIII	Hospi tal	Cost	
		Charges			0001	
Cost Center Description	Inpatient	Outpati ent	Total (col. (6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 620, 868		3, 620, 86	8		30.00
31. 00 03100 I NTENSI VE CARE UNI T	433, 007		433, 00	7		31.00
43. 00 04300 NURSERY	228, 096		228, 09	6		43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	620, 704	4, 504, 831	5, 125, 53	5 0. 400642	0.00000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	26, 954	24, 893	51, 84	7 1. 504504	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	126, 368	702, 656	829, 02	4 0. 027476	0.00000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	507, 004	12, 764, 943	13, 271, 94	7 0. 131126	0.00000	54.00
54. 01 05401 ULTRASOUND	191, 682	2, 558, 096	2, 749, 77	8 0. 091833	0.00000	54.01
56. 00 05600 RADI OI SOTOPE	8, 343	504, 191	512, 53	4 0. 287762	0.00000	56.00
60. 00 06000 LABORATORY	886, 589	13, 639, 618	14, 526, 20	7 0. 196441	0. 000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	202, 541	304, 822	507, 36	3 0. 036877	0. 000000	63.00
64.00 06400 INTRAVENOUS THERAPY	163, 063	1, 152, 099	1, 315, 16	2 0. 123913	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	638, 765	1, 716, 199	2, 354, 96	4 0. 383354	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	132, 491	2, 406, 205	2, 538, 69	6 0. 569124	0. 000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	9, 570	432, 387	441, 95	7 0. 502499	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	7, 411	102, 052	109, 46	3 1. 111161	0. 000000	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	5, 339	31, 191	36, 53	0 0. 319901	0. 000000	70.00
70. 01 07001 CARDI OPULMONARY	1, 616	388, 588	390, 20	4 0. 389396	0.000000	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 084, 709	3, 835, 646	5, 920, 35	5 0. 149857	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	91, 550	273, 243	364, 79	3 0. 175305	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	995, 091	2, 393, 109	3, 388, 20	0 0. 512356	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	112, 021	112, 02	1 0. 579222	0.00000	90.00
90. 01 09001 JV CLINIC	0	1, 398, 678	1, 398, 67		0.00000	90.01
90. 02 09002 CLINIC - LAKESIDE	0	843, 698	843, 69	8 0. 933629	0.00000	90.02
90. 03 09003 CLINIC - QUICKCARE	0	550, 516		6 0. 781877	0.00000	90.03
91.00 09100 EMERGENCY	255, 109	9, 404, 209	9, 659, 31	8 0. 281142	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	59, 961	2, 385, 018	2, 444, 97	9 0. 667205	0. 000000	92.00
93. 00 04950 BEHAVI OR HEALTH	3, 738	744, 276	748, 01	4 0. 729639	0.00000	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	390, 615				101.00
200.00 Subtotal (see instructions)	11, 300, 569	63, 563, 800	74, 864, 36	9		200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	11, 300, 569	63, 563, 800	74, 864, 36	9		202.00

ealth Financial Systems St	JELIVAN COUNTY COMM	UNITY HUSPITAL	In Lie	u of Form CMS-2552-
OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1327	Peri od:	Worksheet C
			From 01/01/2018	
			To 12/31/2018	Date/Time Prepared
		Title XVIII	Hospi tal	5/30/2019 2:35 pm Cost
Cost Center Description	PPS Inpatient		позрітаі	COST
COST Center Description	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
0. 00 03000 ADULTS & PEDIATRICS				30.
I. 00 03100 I NTENSI VE CARE UNI T				31.
3. 00 04300 NURSERY				43.
ANCI LLARY SERVICE COST CENTERS				101
0. 00 05000 OPERATI NG ROOM	0. 000000			50.
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0, 000000			52.
8. 00 05300 ANESTHESI OLOGY	0. 000000			53.
. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.
. 01 05401 ULTRASOUND	0. 000000			54.
00 05600 RADI OI SOTOPE	0, 000000			56.
00 06000 LABORATORY	0.000000			60.
. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.
. 00 06400 I NTRAVENOUS THERAPY	0.000000			64.
. 00 06500 RESPIRATORY THERAPY	0. 000000			65.
0. 00 06600 PHYSI CAL THERAPY	0.000000			66.
2. 00 06700 OCCUPATI ONAL THERAPY	0.000000			67.
3. 00 06800 SPEECH PATHOLOGY	0. 000000			68.
0. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000			70.
0. 01 07001 CARDI OPULMONARY	0. 000000			70.
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			70.
2. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000			71.
6. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.
OUTPATIENT SERVICE COST CENTERS	0.000000			/3.
0.00 09000 CLINIC	0, 000000			90.
0. 01 09001 JV CLINIC	0. 000000			90.
0. 02 09002 CLINIC - LAKESIDE	0. 000000			90.
0. 03 09003 CLINIC - QUICKCARE	0. 000000			90.
. 00 09100 EMERGENCY	0. 000000			91.
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.
8. 00 04950 BEHAVI OR HEALTH	0. 000000			93.
OTHER REIMBURSABLE COST CENTERS	0.000000			70.
01. 00 10100 HOME HEALTH AGENCY				101.
00.00 Subtotal (see instructions)				200.
1.00 Less Observation Beds				201.
02.00 Total (see instructions)				202.

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-1327	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/30/2019 2:3	pared:
	_	Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1100	2.00	0.00	11 00	0100	
30. 00 03000 ADULTS & PEDI ATRI CS	4, 445, 385		4, 445, 38	5 0	4, 445, 385	30.00
31. 00 03100 I NTENSI VE CARE UNI T	867, 794		867, 79			•
43. 00 04300 NURSERY	148,095		148, 09			
ANCI LLARY SERVI CE COST CENTERS	1	I				1
50. 00 05000 OPERATI NG ROOM	2,053,504		2, 053, 50	4 0	2, 053, 504	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	78,004		78, 00			
53.00 05300 ANESTHESI OLOGY	22, 778		22, 77			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 740, 298		1, 740, 29			•
54. 01 05401 ULTRASOUND	252, 519		252, 51		252, 519	•
56. 00 05600 RADI OI SOTOPE	147, 488		147, 48		147, 488	•
60. 00 06000 LABORATORY	2, 853, 548		2, 853, 54			
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	18, 710		18, 71		18, 710	•
64.00 06400 I NTRAVENOUS THERAPY	162, 966		162, 96			•
65. 00 06500 RESPI RATORY THERAPY	902, 786				902, 786	
66.00 06600 PHYSI CAL THERAPY	1, 444, 832				1, 444, 832	
67.00 06700 OCCUPATIONAL THERAPY	222,083		222, 08		222, 083	
68.00 06800 SPEECH PATHOLOGY	121,631		121, 63		121, 631	•
70.00 07000 ELECTROENCEPHALOGRAPHY	11, 686		11, 68		11, 686	
70. 01 07001 CARDI OPULMONARY	151, 944		151, 94		151, 944	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	887, 205		887, 20		887, 205	•
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	63, 950		63, 95		63, 950	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 735, 964		1, 735, 96	4 0	1, 735, 964	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	64, 885		64, 88	5 0	64, 885	90.00
90. 01 09001 JV CLINIC	843, 753		843, 75	3 0	843, 753	90.01
90. 02 09002 CLINIC - LAKESIDE	787, 701		787, 70	1 0	787, 701	90.02
90. 03 09003 CLINIC - QUICKCARE	430, 436		430, 43	6 0	430, 436	90.03
91. 00 09100 EMERGENCY	2, 715, 641		2, 715, 64	1 0	2, 715, 641	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 631, 301		1, 631, 30	1	1, 631, 301	92.00
93.00 04950 BEHAVI OR HEALTH	545, 780		545, 78	0 0	545, 780	93.00
OTHER REIMBURSABLE COST CENTERS]
101.00 10100 HOME HEALTH AGENCY	603, 117		603, 11	7	603, 117	
200.00 Subtotal (see instructions)	25, 955, 784	0	25, 955, 78	4 0		
201.00 Less Observation Beds	1, 631, 301		1, 631, 30		1, 631, 301	
202.00 Total (see instructions)	24, 324, 483	0	24, 324, 48	3 0	24, 324, 483	202.00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CC	CN: 15-1327	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/30/2019 2:3	pared:	
				e XIX	Hospi tal	Cost		
	Cost Center Description	Inpati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o		
		6.00	7.00	8.00	9.00	10.00		
1	NPATIENT ROUTINE SERVICE COST CENTERS			•				
30.00	D3000 ADULTS & PEDIATRICS	3, 620, 868		3, 620, 86	8		30.00	
31.00	D3100 INTENSIVE CARE UNIT	433, 007		433, 00)7		31.00	
	D4300 NURSERY	228, 096		228, 09	6		43.00	
	ANCILLARY SERVICE COST CENTERS							
	D5000 OPERATI NG ROOM	620, 704	4, 504, 831	5, 125, 53		0. 000000		
	D5200 DELIVERY ROOM & LABOR ROOM	26, 954	24, 893	51, 84		0. 000000		
	D5300 ANESTHESI OLOGY	126, 368	702, 656			0. 000000	53.00	
	D5400 RADI OLOGY-DI AGNOSTI C	507, 004	12, 764, 943			0. 000000		
	05401 ULTRASOUND	191, 682	2, 558, 096			0. 000000		
	D5600 RADI OI SOTOPE	8, 343	504, 191	512, 53		0. 000000		
	D6000 LABORATORY	886, 589	13, 639, 618			0.00000		
	D6300 BLOOD STORING, PROCESSING & TRANS.	202, 541	304, 822	507, 36		0. 000000		
	D6400 I NTRAVENOUS THERAPY	163, 063	1, 152, 099			0. 000000		
	06500 RESPI RATORY THERAPY	638, 765	1, 716, 199			0. 000000		
	D6600 PHYSI CAL THERAPY	132, 491	2, 406, 205	2, 538, 69		0. 000000		
	D6700 OCCUPATI ONAL THERAPY	9, 570	432, 387	441, 95		0. 000000		
	D6800 SPEECH PATHOLOGY	7, 411	102, 052	109, 46		0. 000000		
	07000 ELECTROENCEPHALOGRAPHY	5, 339	31, 191	36, 53		0. 000000	70.00	
	07001 CARDI OPULMONARY	1, 616	388, 588			0. 000000		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 084, 709	3, 835, 646			0. 000000		
	D7200 IMPL. DEV. CHARGED TO PATIENT	91, 550	273, 243			0. 000000		
	D7300 DRUGS CHARGED TO PATIENTS	995, 091	2, 393, 109	3, 388, 20	0 0. 512356	0.00000	73.00	
	DUTPATIENT SERVICE COST CENTERS							
	09000 CLI NI C	0	112, 021	112, 02		0.00000		
	D9001 JV CLINIC	0	1, 398, 678			0. 000000		
	D9002 CLINIC - LAKESIDE	0	843, 698			0. 000000		
	D9003 CLINIC – QUICKCARE	0	550, 516	550, 51		0.00000		
	D9100 EMERGENCY	255, 109	9, 404, 209			0. 000000		
	D9200 OBSERVATION BEDS (NON-DISTINCT PART)	59, 961	2, 385, 018			0. 000000		
	D4950 BEHAVI OR HEALTH	3, 738	744, 276	748, 01	4 0. 729639	0.00000	93.00	
	OTHER REIMBURSABLE COST CENTERS							
	10100 HOME HEALTH AGENCY	0	390, 615				101.00	
200.00	Subtotal (see instructions)	11, 300, 569	63, 563, 800	74, 864, 36	9		200. 00	
201.00	Less Observation Beds		/a				201.00	
202.00	Total (see instructions)	11, 300, 569	63, 563, 800	74, 864, 36	99		202.00	

ealth Financial Systems SU	ILLIVAN COUNTY COMM	UNITY HUSPITAL	In Lie	u of Form CMS-2552-
OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1327	Peri od:	Worksheet C
			From 01/01/2018	
			To 12/31/2018	Date/Time Prepared
		Title XIX	Hospi tal	5/30/2019 2:35 pm
Cost Center Description	PPS Inpatient		HOSPILA	Cost
cost center bescription	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
0. 00 03000 ADULTS & PEDIATRICS				30.
1. 00 03100 INTENSIVE CARE UNIT				30.
3. 00 04300 NURSERY				43.
ANCI LLARY SERVICE COST CENTERS				43.
0. 00 05000 OPERATING ROOM	0. 000000			50.
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0.000000			50.
3. 00 05300 ANESTHESI OLOGY	0. 000000			53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.
I. 01 05401 ULTRASOUND	0. 000000			54.
0. 00 05600 RADI OI SOTOPE	0. 000000			56.
0. 00 06000 LABORATORY	0. 000000			60.
. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.
00 06400 INTRAVENOUS THERAPY	0. 000000			64.
5. 00 06500 RESPI RATORY THERAPY	0. 000000			65.
5. 00 06600 PHYSI CAL THERAPY	0. 000000			66.
7. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.
3. 00 06800 SPEECH PATHOLOGY	0. 000000			68.
D. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.
D. 01 07001 CARDI OPULMONARY	0. 000000			70.
I. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.
OUTPATIENT SERVICE COST CENTERS				
0. 00 09000 CLINIC	0. 000000			90.
). 01 09001 JV CLINIC	0. 000000			90.
). 02 09002 CLINIC - LAKESIDE	0. 000000			90.
D. 03 09003 CLINIC - QUICKCARE	0. 000000			90.
1.00 09100 EMERGENCY	0. 000000			91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.
3. 00 04950 BEHAVI OR HEALTH	0. 000000			93.
OTHER REIMBURSABLE COST CENTERS				
D1. 00 10100 HOME HEALTH AGENCY				101.
00.00 Subtotal (see instructions)				200.
01.00 Less Observation Beds				201.
02.00 Total (see instructions)				202.

Health Financial Systems SUL	LIVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Peri od:	Worksheet D	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/30/2019 2:3	pared:
		Title	e XVIII	Hospi tal	Cost	s pili
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	5	· · ·	
	26)	,	, i			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	÷	•	•			
50.00 05000 OPERATING ROOM	249, 438	5, 125, 535	0. 04866	6 142, 087	6, 915	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	10, 533	51, 847	0. 20315	55 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	7,643	829, 024	0.00921	9 31, 826	293	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	154, 956	13, 271, 947	0. 0116	240, 638	2, 809	54.00
54. 01 05401 ULTRASOUND	7, 887	2, 749, 778	0.00286	68 115, 431	331	54.01
56. 00 05600 RADI OI SOTOPE	7, 324	512, 534	0.01429	5, 632	80	56.00
60. 00 06000 LABORATORY	87, 530	14, 526, 207	0. 00602	497, 416	2, 997	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	2, 525	507, 363	0.00497	7 56, 476	281	63.00
64.00 06400 I NTRAVENOUS THERAPY	9, 849	1, 315, 162	0.00748	95, 418	715	64.00
65. 00 06500 RESPI RATORY THERAPY	40, 564	2, 354, 964	0. 01722	303, 274	5, 224	65.00
66. 00 06600 PHYSI CAL THERAPY	99, 339	2, 538, 696	0. 03913	31, 681	1, 240	66.00
67.00 06700 OCCUPATI ONAL THERAPY	5, 577	441, 957	0. 0126	9 1, 454	18	67.00
68.00 06800 SPEECH PATHOLOGY	3, 991	109, 463	0. 03646	5, 379	196	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	2, 981	36, 530	0. 08160	3, 867	316	70.00
70. 01 07001 CARDI OPULMONARY	22, 247	390, 204	0. 05701	4 0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	32, 271	5, 920, 355	0.00545	628, 642	3, 427	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 318	364, 793	0.00635	22, 878	145	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	43, 646	3, 388, 200	0. 01288	482, 751	6, 219	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	5, 718				0	
90. 01 09001 JV CLINIC	68, 751				0	
90. 02 09002 CLINIC - LAKESIDE	84, 971				0	
90. 03 09003 CLINIC – QUICKCARE	61, 656	550, 516			0	90.03
91. 00 09100 EMERGENCY	152, 368				161	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	127, 581				0	92.00
93. 00 04950 BEHAVI OR HEALTH	60, 499				0	
200.00 Total (lines 50 through 199)	1, 352, 163	70, 191, 783		2, 675, 071	31, 367	200.00

Heal th	Financial Systems SU	LLIVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-:	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE SH COSTS	RVICE OTHER PASS			Period: From 01/01/2018 To 12/31/2018		
			Titl€	e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown	-	Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3.00	
	ANCI LLARY SERVICE COST CENTERS			-			
50.00	05000 OPERATING ROOM	0	C)	0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C)	0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
54.01	05401 ULTRASOUND	0	C		0 0	0	54.01
56.00	05600 RADI OI SOTOPE	0	C		0 0	0	56.00
60.00	06000 LABORATORY	0	C		0 0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	C		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	70.00
70.01	07001 CARDI OPULMONARY	0	C		0 0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	C)	0 0	0	90.00
90.01	09001 JV CLINIC	0	C		0 0	0	90.01
90. 02	09002 CLINIC - LAKESIDE	0	C		0 0	0	90.02
90.03	09003 CLINIC - QUICKCARE	0	C		0 0	0	90.03
91.00	09100 EMERGENCY	0	C		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	04950 BEHAVI OR HEALTH	0	C		0 0	0	93.00
200.00		0	C		0 0	0	200.00
					1		•

Health Financial Systems SUL	LIVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS	S Provider C	CN: 15-1327	Period: From 01/01/2018 To 12/31/2018		pared:
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1	-	-		-	
50. 00 05000 OPERATI NG ROOM	0	0		0 5, 125, 535		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 51, 847		
53. 00 05300 ANESTHESI OLOGY	0	0		0 829, 024		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 13, 271, 947		
54. 01 05401 ULTRASOUND	0	0		0 2, 749, 778		
56. 00 05600 RADI OI SOTOPE	0	0		0 512, 534		
60. 00 06000 LABORATORY	0	0		0 14, 526, 207	0.000000	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 507, 363		
64.00 06400 INTRAVENOUS THERAPY	0	0		0 1, 315, 162		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 2, 354, 964		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 538, 696		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 441, 957		
68.00 06800 SPEECH PATHOLOGY	0	0)	0 109, 463	0.000000	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 36, 530	0. 000000	70.00
70. 01 07001 CARDI OPULMONARY	0	C)	0 390, 204	0. 000000	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C)	0 5, 920, 355	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0)	0 364, 793	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C)	0 3, 388, 200	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 112, 021	0. 000000	
90. 01 09001 JV CLINIC	0	0		0 1, 398, 678		
90. 02 09002 CLINIC - LAKESIDE	0	0)	0 843, 698	0.000000	90.02
90. 03 09003 CLINIC - QUICKCARE	0	0)	0 550, 516	0. 000000	90.03
91. 00 09100 EMERGENCY	0	0)	0 9, 659, 318	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 2, 444, 979		
93. 00 04950 BEHAVI OR HEALTH	0	0		0 748, 014		•
200.00 Total (lines 50 through 199)	0	0		0 70, 191, 783		200.00

Health Financial Systems SUL	LIVAN COUNTY COM	MUNITY HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF		Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/30/2019 2:3	pared:
		Title	XVIII	Hospi tal	Cost	o pili
Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.	Ũ	Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			-		-	
50.00 05000 OPERATI NG ROOM	0. 000000	142, 087		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	31, 826		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	240, 638		0 0	0	54.00
54. 01 05401 ULTRASOUND	0. 000000	115, 431		0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0. 000000	5, 632		0 0	0	56.00
60. 00 06000 LABORATORY	0. 000000	497, 416		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	56, 476		0 0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	95, 418		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	303, 274		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	31, 681		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 454		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	5, 379		0 0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	3, 867		0 0	0	70.00
70. 01 07001 CARDI OPULMONARY	0. 000000	0		0 0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	628, 642		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	22, 878		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	482, 751		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 JV CLINIC	0. 000000	0		0 0	0	90. 01
90. 02 09002 CLINIC - LAKESIDE	0. 000000	0		0 0	0	90. 02
90. 03 09003 CLINIC – QUICKCARE	0. 000000	0		0 0	0	90.03
91.00 09100 EMERGENCY	0. 000000	10, 221		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
93.00 04950 BEHAVI OR HEALTH	0. 000000	0		0 0	0	93.00
200.00 Total (lines 50 through 199)		2, 675, 071		0 0	0	200. 00

Health Financial Systems SUL	LIVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C		Period: From 01/01/2018 Fo 12/31/2018	Date/Time Pre	pared:
		Title	XVIII	Hospi tal	5/30/2019 2:3 Cost	s pili
		iiiie	Charges	nospi tai	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	()	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 400642	0	1, 626, 49	7 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 504504	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 027476	0	214, 75	6 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 131126	0	4, 640, 16	3 0	0	54.00
54. 01 05401 ULTRASOUND	0. 091833	0	683, 59	4 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0. 287762	0	177, 57		0	56.00
60. 00 06000 LABORATORY	0. 196441	0	5, 024, 94		0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 036877	0	120, 26		0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 123913	0	588, 72		0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 383354	0	630, 43		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 569124	0	927,06		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 502499	0	120, 65		0	67.00
68.00 06800 SPEECH PATHOLOGY	1. 111161	0	15, 25		0	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 319901	0	8, 89		0	70.00
70. 01 07001 CARDI OPULMONARY	0. 389396	0	213, 72		0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 149857	0	1, 327, 68		0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 175305	0	99, 45		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 512356	0	685, 01		0	73.00
OUTPATIENT SERVICE COST CENTERS					-	
90. 00 09000 CLI NI C	0. 579222	0	47,03	4 0	0	90.00
90. 01 09001 JV CLINIC	0. 603250	0	822, 26		0	90.01
90. 02 09002 CLINIC - LAKESIDE	0. 933629	0	168, 41		0	90.02
90. 03 09003 CLINIC - QUICKCARE	0. 781877	0	32, 52		0	90.03
91. 00 09100 EMERGENCY	0. 281142	0	2, 918, 96		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 667205	0	929, 00		0	92.00
93. 00 04950 BEHAVI OR HEALTH	0. 729639	0	532, 57		0	93.00
200.00 Subtotal (see instructions)		0	22, 555, 45		0	200.00
201.00 Less PBP Clinic Lab. Services-Program		Ū.	,,	0	Ū	201.00
Only Charges				_		
202.00 Net Charges (line 200 - line 201)		0	22, 555, 45	9 123, 169	0	202. 00

Health Financial Systems SUL	LIVAN COUNTY CO	MMUNITY HOSPITA	AL	In Lie	u of Form CMS.	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider CC		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pro 5/30/2019 2:	epared: 35 pm
	1	Title	XVIII	Hospi tal	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coi ns.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	(54 (40					
50. 00 05000 OPERATING ROOM	651, 643					50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	5, 901	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	608, 446					54.00
54. 01 05401 ULTRASOUND	62, 776					54.01
56. 00 05600 RADI 0I SOTOPE	51,099					56.00
	987, 106					60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	4, 435					63.00
64.00 06400 INTRAVENOUS THERAPY	72, 950					64.00
65. 00 06500 RESPI RATORY THERAPY	241, 680					65.00
66. 00 06600 PHYSI CAL THERAPY	527, 614					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	60, 628					67.00
68. 00 06800 SPEECH PATHOLOGY	16, 951	0				68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 847					70.00
70. 01 07001 CARDI OPULMONARY	83, 223					70.01
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	198, 962					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	17, 434					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	350, 973	55, 472				73.00
0UTPATI ENT_SERVICE_COST_CENTERS 90. 00 09000 CLINIC	27, 243	0				
90. 00 09000 CLINIC 90. 01 09001 JV CLINIC	496, 029					90.00 90.01
90. 02 09002 CLINIC - LAKESIDE 90. 03 09003 CLINIC - QUICKCARE	157, 232 25, 429					90. 02 90. 03
90. 03 09003 CLINIC - OUTCREARE 91. 00 09100 EMERGENCY	820, 643					90.03
91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	619, 837	-				91.00
92.00 04950 BEHAVIOR HEALTH	388, 584	-				92.00
200.00 Subtotal (see instructions)	6, 479, 665					200.00
201.00 Less PBP Clinic Lab. Services-Program	0, 479, 003					200.00
Only Charges						201.00
202. 00 Net Charges (line 200 - line 201)	6, 479, 665	57, 705				202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-322 Component CCN: 15-322 To Provider CCN: 15-322 To	Health Financial Systems SUL	LIVAN COUNTY COM	MMUNITY HOSPIT.	AL	In Lie	eu of Form CMS-2	2552-10
ANCI LLARY SERVICE COST CENTERS Cost Control Description Cost Cost Control Cost Cost Cost Cost Cost Cost Cost Cost	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CO				
And Listen Product Services (cs) Services (cs) Cost Cost center Description Cost Cost Cost Cost Cost Cost Reimbursed Reimbursed Reimbursed Subject To Ded. & Coins Subject To Ded. & Coins Subject To Ded. & Coins (cse inst.) Cost Cost Cost Cost Cost Cost Cost Cost			Component (nared
Anci LLARY SERVICE COST CENTERS Cost Cost Subject To Baseria prior Center Description Cost Cost Cost Subject To Baseria Center Cost Subject To Baseria Center Cent			oomponente v			5/30/2019 2:3	5 pm
Cost Center Description Cost to Charge PPS Reinbursed Worksheet C, Part I, col. 9 Services (see inst.) Cost Reinbursed Services Subject To det & Coins. (see inst.) Cost Reinbursed Services Subject To det & Coins. (see inst.) PPS Services Subject To det & Coins. (see inst.) 50.00 OS000 (PERATING ROOM 0.400642 0 0 0 5.00 50.00 OS000 (PERATING ROOM 0.400642 0 0 0 50.00 50.00 OS000 (PERATING ROOM 0.207476 0 0 0 53.00 50.00 OS000 (ARESTHES) CLOCY 0.27476 0 0 0 54.00 54.00 OS000 (ARD RADIOLOGY-DI AGNOSTIC 0.131126 0 0 0 54.01 56.00 OS000 (ABD STHESTING PROCESSING & TRANS. 0.383354 0 0 0 0 66.00 66.00 OS000 SPECH PATHERAPY 0.569124 0 0 0 0 66.00 67.00 OCCOD CLEPHALOR			Title	XVIII	Swing Beds - SNF	Cost	
Ratio From Part I, col. 9 Relinbursed inst.) Relinbursed Subject To Ded. & Coins. Relinbursed Subject To Ded. & Coins. Relinbursed Subject To Ded. & Coins. Relinbursed Subject To Ded. & Coins. ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 (DEFLIVERY NOM & LABOR ROOM 0.400642 0 0 0 50.00 50.00 05000 (DELIVERY NOM & LABOR ROOM 1.504504 0 0 0 52.00 53.00 05300 (RADIOLOSY) 0.127476 0 0 0 53.00 54.01 05400 (RADIOLOSY) 0.131126 0 0 0 54.00 54.00 05400 (RADIOLOSY) 0.19441 0 0 0 56.00 63.00 06300 LABORATORY 0.196441 0 0 0 66.00 06500 RESPIRATORY THERAPY 0.383354 0 0 0 66.00 06700 OCCUPATIONAL THERAPY 0.569124 0 0 0 0 66.00 06700 OCCUPATIONAL THERAPY 0.569					-		
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72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.175305 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.512356 0 0 0 0 73.00 001 09000 CLINIC 0.579222 0 0 0 90.00 90.01 90.00 09001 JV CLINIC 0.603250 0 0 0 90.02 90.01 09002 CLINIC - LAKESIDE 0.93629 0 0 0 90.02 90.03 09003 CLINIC - QUICKCARE 0.781877 0 0 0 90.03 91.00 09100 EMERGENCY 0.281142 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0.667205 0 0 0 92.00 93.00 04950 BEHAVIOR HEALTH 0.729639 0 0 0 93.00 200.00 Less PBP Clinic Lab. Services-Program 0 0 0 0 201.00 201.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>-</td> <td></td>			0			-	
73.00 07300 DRUGS CHARGED TO PATIENTS 0.512356 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 0.579222 0 0 0 0 90.00 90.00 90.01 90.01 90.01 90.01 0 0 0 90.00 90.01 90.01 90.02 CLINIC 0.603250 0 0 0 90.02 90.02 CLINIC 0.603250 0 0 0 90.02 90.02 90.03 90.03 90.03 90.03 90.03 90.03 90.03 90.03 90.03 91.00 90.02 91.00 91.00 91.00 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 93.00 92.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 90.00 0 0 93.00 90.00 90.00 92.00			0			-	
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.579222 0 0 0 0 90.00 90.01 09001 JV CLINIC 0.603250 0 0 0 0 90.01 90.02 09002 CLINIC - LAKESIDE 0.933629 0 0 0 0 90.02 90.03 09003 CLINIC - QUICKCARE 0.781877 0 0 0 90.03 91.00 09100 EMERGENCY 0.281142 0 0 0 91.00 92.00 09200 DBSERVATION BEDS (NON-DI STINCT PART) 0.667205 0 0 0 92.00 93.00 04950 BEHAVIOR HEALTH 0.729639 0 0 0 93.00 200.00 Subtotal (see instructions) 0 0 0 0 200.00 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00			0			-	
90.00 09000 CLINIC 0.579222 0 0 0 0 90.00 90.01 09001 JV CLINIC 0.603250 0 0 0 0 90.01 90.02 09002 CLINIC - LAKESIDE 0.933629 0 0 0 0 90.02 90.03 09003 CLINIC - QUICKCARE 0.781877 0 0 0 90.03 91.00 PMERGENCY 0.281142 0 0 0 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 0.667205 0 0 0 92.00 93.00 04950 BEHAVIOR HEALTH 0.729639 0 0 0 93.00 200.00 Subtotal (see instructions) 0 0 0 200.00 200.00 201.00 201.00 201.00 201.00 0 0 0 201.00 201.00 0 0 201.00 0 0 201.00 0 0 201.00 201.00 201.00 0 201.00 201.00 201.00 201.00 201.		0. 312330	0		0 0		/3.00
90.01 09001 JV CLINIC 0.603250 0 0 0 90.01 90.02 09002 CLINIC - LAKESIDE 0.933629 0 0 0 90.02 90.03 09003 CLINIC - QUICKCARE 0.781877 0 0 0 90.03 91.00 09100 EMERGENCY 0.281142 0 0 0 91.00 92.00 09SERVATION BEDS (NON-DISTINCT PART) 0.667205 0 0 0 92.00 93.00 04950 BEHAVIOR HEALTH 0.729639 0 0 0 93.00 200.00 Subtotal (see instructions) 0 0 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00		0. 579222	0		0 0	0	90.00
90. 02 09002 CLINIC - LAKESIDE 0.933629 0 0 0 90.02 90. 03 09003 CLINIC - QUICKCARE 0.781877 0 0 0 90.03 91. 00 09100 EMERGENCY 0.281142 0 0 0 91.00 92. 00 09SERVATION BEDS (NON-DISTINCT PART) 0.667205 0 0 0 92.00 93. 00 04950 BEHAVIOR HEALTH 0.729639 0 0 0 93.00 200. 00 Subtotal (see instructions) 0 0 0 0 200.00 201.00 0 0 0 201.00 0 0 201.00 0 0 201.00 0 0 0 201.00 0 0 0 201.00 0 0 201.00 0 201.00 0 0 0 201.00 0 201.00 0 201.00 0 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 201.00 201.00 201.00 <td< td=""><td></td><td></td><td>0</td><td></td><td>0 0</td><td>-</td><td></td></td<>			0		0 0	-	
90.03 09003 CLINIC - QUICKCARE 0.781877 0 0 0 90.03 91.00 09100 EMERGENCY 0.281142 0 0 0 91.00 92.00 09SERVATION BEDS (NON-DISTINCT PART) 0.667205 0 0 0 92.00 93.00 04950 BEHAVIOR HEALTH 0.729639 0 0 0 93.00 200.00 Subtotal (see instructions) 0 0 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00			0		0 0	0	
91.00 09100 EMERGENCY 0.281142 0 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.667205 0 0 0 92.00 93.00 04950 BEHAVIOR HEALTH 0.729639 0 0 0 93.00 200.00 Subtotal (see instructions) 0 0 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00			0		0 0	0	90.03
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 667205 0 0 0 92. 00 93. 00 04950 BEHAVI OR HEALTH 0. 729639 0 0 0 93. 00 200. 00 Subtotal (see instructions) 0 0 0 0 0 200. 00 201. 00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201. 00			0		0 0	0	91.00
93. 00 04950 BEHAVI OR HEALTH 0. 729639 0 0 0 93. 00 200. 00 Subtotal (see instructions) 0 0 0 0 0 200. 00 201. 00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 0 201. 00			0		0 0	0	
200.00Subtotal (see instructions)000200.00201.00Less PBP Clinic Lab. Services-Program00201.00Only Charges00201.00			0		0 0	0	
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges 0 0 201.00			0		0 0	0	200. 00
Only Charges					0 0	l	201.00
202.00 Net Charges (line 200 - line 201) 0 0 0 0 0 202.00						ł	
	202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00

Health Financial Systems SULI	LIVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-2552-1	10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared	
		•			5/30/2019 2:35 pm	_
			XVIII	Swing Beds - SNF	Cost	_
Cost Conton Description	Cost	sts Cost	-			
Cost Center Description	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						_
50.00 05000 OPERATI NG ROOM	0	0	1		50.0	00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52.0)0
53. 00 05300 ANESTHESI OLOGY	0	0			53.0)0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54.0)0
54. 01 05401 ULTRASOUND	0	0			54.0)1
56. 00 05600 RADI OI SOTOPE	0	0			56.0)0
60. 00 06000 LABORATORY	0	0			60.0)0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.0)0
64. 00 06400 I NTRAVENOUS THERAPY	0	0			64.0)0
65. 00 06500 RESPI RATORY THERAPY	0	0			65.0)0
66. 00 06600 PHYSI CAL THERAPY	0	0			66.0)0
67.00 06700 OCCUPATI ONAL THERAPY	0	0			67.0	
68.00 06800 SPEECH PATHOLOGY	0	0			68.0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			70.0	
70. 01 07001 CARDI OPULMONARY	0	0			70.0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0				72.0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0			73.0)0
OUTPATIENT SERVICE COST CENTERS	-		1			
90. 00 09000 CLI NI C	0	-			90.0	
90. 01 09001 JV CLINIC	0	-	•		90.0	
90. 02 09002 CLINIC - LAKESIDE 90. 03 09003 CLINIC - QUICKCARE	0	0			90.0	
	0	0			90.0 91.0	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			91.0	
93. 00 04950 BEHAVIOR HEALTH	0				92.0	
200.00 Subtotal (see instructions)		-			200. 0	
200.00 Subtotal (see Fistractions) 201.00 Less PBP Clinic Lab. Services-Program		-			200.0	
Only Charges	0				201.0	,0
202.00 Net Charges (line 200 - line 201)	0	0			202.0	00
		. 0	I		1202.0	

	LIVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1327	Period: From 01/01/2018 To 12/31/2018		pared:
		Titl	e XIX	Hospi tal	Cost	
			Charges	noopritai	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	. ,	
	Part I, col. 9	,	Subject To	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 400642	0	14, 90	0 80	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 504504	0	8	76 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 027476	0	3, 22	23 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 131126	0	244, 8	0 8	0	54.00
54. 01 05401 ULTRASOUND	0. 091833	0	81, 11	12 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 287762	0	3, 90	60 0	0	56.00
60. 00 06000 LABORATORY	0. 196441	0	288, 05	53 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 036877	0	8, 40	09 0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0. 123913	0	10, 60	06 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 383354	0	28, 73	35 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 569124	0	25, 20	01 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 502499	0	5, 05	6 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1. 111161	0	6, 7	78 0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 319901	0	80	0 0	0	70.00
70. 01 07001 CARDI OPULMONARY	0. 389396	0	1, 08	37 0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 149857	0	89, 43	35 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 175305	0	1, 7:	30 O	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 512356	0	35, 92	25 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	·	•	•	÷		1
90. 00 09000 CLINIC	0. 579222	0	2, 3	79 0	0	90.00
90. 01 09001 JV CLINIC	0. 603250	0	12, 49	99 0	0	90.01
90. 02 09002 CLINIC - LAKESIDE	0. 933629	0		0 0	0	90.02
90. 03 09003 CLINIC – QUICKCARE	0. 781877	0		0 0	0	90.03
91.00 09100 EMERGENCY	0. 281142	0	323, 32	28 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 667205	0	95, 63	34 0	0	92.00
93.00 04950 BEHAVIOR HEALTH	0. 729639	0		0 0	0	93.00
200.00 Subtotal (see instructions)		0	1, 284, 64	12 0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	1, 284, 64	12 0	0	202.00

ealth Financial Systems SUL VPORTIONMENT OF MEDICAL. OTHER HEALTH SERVICES AND		MMUNITY HOSPIT	CN: 15-1327	Period:	u of Form CMS-2 Worksheet D	2552-
IPPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	J VACCINE CUST	Provider C	CN: 15-1327	From 01/01/2018	Part V	
				To 12/31/2018	Date/Time Prep	pared
					5/30/2019 2:35	5 pm
			le XIX	Hospi tal	Cost	
Cost Conton Description	Cost	Cost	-			
Cost Center Description	Reimbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	1			
ANCI LLARY SERVI CE COST CENTERS						
0. 00 05000 OPERATING ROOM	5, 973	()			50.
2.00 05200 DELIVERY ROOM & LABOR ROOM	1, 318	(D			52.
3. 00 05300 ANESTHESI OLOGY	89	(D			53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	32, 102	(D			54.
4. 01 05401 ULTRASOUND	7,449	(D			54.
5. 00 05600 RADI OI SOTOPE	1, 140	(56.
D. 00 06000 LABORATORY	56, 585	(D			60.
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	310	(D			63.
4. 00 06400 I NTRAVENOUS THERAPY	1, 314	(D			64.
5. 00 06500 RESPI RATORY THERAPY	11, 016	(D			65.
6. 00 06600 PHYSI CAL THERAPY	14, 342	(D			66.
7.00 06700 OCCUPATI ONAL THERAPY	2, 541	(D			67.
B. 00 06800 SPEECH PATHOLOGY	7, 531	(D			68.
D. 00 07000 ELECTROENCEPHALOGRAPHY	285	(D			70.
D. 01 07001 CARDI OPULMONARY	423	(D			70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 402		D			71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	303	(72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	18, 406	()			73.
OUTPATIENT SERVICE COST CENTERS	1		1			
D. 00 09000 CLINIC	1, 378					90.
D. 01 09001 JV CLINIC	7, 540					90.
D. 02 09002 CLINIC - LAKESIDE	0					90.
D. 03 09003 CLINIC - QUICKCARE	0					90.
1.00 09100 EMERGENCY	90, 901	(91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	63, 807					92.
3. 00 04950 BEHAVI OR HEALTH	0	(93.
00.00 Subtotal (see instructions)	338, 155	(ע			200.
01.00 Less PBP Clinic Lab. Services-Program	0					201.
000 000 000 000 000 000 000 000 000 00	220 155					202
02.00 Net Charges (line 200 - line 201)	338, 155	l ()		ŀ	202.

Health Financial System

SULLI VAN	COUNTY	COMMUNI TY	HOSPI TAL

leal th	Financial Systems SULLIVAN COUNTY COMM	UNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-1
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1327	Peri od:	Worksheet D-1	
			From 01/01/2018 To 12/31/2018	Date/Time Prep 5/30/2019 2:3	
	Cast Castas Description	Title XVIII	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			3, 500	
. 00 . 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room davs	3, 000 0	2. C 3. C
. 00	do not complete this line.	ijs). Ti you have only p	rvate room days,	0	0.0
. 00	Semi-private room days (excluding swing-bed and observation b			1, 733	4.0
. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	444	5.0
. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om davs) after Decomber	21 of the cost	0	6.0
. 00	reporting period (if calendar year, enter 0 on this line)	on days) after becenber	ST OF THE COST	0	0.0
. 00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	56	7.0
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	8.0
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	a swing-bed and	1, 024	9.0
	newborn days)	0 .			
0.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	444	10.0
1.00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11. (
1.00	December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	11.0
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.0
2 00	through December 31 of the cost reporting period	V only (including prive	to room days)	0	12
3.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13. (
4.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.0
5.00	Total nursery days (title V or XIX only)		-	0	
6.00	Nursery days (title V or XIX only)			0	16. (
7.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31 (of the cost		17. (
7.00	reporting period	the ough becember of t			17. \
8.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18. (
9.00	reporting period Medicaid rate for swing-bed NF services applicable to service	c through December 21 of	E the cost	199.09	19. (
9.00	reporting period	es through becember 31 0	the cost	199.09	17.0
0. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20. (
4 00	reporting period	、 、		4 445 005	
1.00 2.00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	4, 445, 385 0	
2.00	5 x line 17)	Set 31 of the cost repor	ting period (The	0	22.
3.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	ng period (line 6	0	23. (
4 00	x line 18)			11 140	24
4.00	Swing-bed cost applicable to NF type services through Decembe 7×1 (ine 19)	er 31 of the cost report	ng period (line	11, 149	24.1
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25. (
	x line 20)				
6.00	Total swing-bed cost (see instructions)	(Line 21 minus Line 24)		582, 808	
7.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTTTE 21 MITTUS TTTTE 20)		3, 862, 577	27.0
8.00	General inpatient routine service charges (excluding swing-be	ed and observation bed cl	narges)	0	28.
9.00	Private room charges (excluding swing-bed charges)		-	0	
0.00	Semi-private room charges (excluding swing-bed charges)			0	30.
1.00 2.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ Tine 28)		0. 000000 0. 00	
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
4.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0.00	
5.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
6.00	Private room cost differential adjustment (line 3 x line 35)	and private ream eact -	fforontial (lis-	0 2 942 577	
7.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	inerential (IINe	3, 862, 577	37.
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 287. 52	
8.00 9.00		e instructions) e 38)		1, 287. 52 1, 318, 420 0	39.

IPUI	ATION OF INPATIENT OPERATING COST		Provider C	F	eriod: rom 01/01/2018 o 12/31/2018		
						5/30/2019 2:3	
	Cost Center Description	Total Inpatient Costl	Total		Hospital Program Days	Cost Program Cost (col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
00	NURSERY (title V & XIX only)	0	2.00				42.
	Intensive Care Type Inpatient Hospital Units			0.00			1
00	INTENSIVE CARE UNIT	867, 794	177	4, 902. 79	109	534, 404	43.
00	CORONARY CARE UNIT						44.
00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45
00 00							46
00	Cost Center Description	I					
						1.00	
00	Program inpatient ancillary service cost (Wks			``		703, 862	
00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	11 through 48)(s	see instructio	ns)		2, 556, 686	49
00	Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst D sum	of Parts L and	0	50
00	Pass through costs applicable to Program inpa	atient ancillary	/ services (fr	om Wkst. D, su	m of Parts II	0	51
00	and IV)	50 and 51				_	E 2
00 00	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclud		ated non-nhy	sician anesthe	tist and	0	
20	medical education costs (line 49 minus line 5						
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
00	Program discharges					0	
00 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operati	ng cost and tar	rget amount (l	ine 56 minus l	ine 53)	0	
00	Bonus payment (see instructions)		g			0	
00	Lesser of lines 53/54 or 55 from the cost rep	orting period e	ending 1996, ι	pdated and com	pounded by the	0.00	59
~~	market basket					0.00	
00 00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines				he amount by	0.00	
00	which operating costs (line 53) are less than					0	
	amount (line 56), otherwise enter zero (see i		C		5		
00	Relief payment (see instructions)					0	
00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see Instruc	ctions)			0	63
00	Medicare swing-bed SNF inpatient routine cost	ts through Decem	nber 31 of the	cost reportin	g period (See	571, 659	64
	instructions)(title XVIII only)	0		·			
00	Medicare swing-bed SNF inpatient routine cost	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line A	54 nlus line A	5)(title XVIII	only) For	571, 659	66
00	CAH (see instructions)				0my). 10	571,057	
00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	f the cost rep	orting period	0	67
~~	(line 12 x line 19)		1 01 6				1
00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs atter De	ecember 31 or	the cost repor	ting period	0	68
00	Total title V or XIX swing-bed NF inpatient i	routine costs (I	ine 67 + line	68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU	IRSING FACILITY,	AND ICF/IID	ONLY			
00	Skilled nursing facility/other nursing facili						70
00 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ne /U ÷ line	2)			71
00	Medically necessary private room cost application	,	(line 14 x li	ne 35)			73
00	Total Program general inpatient routine servi	U U	•	,			74
00	Capital-related cost allocated to inpatient i				rt II, column		75
00	26, line 45)	2)					
00 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76
00	Inpatient routine service cost (line 74 minus						78
00	Aggregate charges to beneficiaries for excess	s costs (from pr		· .			79
00	Total Program routine service costs for compa		ost limitation	(line 78 minu	s line 79)		80
00 00	Inpatient routine service cost per diem limit						81
00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82
00	Program inpatient ancillary services (see ins		1				84
00	Utilization review - physician compensation	(see instruction					85
00	Total Program inpatient operating costs (sum		ough 85)				86
00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					1, 267	87
00	- · · · · · · · · · · · · · · · · · · ·		1.1				
00	Adjusted general inpatient routine cost per o	len (Ine Z/ ÷	line 2)			1, 287. 53	1 88

Health Financial Systems SUL	LIVAN COUNTY CC	MMUNITY HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2018 Fo 12/31/2018		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	347,664	4, 445, 385	0. 078208	3 1, 631, 301	127, 581	90.00
91.00 Nursing School cost	0	4, 445, 385	0.00000	1, 631, 301	0	91.00
92.00 Allied health cost	0	4, 445, 385	0.00000	1, 631, 301	0	92.00
93.00 All other Medical Education	0	4, 445, 385	0.00000	1, 631, 301	0	93.00

SULLI VAN	COUNTY	COMMUNI TY	HOSPI TAL

	Financial Systems SULLIVAN COUNTY COMML ATION OF INPATIENT OPERATING COST	JNETY HOSPITAL Provider CCN: 15-1327	Period:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2018 To 12/31/2018	Date/Time Pre 5/30/2019 2:3	parec 5 pm
		Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
I. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s excluding newborn)		3, 500	1.
2.00 3.00	Inpatient days (including private room days, excluding swing-b Private room days (excluding swing-bed and observation bed day do not complete this line.	bed and newborn days)	rivate room days,	3, 000 0	
. 00 . 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo reporting period		er 31 of the cost	1, 733 444	4. 5.
. 00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6.
. 00	Total swing-bed NF type inpatient days (including private roor reporting period	m days) through December	- 31 of the cost	56	7.
. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	m days) after December 3	31 of the cost	0	8.
0. 00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	g swing-bed and	27	9.
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		room days)	0	10.
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		room days) after	0	11.
	Swing-bed NF type inpatient days applicable to titles V or XLX through December 31 of the cost reporting period		5,	0	
	Swing-bed NF type inpatient days applicable to titles V or XL after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	ne)	0	
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			256	15.
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 d	of the cost		17.
8.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost		18.
9. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	f the cost	199.09	19.
0. OO	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	the cost	0.00	20
	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December 5×1 ine 17)		ting period (line	4, 445, 385 0	21 22
3.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23
4.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	r 31 of the cost reporti	ng period (line	11, 149	24
5.00	Swing-bed cost applicable to NF type services after December (x line 20)	31 of the cost reporting	g period (line 8	0	25
6. 00 7. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		582, 808 3, 862, 577	
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 30.
1.00	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0. 000000	31
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	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 instru	rtions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x lin		500137	0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36.
	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	3, 862, 577	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 207 52	20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 287. 52 34, 763	
	Medically necessary private room cost applicable to the Progra	-		0	40.
	Total Program general inpatient routine service cost (line 39			34, 763	

MPUT	ATION OF INPATIENT OPERATING COST		Provider C	1	Period: From 01/01/2018 Fo 12/31/2018		
						5/30/2019 2:3	
	Cost Center Description	Total Inpatient Cost	Total	e XIX Average Per Diem (col. 1 - col. 2)	Hospital Program Days	Cost Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00	NURSERY (title V & XIX only)	148, 095	256	578.50	0 60	34, 710) 42.
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	867, 794	177	4, 902. 79	8	39, 222	2 43
00	CORONARY CARE UNIT	007, 794	177	4, 902. /	0	39,222	43
00	BURN INTENSIVE CARE UNIT						45
00	SURGI CAL I NTENSI VE CARE UNI T						46
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
00	Dragnom innationt anaillanu aanuiga aast (WW		line 200)			1.00	40
00 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			ne)		103, 176 211, 871	
00	PASS THROUGH COST ADJUSTMENTS		see matruetre	///3/		211,071	
00	Pass through costs applicable to Program inpa	atient routine :	services (from	n Wkst. D, sum	of Parts I and	0	50
	111)						
00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, su	um of Parts II	0	51
00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				0	52
00	Total Program inpatient operating cost exclude	,	lated. non-phy	sician anesthe	etist, and		
	medical education costs (line 49 minus line 5						
	TARGET AMOUNT AND LIMIT COMPUTATION						
00	Program discharges					0	
00	Target amount per discharge					0.00	
00 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	na cost and ta	ract amount (1	ino 56 minus l	ino 52)	0	
00	Bonus payment (see instructions)	ng cost and ta	rget anount (r		THE 55)	0	
00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endina 1996. u	updated and cor	pounded by the		
	market basket	5 1	5				
00	Lesser of lines 53/54 or 55 from prior year of					0.00	
00	If line 53/54 is less than the lower of lines					0	61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% or	the target		
00	Relief payment (see instructions)	listi ucti olisj				0	62
00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	e cost reportir	ng period (See	0	64
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	neriod (See	0	65
00	instructions) (title XVIII only)			Jost reporting	period (See		/ 00
00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66
	CAH (see instructions)						
00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost rep	porting period	0	67
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repor	ting period	0	68
	(line 13 x line 20)				511	_	
. 00	Total title V or XIX swing-bed NF inpatient n			,		0) 69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili					1	70
00	Adjusted general inpatient routine service co						71
00	Program routine service cost (line 9 x line 1			2)			72
00	Medically necessary private room cost applica	· ·	(line 14 x li	ne 35)			73
00	Total Program general inpatient routine servi	U	•				74
00	Capital -related cost allocated to inpatient i	routine service	costs (from W	lorksheet B, Pa	art II, column		75
00	26, line 45) Por diam capital related costs (line 75 · lin	20 2)					
00 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76
00	Inpatient routine service cost (line 74 minus						78
00	Aggregate charges to beneficiaries for excess		rovi der record	ls)			79
00	Total Program routine service costs for compa	arison to the c	ost limitatior	n (line 78 minu	us line 79)		80
00	Inpatient routine service cost per diem limit						81
00	Inpatient routine service cost limitation (li		· .				82
00	Reasonable inpatient routine service costs (s		S)				83
00 00	Program inpatient ancillary services (see ins		ns)				84
00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
. 00	Total observation bed days (see instructions)					1, 267	
. 00	Adjusted general inpatient routine cost per o	diem (line 27 ÷	line 2)			1, 287. 53	88 88
00	Observation bed cost (line 87 x line 88) (see					1, 631, 301	

Health Financial Systems SUL	LIVAN COUNTY CO	OMMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	347,664	4, 445, 385	0. 078208	3 1, 631, 301	127, 581	90.00
91.00 Nursing School cost	(4, 445, 385	0.00000	0 1, 631, 301	0	91.00
92.00 Allied health cost	(4, 445, 385	0.00000	1, 631, 301	0	92.00
93.00 All other Medical Education	(4, 445, 385	0.00000	1, 631, 301	0	93.00

	TY COMMUNITY HOSPIT			eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1327	Period: From 01/01/2018	Worksheet D-3	3
			To 12/31/2018		epared:
				5/30/2019 2:3	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	+
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			1, 910, 296		30. 00
31.00 03100 INTENSIVE CARE UNIT			273, 274		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM		0.4006	42 142, 087	56, 926	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		1. 50450		-	
53. 00 05300 ANESTHESI OLOGY		0. 0274			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1311			
54. 01 05401 ULTRASOUND		0. 0918			
56. 00 05600 RADI 0I SOTOPE		0. 2877			
60. 00 06000 LABORATORY		0. 1964			
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0368			
64. 00 06400 I NTRAVENOUS THERAPY		0. 1239			
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 3833 0. 5691			
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY		0. 5024			
68. 00 06800 SPEECH PATHOLOGY		1. 11110			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 3199			
70. 01 07001 CARDI OPULMONARY		0. 3893			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1498			
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 17530			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 5123			
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 5792	22 0	C	90.00
90. 01 09001 JV CLINIC		0. 6032	50 0	C	90.01
90. 02 09002 CLINIC - LAKESIDE		0. 9336		-	
90. 03 09003 CLINIC - QUICKCARE		0. 7818		, v	
91. 00 09100 EMERGENCY		0. 2811			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.66720		-	
93.00 04950 BEHAVIOR HEALTH	>	0. 7296		-	
200.00 Total (sum of lines 50 through 94 and 96 through			2, 675, 071		
201.00 Less PBP Clinic Laboratory Services-Program only	cnarges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1	2, 675, 071	I	202.00

leal th Financial Systems SULLIVAN COUNTY COMMUNIT		CCN: 15-1327	Peri od:	eu of Form CMS- Worksheet D-3	
INPATIENT ANGILLARY SERVICE GUST APPORTIUNMENT	ovider c	UN: 15-1327	From 01/01/2018		,
Co	mponent	CCN: 15-Z327	To 12/31/2018		epared
	•			5/30/2019 2:3	<u>}5 pm</u>
	Title	e XVIII	Swing Beds - SNI		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	+
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.0
31. 00 03100 I NTENSI VE CARE UNI T					31.0
43. 00 04300 NURSERY					43.0
ANCI LLARY SERVICE COST CENTERS					43.0
50. 00 05000 OPERATING ROOM		0.4006	42 0	0 0	50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM		1. 5045			
53. 00 05300 ANESTHESI OLOGY		0. 0274		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1311		-	
54. 01 05401 ULTRASOUND		0. 0918			
56. 00 05600 RADI 0I SOTOPE		0. 2877		-	
50. 00 06000 LABORATORY		0. 1964			
53. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 0368			
54. 00 06400 I NTRAVENOUS THERAPY		0. 1239		-	
55. 00 06500 RESPIRATORY THERAPY		0. 3833			
56. 00 06600 PHYSI CAL THERAPY		0. 5691			
57. 00 06700 0CCUPATI ONAL THERAPY		0.5024			
58. 00 06800 SPEECH PATHOLOGY		1. 1111			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 3199			
70. 01 07000 ELECTROENCEMILLOGRAFIT		0. 3199			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3893		-	
				9,117	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1753		-	
OUTPATIENT SERVICE COST CENTERS		0. 5123	56 105, 960	54, 289	- /3.1
00.00 09000 CLINIC		0. 5792	22 0	0	90.
20. 01 09001 JV CLINIC		0.6032			
20. 02 09002 CLINIC - LAKESIDE		0. 9336			
0. 02 09002 CLINIC - LAKESTEL 00. 03 09003 CLINIC - QUICKCARE		0. 7818			
0. 03 109003 CETNTC - COTCRARE 01. 00 09100 EMERGENCY		0. 2811	-		
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2811			
23. 00 109200 DESERVATION BEDS (NON-DISTINCT PART) 23. 00 104950 BEHAVIOR HEALTH		0. 8672			
20.00 Total (sum of lines 50 through 94 and 96 through 98)		0.7290		-	
200.00 [10tal (sum of lines 50 through 94 and 96 through 98) 201.00 [Less PBP Clinic Laboratory Services-Program only charges (I	ino (1)		394, 733	154, 271	200.
	ine or)		204 700		
202.00 Net charges (line 200 minus line 201)		1	394, 733	2	202. (

i i i i i j i i i	SULLIVAN COUNTY COMMUNITY HOSPITAL Provider CCN: 15-1327			u of Form CMS-2552-1	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1327	Period: From 01/01/2018	Worksheet D-3	5
			To 12/31/2018		pared:
				5/30/2019 2:3	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs (col. 1 x col.	
			Charges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS			19, 940		30. 0
31. 00 03100 I NTENSI VE CARE UNI T			20, 057		31.0
43. 00 04300 NURSERY			53, 460		43.0
ANCI LLARY SERVI CE COST CENTERS				•	
50.00 05000 OPERATING ROOM		0.40064			
52.00 05200 DELIVERY ROOM & LABOR ROOM		1. 50450			
53. 00 05300 ANESTHESI OLOGY		0. 0274			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13112			
54. 01 05401 ULTRASOUND		0. 09183			
56. 00 05600 RADI 0I SOTOPE		0. 28776		-	
50. 00 06000 LABORATORY		0. 1964			
53. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 0368			
54.00 06400 INTRAVENOUS THERAPY		0. 1239		-	
55. 00 06500 RESPI RATORY THERAPY		0. 3833			
56. 00 06600 PHYSI CAL THERAPY		0. 56912			
57.00 06700 OCCUPATI ONAL THERAPY		0. 50249		-	
58.00 06800 SPEECH PATHOLOGY		1. 11110		-	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 31990			
70. 01 07001 CARDI OPULMONARY		0. 38939		-	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 1498			
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 17530			
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		0. 5123	20, 097	10, 297	73.0
20. 00 09000 CLINIC		0. 57922	22 0	0	90.0
20. 00 102000 CLINIC 20. 01 102001 JV CLINIC		0. 6032			
20. 02 09002 CLINIC - LAKESIDE		0. 93362		, o	
20. 03 09003 CLINIC - QUICKCARE		0. 7818		-	
20. 03 109003 CEITING - ODTERCARE		0. 28114		-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 66720			
93. 00 04950 BEHAVI OR HEALTH		0. 72963			
200.00 Total (sum of lines 50 through 94 and 96 thro	ough 98)	0.7270	313, 784		
201.00 Less PBP Clinic Laboratory Services-Program of			0.0,704	100,170	201.0
202.00 Net charges (line 200 minus line 201)		1	313, 784		202. 0

_CUL	Financial Systems SULLIVAN COUNTY COMMU ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1327	Period: From 01/01/2018 To 12/31/2018		pared
		Title XVIII	Hospi tal	Cost	5 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
00	Medical and other services (see instructions)	tione)		6, 537, 370	
00 00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	LI ONS)		0	
00	Outlier payment (see instructions)			0	
D1	Outlier reconciliation amount (see instructions)			0	
00 00	Enter the hospital specific payment to cost ratio (see instruc Line 2 times line 5	ctions)		0.000	1
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0	1
00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	
00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 6, 537, 370	
00	COMPUTATION OF LESSER OF COST OR CHARGES			0, 537, 370	1
	Reasonabl e charges				
	Ancillary service charges	(0)			12.
00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li Total reasonable charges (sum of lines 12 and 13)	ne 69)		0	
00	Customary charges			0	14.
00	Aggregate amount actually collected from patients liable for p				15.
00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16.
00	had such payment been made in accordance with 42 CFR §413.13(ϵ Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.
	Total customary charges (see instructions)			0	
00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	0	19.
00	instructions)				20.
00	00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)				20.
00	Lesser of cost or charges (see instructions)			6, 602, 744	
2.00 Interns and residents (see instructions)				0	
	Cost of physicians' services in a teaching hospital (see instr Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	uctions)		0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
00	Deductibles and coinsurance amounts (for CAH, see instructions Deductibles and Coinsurance amounts relating to amount on line	-	suctions)	64, 645 3, 429, 483	
00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	-		3, 108, 616	
	instructions)				
00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	
00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 3, 108, 616	
00	· · · · · · · · · · · · · · · · · · ·				31.
00	Subtotal (line 30 minus line 31)			3, 104, 802	32.
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC Composite rate ESRD (from Wkst. I-5, line 11)	ES)		0	33.
	Allowable bad debts (see instructions)			866, 077	
00					35.
00	5				36.
00					37. 38.
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
50	Pioneer ACO demonstration payment adjustment (see instructions	5)			39.
97	Demonstration payment adjustment amount before sequestration			0	
98 99	Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION	ceu devices (see instruc	n ons)	0	
00	O Subtotal (see instructions)				40.
01	Sequestration adjustment (see instructions)				40.
02				0	
00	00 Interim payments 00 Tentative settlement (for contractors use only)			3, 030, 953	
00	Bal ance due provi der/program (see instructions)			563, 444	
00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	chapter 1,	0	
	§115.2 TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90.
00					91.
	Outlier reconciliation adjustment amount (see instructions)			0	71.
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	:N: 15-1327	Period: From 01/01/2018 To 12/31/2018		
			XVIII	Hospi tal	Cost	•
		I npati en	t Part A	Par	rt 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		2, 182, 17	7	3, 030, 953	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero					3.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.00
	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	ADJUSTMENTS TO PROVIDER	08/15/2018	91, 30	00	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3.03
3.04				0	0	3. 04
3.05				0	0	3.05
2 50	Provider to Program ADJUSTMENTS TO PROGRAM	1		0	0	2 50
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	3.50 3.51
3.51				0	0	3. 51
3.52				0	0	3.53
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		91, 30	00	0	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 273, 47	7	3, 030, 953	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider			-		
5.01	TENTATI VE TO PROVIDER			0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
5.50	Provider to Program TENTATIVE TO PROGRAM	1		0	0	5.50
5.50	TENTATIVE TO PROGRAM			0	0	5.50
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		54, 98	36	563, 444	6. 01
6.02	SETTLEMENT TO PROGRAM		0 000 1	0	0	6.02
7.00	Total Medicare program liability (see instructions)		2, 328, 46		3, 594, 397	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C)	1.00	2.00	
8.00	Name of Contractor				2.00	8.00

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C		Fr	riod: om 01/01/2018			
		Component (CCN: 15-Z327	To	12/31/2018	Date/Time Pr 5/30/2019 2:	repa 35	ared
			XVIII	Sw	ing Beds - SNF		_	
		Inpatien	t Part A		Par	tВ		
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	+	
		1.00	2.00		3.00	4.00		
00	Total interim payments paid to provider		677, 2	61			0	1. (
00	Interim payments payable on individual bills, either			0			0	2. (
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,							
	write "NONE" or enter a zero							
00	List separately each retroactive lump sum adjustment							3.
	amount based on subsequent revision of the interim rate							
	for the cost reporting period. Also show date of each							
	payment. If none, write "NONE" or enter a zero. (1)						_	
01	Program to Provider ADJUSTMENTS TO PROVIDER			0			0	3.
02	ADJUSTWENTS TO FROVIDER			0			o	3.
03				0			õ	3.
04				0			0	3.
05				0			0	3.
	Provider to Program							
50	ADJUSTMENTS TO PROGRAM			0			0	3.
51 52				0			0	3. 3.
52 53				0			0	з. З.
54				0			0	3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0			0	3.
	3. 50-3. 98)							
00	Total interim payments (sum of lines 1, 2, and 3.99)		677, 2	61			0	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as							
	appropriate) TO BE COMPLETED BY CONTRACTOR							
00	List separately each tentative settlement payment after							5.
	desk review. Also show date of each payment. If none,							
	write "NONE" or enter a zero. (1)							
~ 4	Program to Provider			0			_	-
01 02	TENTATI VE TO PROVIDER			0 0			0	5. 5.
02				0			o	5.
	Provider to Program						Ť	0.
50	TENTATI VE TO PROGRAM			0			0	5.
51				0			0	5.
52				0			0	5.
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0			0	5.
00	Determined net settlement amount (balance due) based on							6.
	the cost report. (1)							0.
01	SETTLEMENT TO PROVIDER		34, 3	71			0	6.
02	SETTLEMENT TO PROGRAM			0			0	6.
00	Total Medicare program liability (see instructions)		711, 6	32	0.1.		0	7.
					Contractor Number	NPR Date (Mo/Day/Yr)		
		()		1.00	2.00	-	_
00	Name of Contractor		-	-		2.00		8.

Heal th	Financial Systems SULLIVAN COUNTY COMM	UNI TY HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1327	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Pre 5/30/2019 2:3	pared:
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c line 168 $$	ertified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	, , ,			
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32.00
	• • • • •		-		

LCULA	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1327	Period: From 01/01/2018	Worksheet E-2	
		Component CCN: 15-Z327	To 12/31/2018	Date/Time Pre	
		Title XVIII	Swing Beds - SNF	5/30/2019 2:3 Cost	5 pm
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
	Inpatient routine services - swing bed-SNF (see instructions)		577, 376	0	
	Inpatient routine services - swing bed-NF (see instructions)	t A and aum of Wkot D	155 014	0	2.
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins	t A, and sum of wkst. D,	155, 814	0	3.
	Per diem cost for interns and residents not in approved teaching			0.00	4
	instructions)	31 3 ()			
	Program days		444	0	5
	Interns and residents not in approved teaching program (see in			0	6
	Utilization review - physician compensation - SNF optional met	thod only	0	0	7
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		733, 190	0	8
	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		733, 190	0	10
	Deductibles billed to program patients (exclude amounts applic	cable to physician	/ 33, 170	0	
	professional services)		Ū	Ũ	
	Subtotal (line 10 minus line 11)		733, 190	0	12
	Coinsurance billed to program patients (from provider records)) (exclude coinsurance	7, 035	0	13
	for physician professional services)			_	
	80% of Part B costs (line 12 x 80%)		70/ 455	0	
	Subtotal (enter the lesser of line 12 minus line 13, or line ´ OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	14)	726, 155	0	
	Pioneer ACO demonstration payment adjustment (see instructions	-)	0	0	16
	Rural community hospital demonstration project (§410A Demonstr		0		16
	adiustment (see instructions)	ation) payment	Ũ		
. 99	Demonstration payment adjustment amount before sequestration		0	0	16
. 00	Allowable bad debts (see instructions)		0	0	17
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	
	Total (see instructions)		726, 155	0	
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration)		14, 523	0	
	Interim payments		677, 261	0	
	Tentative settlement (for contractor use only)		0///201	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	34, 371	0	
00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	0	0	23
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr				1000
	Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	riod under the 21st			200
	Cost Reimbursement				
	Medicare swing-bed SNF inpatient routine service costs (from N	Nkst. D-1, Pt. II, line			201
	66 (title XVIII hospital))				
	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst. D-3, col. 3, lin	e		202
	200 (title XVIII swing-bed SNF))				000
	Total (sum of lines 201 and 202) Medicare swing-bed SNF discharges (see instructions)				203 204
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-vear demonst	ration	204
	peri od)	The goal of the carre	and by your demonst	i dei on	
5. 00	Medicare swing-bed SNF target amount				205
5. 00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see inst		1		207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	2, COL. I, SUM OF LINES			208
	and 3) Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209
	Reserved for future use	511 0(15)			209
	Comparision of PPS versus Cost Reimbursement				1
	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215

	Financial Systems SULLI ATION OF REIMBURSEMENT SETTLEMENT		NITY HOSPITAL Provider CCN: 15-1327	Peri od:	u of Form CMS- Worksheet E-3	
ALCUL	ATTON OF REFINDORSEMENT SETTLEMENT			From 01/01/2018 To 12/31/2018	Part V Date/Time Pre 5/30/2019 2:3	pare
			Title XVIII	Hospi tal	Cost	
					1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEME	ENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
	Inpatient services				2, 556, 686	
	Nursing and Allied Health Managed Care payment	t (see instructio	ns)		0	
00 00	Organ acquisition Subtotal (sum of lines 1 through 3)				0	
	Primary payer payments				2, 556, 686 0	
	Total cost (line 4 less line 5). For CAH (see	instructions)			2, 582, 253	
	COMPUTATION OF LESSER OF COST OR CHARGES	Thistructrons)			2, 302, 233	1 0
	Reasonabl e charges					1
	Routi ne servi ce charges				0	7
	Ancillary service charges				0	
00	Organ acquisition charges, net of revenue				0	9
. 00	Total reasonable charges				0	10
	Customary charges					
	Aggregate amount actually collected from patie				0	1
. 00	Amounts that would have been realized from pat		payment for services of	n a charge basis	0	12
~~	had such payment been made in accordance with	• • •			0 000000	
	Ratio of line 11 to line 12 (not to exceed 1.0)00000)			0. 000000	
	Total customary charges (see instructions) Excess of customary charges over reasonable co	act (complete opl	viflips 14 sysseds li	no (coo	0	
. 00	instructions)	ost (comprete on	y II IINE 14 exceeds II	ne o) (see	0	15
o. 00	Excess of reasonable cost over customary charge	nes (complete onl	vifline 6 exceeds lin	e 14) (see	0	16
	instructions)	9 (,		-	
7.00	Cost of physicians' services in a teaching hos	spital (see instr	uctions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	•				
	Direct graduate medical education payments (fr		line 49)		0	
	Cost of covered services (sum of lines 6, 17 a	and 18)			2, 582, 253	
	Deductibles (exclude professional component)				345, 672	
	Excess reasonable cost (from line 16)				0	
	Subtotal (line 19 minus line 20 and 21)				2, 236, 581	
	Coinsurance Subtotal (line 22 minus line 23)				2, 680 2, 233, 901	
	Allowable bad debts (exclude bad debts for pro	ofessional servic	es) (see instructions)		2, 233, 901 218, 587	
	Adjusted reimbursable bad debts (see instructi				142, 082	
	Allowable bad debts for dual eligible benefici	,	uctions)		23, 748	
	Subtotal (sum of lines 24 and 25, or line 26)		,		2, 375, 983	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY))			0	
	Pioneer ACO demonstration payment adjustment ()		0	29
. 99	Demonstration payment adjustment amount before	e sequestration			0	29
	Subtotal (see instructions)				2, 375, 983	
	Sequestration adjustment (see instructions)				47, 520	
	Demonstration payment adjustment amount after	sequestrati on			0	
	Interim payments				2, 273, 477	
	Tentative settlement (for contractor use only)				0	
	Balance due provider/program (line 30 minus li				54, 986	
	Protested amounts (nonallowable cost report it §115.2	tems) in accordan	ce with CMS Pub. 15-2,	cnapter 1,	0	34

	Financial Systems SULLIVAN COUNTY COMM ATION OF REIMBURSEMENT SETTLEMENT	UNITY HOSPITAL Provider CCN: 15-1327	Peri od:	u of Form CMS-2 Worksheet E-3	
LCOL		110v1061 66N. 13-1327	From 01/01/2018 To 12/31/2018	Part VII	pare
		Title XIX	Hospi tal	Cost	J pi
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR >	(IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		211, 871		1
00	Medical and other services			338, 155	2
00	Organ acquisition (certified transplant centers only)		0	220 155	3
00 00	Subtotal (sum of lines 1, 2 and 3) Inpatient primary payer payments		211, 871	338, 155	4
00	Outpatient primary payer payments		0	0	e
00	Subtotal (line 4 less sum of lines 5 and 6)		211, 871	338, 155	
00	COMPUTATION OF LESSER OF COST OR CHARGES		211,071	330, 133	1 '
	Reasonabl e Charges				1
00	Routine service charges		0		1 8
00	Ancillary service charges		313, 784	1, 284, 642	9
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		313, 784	1, 284, 642	12
	CUSTOMARY CHARGES				
8.00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13
	basi s				
. 00	Amounts that would have been realized from patients liable fo		on 0	0	14
. 00	a charge basis had such payment been made in accordance with Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CFR 9413.13(e)	0.00000	0. 000000	15
	Total customary charges (see instructions)		313, 784	1, 284, 642	
	Excess of customary charges over reasonable cost (complete on	lvifline 16 exceeds	101, 913	946, 487	
. 00	line 4) (see instructions)		101, 713	740, 407	''
3. 00	Excess of reasonable cost over customary charges (complete on	lvifline 4 exceeds lir	ne O	0	18
	16) (see instructions)	5			
9.00	Interns and Residents (see instructions)		0	0	19
0. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line	16)	211, 871	338, 155	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provi	ders.		
	Other than outlier payments		0	0	22
	Outlier payments		0	0	23
	Program capital payments		0		24
	Capital exception payments (see instructions)		0	0	2!
5.00 7.00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	26
	Customary charges (title V or XIX PPS covered services only)		0	0	28
	Titles V or XIX (sum of lines 21 and 27)		211, 871	338, 155	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		211/0/1	000,100	
0. 00	Excess of reasonable cost (from line 18)		0	0	30
I. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6		211, 871	338, 155	31
2. 00	Deducti bl es		0	0	32
8.00	Coi nsurance		0	0	33
	Allowable bad debts (see instructions)		0	0	34
	Utilization review		0		35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	d 33)	211, 871	338, 155	
	ADJUSTMENT		-211, 871	-338, 155	
	Subtotal (line 36 ± line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	-	39
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
	Interim payments		0	0	41
2.00	Balance due provider/program (line 40 minus line 41)	noo with CMC Dut 15 0	0	0	
3.00	Protested amounts (nonallowable cost report items) in accorda chapter 1, §115.2	nce with UMS PUB 15-2,	0	0	43

	SHEET (If you are nonproprietary and do not maintain e accounting records, complete the General Fund column	Provider C		Period: From 01/01/2018	Worksheet G	
l y)				To 12/31/2018	Date/Time Pre 5/30/2019 2:3	pare 5 pr
		General Fund	Specific Purpose Fund		Plant Fund	
CUE	RRENT ASSETS	1.00	2.00	3.00	4.00	
	ish on hand in banks	2, 308, 666		0 0	0	1 1
	emporary investments	0		0 0	0	
00 No	ites receivable	0		0 0	0	3
00 Ac	counts receivable	7, 973, 811		0 0	0	4
	her recei vabl e	295, 293		0 0	0	
	lowances for uncollectible notes and accounts receivable	-4, 668, 003		0 0	0	6
	iventory	752, 147		0 0	0	
	epaid expenses her current assets	473, 377		0 0	0	
	le from other funds	0		0 0	0	10
	otal current assets (sum of lines 1-10)	7, 135, 291		0 0	0	
	XED ASSETS	7,100,271		0 0	ŭ	1
00 La		1, 032, 727		0 0	0	112
00 La	nd improvements	3, 091, 658		0 0	0	13
	cumulated depreciation	0		0 0	0	14
	i I di ngs	14, 966, 505		0 0	0	15
	cumulated depreciation	-24, 579, 798		0 0	0	16
	easehold improvements	39, 535		0 0 0 0	0	17
	cumulated depreciation xed equipment	6, 479, 752		0 0	0	18
	cumulated depreciation	-296, 551		0 0	0	20
	itomobiles and trucks	270,001		0 0	0	21
1	cumulated depreciation	0		0 0	0	22
	jor movable equipment	19, 638, 836		0 0	0	23
	cumulated depreciation	-2, 881, 664		0 0	0	24
	nor equipment depreciable	0		0 0	0	25
	cumulated depreciation	0		0 0	0	26
	T designated Assets	0		0 0	0	27
	cumulated depreciation nor equipment-nondepreciable	0		0 0	0	29
	tal fixed assets (sum of lines 12-29)	17, 491, 000		0 0	0	30
	HER ASSETS	11/11/000		<u> </u>		
	vestments	11, 311, 376		0 0	0	31
. 00 De	eposits on Leases	0		0 0	0	32
	e from owners/officers	0		0 0	0	33
	her assets	0		0 0	0	34
	otal other assets (sum of lines 31-34)	11, 311, 376		0 0	0	
	otal assets (sum of lines 11, 30, and 35) RRENT LIABILITIES	35, 937, 667		0 0	0	36
	counts payable	773, 671	1	0 0	0	37
	laries, wages, and fees payable	2, 048, 024		0 0	0	38
	yroll taxes payable	17, 195		0 0	0	
	tes and loans payable (short term)	436, 377		0 0	0	40
	ferred income	0		0 0	0	41
	celerated payments	0				42
	e to other funds	0		0 0	0	
	her current liabilities	214, 152		0 0	0	
	vtal current liabilities (sum of lines 37 thru 44) NG TERM LIABILITIES	3, 489, 419		0 0	0	45
	ortgage payable	0		0 0	0	46
	ites payable	5, 077, 142		0 0	0	
	isecured Loans	0		0 0	0	48
	her long term liabilities	0		0 0	0	
	otal long term liabilities (sum of lines 46 thru 49)	5, 077, 142		0 0	0	
	tal liabilities (sum of lines 45 and 50)	8, 566, 561		0 0	0	51
	PITAL ACCOUNTS	07 071 10/				1
	neral fund balance pecific purpose fund	27, 371, 106		0		52
	poor created - endowment fund balance - restricted			~ 		54
	phonor created - endowment fund balance - unrestricted			0		55
	overning body created - endowment fund balance			0		56
	ant fund balance - invested in plant				0	
	ant fund balance - reserve for plant improvement,				0	
	placement, and expansion					
	tal fund balances (sum of lines 52 thru 58)	27, 371, 106		0 0	0	
00 To	otal liabilities and fund balances (sum of lines 51 and	35, 937, 667	1	0 0	0	60

STATEM	Financial Systems SULI ENT OF CHANGES IN FUND BALANCES	IVAN COUNTY COM	Provider CC		Pe	ri od:	u of Form CMS Worksheet G-	1	
						om 01/01/2018		ер	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fur	d	
		1.00	0.00	0.00		1.00	5.00		
1.00	Fund balances at beginning of period	1.00	2.00 27,073,260	3.00		4.00	5.00		1. (
2.00	Net income (loss) (from Wkst. G-3, line 29)		27, 073, 280 297, 846			0			2.0
3.00	Total (sum of line 1 and line 2)		27, 371, 106			0			3.0
1.00	Additions (credit adjustments) (specify)	0	27,071,100		0	0		0	4.0
5.00		0			0			0	5.0
5.00		0			0			0	6. (
7.00		0			0			0	7.0
3.00		0			0			0	8. (
9.00		0			0			0	9. (
10.00	Total additions (sum of line 4–9)		0			0			10. (
1.00	Subtotal (line 3 plus line 10)		27, 371, 106			0			11. (
2.00	Deductions (debit adjustments) (specify)	0			0				12.0
3.00		0			0				13.0
4.00		0			0				14.
5.00 6.00		0			0				15. 16.
7.00		0			0				17.
	Total deductions (sum of lines 12-17)	0	0		0	0		- 1	18.0
19.00	Fund balance at end of period per balance		27, 371, 106			0			19. (
	sheet (line 11 minus line 18)		,,			-			
		Endowment Fund	PI ant	Fund	_				
		6.00	7.00	8.00					
. 00	Fund balances at beginning of period	0			0				1. (
2.00	Net income (loss) (from Wkst. G-3, line 29)								2.0
. 00	Total (sum of line 1 and line 2)	0	0		0				3.
. 00	Additions (credit adjustments) (specify)		0						4. 5.
. 00			0						э. 6.
. 00			0						7.
. 00			0						8.
0.00			0						9.
0.00	Total additions (sum of line 4-9)	0	-		0				10.
1.00	Subtotal (line 3 plus line 10)	0			0				11.
2.00	Deductions (debit adjustments) (specify)		0						12.
3.00			0						13.
4.00			0						14.
5.00			0						15.
6.00			0						16.
17.00			0						17.
	Total deductions (sum of lines 12-17)	0			0				18. (
19.00	Fund balance at end of period per balance	0			0				19. (

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-1327		riod: om 01/01/2018 12/31/2018	Worksheet G-2 Parts I & II Date/Time Pre 5/30/2019 2:3	pared:
	Cost Center Description		Inpati ent		Outpati ent	Total	[
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						-
	General Inpatient Routine Services						1
1.00	Hospi tal		3, 299, 9	66		3, 299, 966	
2.00	SUBPROVIDER - IPF						2.00
3.00 4.00	SUBPROVI DER – I RF SUBPROVI DER						3.00
4.00 5.00	Swing bed - SNF			0		0	
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY			Ŭ		0	7.00
8.00	NURSI NG FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		3, 299, 9	66		3, 299, 966	10.00
	Intensive Care Type Inpatient Hospital Services		· · · ·			· · · ·	1
11.00	INTENSIVE CARE UNIT		433, 0	07		433, 007	11.00
12.00	CORONARY CARE UNI T						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	433, 0	07		433, 007	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16))	3, 732, 9		40.054.000	3, 732, 973	
18.00	Ancillary services		7, 696, 0		49, 354, 930	57,050,951	
19.00 20.00	Outpatient services		324, 0	0	13, 171, 729 0	13, 495, 789 0	
20.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
21.00	HOME HEALTH AGENCY			0	390, 615	390, 615	
23.00	AMBULANCE SERVICES				370, 013	370, 013	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 & OTHER		228, 0	96	21, 944	250, 040	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	11, 981, 1	50	62, 939, 218	74, 920, 368	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				27, 099, 573		29.00
30.00	ADD (SPECIFY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0	0		35.00
36.00 37.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECIFY)			0 0			37.00
38.00				0			38.00
39.00 40.00				0			40.00
40.00				0			40.00
41.00	Total deductions (sum of lines 37-41)			Ű	0		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer			27, 099, 573		42.00
10.00	to Wkst. G-3, line 4)				21,077,073		-5.00

Heal th	Financial Systems SULLIVAN COUNTY COMMU	JNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1327	Peri od:	Worksheet G-3	
			From 01/01/2018 To 12/31/2018	Date/Time Prep 5/30/2019 2:3	
				373072019 2.3	5 pm
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	e 28)		74, 920, 368	1.00
2.00	Less contractual allowances and discounts on patients' account			48, 050, 267	2.00
3.00	Net patient revenues (line 1 minus line 2)			26, 870, 101	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		27, 099, 573	
5.00	Net income from service to patients (line 3 minus line 4)			-229, 472	5.00
	OTHER I NCOME		I		
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			157, 065	7.00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			1	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			151, 905	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other th	han patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			37, 588	17.00
18.00	Revenue from sale of medical records and abstracts			4, 296	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			222, 771	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER (SPECIFY)			0	24.00
25.00	Total other income (sum of lines 6-24)			573, 626	25.00
26.00	Total (line 5 plus line 25)			344, 154	26.00
27.00	OTHER EXPENSES			46, 308	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			46, 308	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			297, 846	29.00

	Financial Systems SIS OF HOSPITAL-BASED HOME HEALT			MMUNITY HOSPIT Provider C		Peri od:	u of Form CMS-2 Worksheet H	2002.
				HHA CCN:	15-7542	From 01/01/2018 To 12/31/2018	Date/Time Pre	pare
						Home Health	5/30/2019 2:3 PPS	5 pm
			Free Lawson	T		Agency I	Total (sum of	
		Sal ari es	Employee Benefits	Transportation (see	chased	ur Other Costs	cols. 1 thru	
		1.00	2.00	instructions)	Servi ces	F_00	5)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	6.00	
0	Capital Related - Bldg. &			C		0	0	1.
0	Fixtures Capital Related - Movable					0	0	2.
0	Equi pment					0	0	2.
0	Plant Operation & Maintenance	0	0	-		0 0	0	
0 0	Transportation Administrative and General	94, 563	0	-		0 0 0 33, 915	133, 125	4. 5.
	HHA REIMBURSABLE SERVICES		-	· ·				
0 0	Skilled Nursing Care Physical Therapy	149, 286 18, 691	0			0 0 0 0	156, 621 19, 609	
0	Occupational Therapy	22, 966	0	-		0 0	24, 095	
0	Speech Pathology	962	0	47		0 0	1,009	9.
00 00	Medical Social Services Home Health Aide	2, 473 20, 671	0			0 0	2, 595 21, 687	
00	Supplies (see instructions)	20, 071	0	0		0 0	0	
00	Drugs	0	0	-		0 0	0	
00	DME HHA NONREI MBURSABLE SERVI CES	0	0	C	1	0 0	0	14
00	Home Dialysis Aide Services	0	0	C		0 0	0	15
00	Respiratory Therapy	0	0	-		0 0	0	
00 00	Private Duty Nursing Clinic	0	0			0 0	0	
00	Health Promotion Activities	0	0			0 0	0	
00	Day Care Program	0	0	C)	0 0	0	
00 00	Home Delivered Meals Program Homemaker Service	0	0			0 0		21 22
00	All Others (specify)	0	0			0 0	0	23
50	Tel emedi ci ne	0	0	0		0 0	0	
00	Total (sum of lines 1-23)	309, 612 Recl assi fi cati	0 Reclassified	15,214 Adjustments	Net Expenses	0 33, 915	358, 741	24.
		on	Trial Balance		for Allocatio	on		
			(col. 6 + col.7)		(col. 8 + col 9)	l.		
		7.00	8.00	9.00	10.00			
0	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0	0		0		1 1
0	Fixtures	0	0			0		'
0	Capital Related - Movable	0	0	C		0		2
0	Equipment Plant Operation & Maintenance	0	0	c c		0		3
0	Transportation	0	0	C)	0		4
0	Administrative and General HHA REIMBURSABLE SERVICES	0	133, 125	0	133, 12	25		5
0	Skilled Nursing Care	0	156, 621	C	156, 6	21		6
0	Physical Therapy	0	19, 609		19, 60			7.
0 0	Occupational Therapy Speech Pathology	0	24, 095 1, 009		24, 0			8.
0	Medical Social Services	0	2, 595		2,5			10
00	Home Health Aide	0	21, 687	0	21, 6			11
00	Supplies (coo instructions)	0	0	-		0		12
00 00	Supplies (see instructions)	0				0		14
00	Drugs DME	0	0	0		0		
00 00 00 00	Drugs DME HHA NONREI MBURSABLE SERVI CES	0	0	1	1			1
00 00 00 00	Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	C		0		
00 00 00 00	Drugs DME HHA NONREI MBURSABLE SERVI CES	0	0	C C				16
00 00 00 00 00 00 00 00	Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0		0 0 0 0		16 17 18
00 00 00 00 00 00 00 00 00	Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	0	0 0 0 0 0 0 0 0			0 0 0 0 0		16 17 18 19
00 00 00 00 00 00 00 00	Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0 0 0 0 0	0 0 0 0 0 0			0 0 0 0		16 17 18 19 20
00 00 00 00 00 00 00 00 00 00 00	Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	0 0 0 0 0				0 0 0 0 0		16 17 18 19 20 21 22
00 00 00 00 00 00 00 00 00 00 00 00	Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 0 0				0 0 0 0 0		15. 16. 17. 18. 19. 20. 21. 22. 23. 23.

	ALLOCATION - HHA GENERAL SERVICE	E COST			CN: 15-1327	Period: From 01/01/2018		
				HHA CCN:	15-7542	To 12/31/2018		
						Home Health Agency I	PPS	
			Capital Rela	ated Costs				
		Net Expenses for Cost	BI dgs & Fi xtures	Movable Equipment	Plant Operation &	Transportation	Subtotal (col s. 0-4)	1
		Allocation	TIXtures	Equi pilleri t	Maintenance			
		(from Wkst. H, col. 10)						
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	4A. 00	
00	Capital Related - Bldg. &	0	0				0	1.
00	Fixtures Capital Related - Movable	0		C)		0	2.
	Equi pment						-	
00 00	Plant Operation & Maintenance Transportation	0	0			0 0	0	3. 4.
00	Administrative and General	133, 125	0	C		0 0	133, 125	1
00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	156, 621	0	C		0 0	156, 621	6.
00	Physical Therapy	19, 609	0	C		0 0	19, 609	
00 00	Occupational Therapy	24, 095 1, 009	0	C		0 0	24, 095 1, 009	
00	Speech Pathology Medical Social Services	2, 595	0	C		0 0	2, 595	
00	Home Health Aide	21, 687	0	C		0 0	21, 687	11.
00 00	Supplies (see instructions) Drugs	0	0	C		0 0	0	
00	DME	0	0	C		0 0		
00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	C	1	0 0	0	1 1 5
00 00	Respi ratory Therapy	0	0	C		0 0	0	
00	Private Duty Nursing	0	0	C		0 0	0	
00 00	Clinic Health Promotion Activities	0	0	C		0 0	0	
00	Day Care Program	0	0	C		0 0	0	
. 00	Home Delivered Meals Program Homemaker Service	0	0	C		0 0	0	
00	All Others (specify)	0	0	C		0 0	0	
50	Tel emedi ci ne	0	0	C		0 0	0	
. 00	Total (sum of lines 1-23)	358,741 Admi ni strati ve	Total (cols.	C		0 0	358, 741	24.
		& General	4A + 5)					-
	GENERAL SERVICE COST CENTERS	5.00	6.00					
00	Capital Related - Bldg. &							1.
00	Fixtures Capital Related - Movable							2.
	Equi pment							
00 00	Plant Operation & Maintenance Transportation							3.
00	Administrative and General	133, 125						4. 5.
20	HHA REI MBURSABLE SERVI CES	02 414	249, 037					,
00 00	Skilled Nursing Care Physical Therapy	92, 416 11, 570	249, 037					6. 7.
	Occupational Therapy	14, 217	38, 312					8.
	Speech Pathology	595	1, 604					9. 10.
00	Medical Social Services	1. 531	4, 126					11.
00 00 00	Home Health Aide	1, 531 12, 796	4, 126 34, 483					
00 00 00	Home Health Aide Supplies (see instructions)	12, 796 0	34, 483 0					
00 00 00 00 00	Home Health Aide Supplies (see instructions) Drugs DME	12, 796	34, 483					13.
00 00 00 00 00 00	Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES	12, 796 0 0 0	34, 483 0 0 0					13. 14.
00 00 00 00 00 00	Home Health Aide Supplies (see instructions) Drugs DME	12, 796 0 0	34, 483 0 0					13. 14. 15.
00 00 00 00 00 00	Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	12, 796 0 0 0 0 0 0 0	34, 483 0 0 0 0 0 0 0 0					13. 14. 15. 16. 17.
00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	12, 796 0 0 0 0 0 0 0 0 0 0	34, 483 0 0 0 0 0 0 0 0 0 0 0					13. 14. 15. 16. 17. 18.
00 00 00 00 00 00 00 00 00 00 00	Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	12, 796 0 0 0 0 0 0 0	34, 483 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					13. 14. 15. 16. 17. 18. 19. 20.
00 00 00 00 00 00 00 00 00 00 00 00	Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	12, 796 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	34, 483 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					12. 13. 14. 15. 16. 17. 18. 19. 20. 21.
00 00 . 00 . 000 . 00 . 0	Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	12, 796 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	34, 483 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					13. 14. 15. 16. 17. 18. 19. 20.

In Lieu of Form CMS-2552-10

CUST A	LLOCATION - HHA STATISTICAL BAS	SI S		Provider CO HHA CCN:	CN: 15-1327 15-7542	Period: From 01/01/2018 To 12/31/2018	Worksheet H-1 Part II Date/Time Prep 5/30/2019 2:35	pared: 5 pm
						Home Health Agency I	PPS	
		Capital Rel	ated Costs					
		BI dgs & Fi xtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Pl ant Operation & Maintenance (SQUARE FEET)	Transportatio (MI LEAGE)	onReconciliation	Admi ni strati ve & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS					-		
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see	0	0	0		0		4.00
5.00	instructions) Administrative and General	0	0	0		0 -133, 125	225, 616	5.00
	HHA REIMBURSABLE SERVICES					0 100, 120	220,010	0.00
6.00	Skilled Nursing Care	0	0	0		0 0	156, 621	6.00
	Physical Therapy	0	0	0		0 0	19, 609	
	Occupational Therapy	0	0	0		0 0	24, 095	
9.00	Speech Pathology	0	0	0		0 0	1, 009	
	Medical Social Services	0	0	0		0 0	2, 595	
	Home Health Aide	0	0	0		0 0	21, 687	
	Supplies (see instructions)	0	0	0		0 0	0	12.00
	Drugs	0	0	0		0	0	13.00
	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.00
	Home Dialysis Aide Services	0	0	0	1	0 0	0	15.00
	Respiratory Therapy	0	0	0		0 0	0	16.00
	Private Duty Nursing	0	0	0		0 0	0	17.00
	Clinic	0	0	0		0 0	0	18.00
	Health Promotion Activities	0	0	0		0 0	0	19.00
	Day Care Program	0	0	0		0 0	0	20.00
	Home Delivered Meals Program	0	0	0		0 0	0	21.00
	Homemaker Service	0	0	0		0 0	0	22.00
	All Others (specify)	0	0	0		0 0	0	23.00
23.50	Tel emedi ci ne	0	0	0		0 0	0	23.50
	Total (sum of lines 1-23)	0	0	0		0 -133, 125	225, 616	
25.00	Cost To Be Allocated (per	0	0	0		0	133, 125	25.00
o (Worksheet H-1, Part I)		0 005	0 005				
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.0000	00	0. 590051	26.00

	n Financial Systems		IVAN COUNTY CON	MUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
ALLOC.	ATION OF GENERAL SERVICE COSTS T	O HHA COST CENT	FERS	Provider CC	CN: 15-1327 15-7542	Period: From 01/01/2018 To 12/31/2018		pared:
						Home Health Agency I	PPS	
			CAPITAL REL	ATED COSTS		Agency		
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FI XT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	I S/ACCOUNTI NG/ MARKETI NG	-
		0	1.00	2.00	4.00	4A	5. 01	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Homemaker Service All Others (specify)	0 249, 037 31, 179 38, 312 1, 604 4, 126 34, 483 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 669 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 937 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	83, 5 ⁻ 83, 5 ⁻	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	13, 487 1, 689 2, 075 87 223 1, 867 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ \end{array}$
	Cost Center Description	Subtotal	BUSINESS OFFICE & ADMITTING	Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LI NEN SERVI CE	
1.00	Administrative and General	5A. 01 103, 496	5.02	5A. 02 103, 496	5.03 10,33	7.00	8.00	1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 16.00 17.00 18.00 21.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	262, 524 32, 868 40, 387 1, 691 4, 349 36, 350 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		103, 440 262, 524 32, 868 40, 387 1, 691 4, 349 36, 350 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26, 2: 3, 24 4, 0: 16 4: 3, 6: 48, 10	20 0 33 0 34 0 59 0 34 0 35 0 34 0 35 0 36 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ \end{array}$

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

	Financial Systems TION OF GENERAL SERVICE COSTS T		<u>I VAN COUNTY CON</u> TERS		CN: 15-1327 15-7542	Period: From 01/01/2 To 12/31/2		2 epared:
						Home Healt		so pili
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI	Agency I CENTRAL ON SERVICES SUPPLY	PHARMACY &	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 5.00 7.00 3.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 19.00 19.50 20.00 21.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	5, 419 5, 419 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				46 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13.00 426 0 <td>2.00 2.00 3.00 4.00 5.00 5.00 6.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 17.00 18.00 19.00 19.50</td>	2.00 2.00 3.00 4.00 5.00 5.00 6.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 17.00 18.00 19.00 19.50
	of column 26, line 20 minus column 26, line 1, rounded to <u>6 decimal places.</u> Cost Center Description	MEDI CAL RECORDS & LI BRARY	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Co & Post Stepdown		Allocated HHA A&G (see Part II)	
		16.00	19.00	24.00	Adjustments 25.00	26.00	27.00	
. 00 . 00 . 00 . 00 . 00 . 00 . 00 0. Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to	16.00 2,853 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		24.00 187,177 288,744 36,151 44,421 1,860 4,783 39,981 0 0 0 0 0 0 0 0 0 0 0 0 0		0 187, 0 288, 0 36, 0 44, 0 1, 0 4,	177 744 129, 938 151 16, 266 421 19, 990 860 837 783 2, 152 981 17, 992 0 0 0	3 3 C 4 C 4 C 7 5 C C 2 6 C C 2 7 C C 2 7 C D S 0 9 C D O O 0 10 C D 11 C 0 12 C D 13 C 0 14 C D 15 C 0 15 C D 18 C 0 18 C D 18 C 0 19 5 7 20 C	

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

Heal th	Financial Systems	SULL	IVAN COUNTY COMM	UNITY HOSPIT	TAL	In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider C	CN: 15-1327	Period:	Worksheet H-2	
				HHA CCN:	15-7542	From 01/01/2018 To 12/31/2018		nared
					10 7012		5/30/2019 2:3	
						Home Health	PPS	
		T 1 1 1114				Agency I		
	Cost Center Description	Total HHA Costs						
		28.00				-		
1.00	Administrative and General	20100						1.00
2.00	Skilled Nursing Care	418, 682						2.00
3.00	Physical Therapy	52, 419						3.00
4.00	Occupational Therapy	64, 411						4.00
5.00	Speech Pathology	2, 697						5.00
6.00	Medical Social Services	6, 935						6.00
7.00	Home Health Aide	57, 973						7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10.00
11.00	Home Dialysis Aide Services	0						11.00
12.00	Respiratory Therapy	0						12.00
13.00	Private Duty Nursing	0						13.00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17.00	Home Delivered Meals Program	0						17.00
18.00	Homemaker Service	0						18.00
19.00	All Others (specify)	0						19.00
19.50	Tel emedi ci ne	0						19.50
20.00	Total (sum of lines 1-19) (2)	603, 117						20.00
21.00	Unit Cost Multiplier: column							21.00
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
		I						I

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

Health Financial Systems		I VAN COUNTY CO				u of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS T BASIS	O HHA COST CEN	TERS STATISTICA	L Provider C	CN: 15-1327 15-7542	Period: From 01/01/2018 To 12/31/2018	Worksheet H-2 Part II Date/Time Prep 5/30/2019 2:35	pared: 5 pm
					Home Health Agency I	PPS	<u> </u>
	CAPI TAL REL	ATED COSTS					
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliati	on I S/ACCOUNTI NG/ MARKETI NG (ACCUM. COST)	Reconciliation	
	1.00	2.00	4.00	5A. 01	5. 01	5A. 02	
 Administrative and General Skilled Nursing Care O Skilled Nursing Care O Occupational Therapy O Medical Social Services O Home Health Aide O Supplies (see instructions) O Drugs O ODME O Home Dialysis Aide Services O Respiratory Therapy O Private Duty Nursing O Clinic O Haelth Promotion Activities O Day Care Program O Home Delivered Meals Program O Homemaker Service O All Others (specify) S Telemedicine O Total (sum of lines 1-19) O Total cost to be allocated O Unit cost multiplier 	949 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	949 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	309, 612 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$ \begin{smallmatrix} 0 & 98, 179 \\ 0 & 249, 037 \\ 0 & 311, 179 \\ 0 & 38, 312 \\ 0 & 1, 604 \\ 0 & 4, 126 \\ 0 & 34, 483 \\ 0 & 0 \\$	-4, 349 -36, 350 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00 5.00
Cost Center Description	BUSI NESS OFFI CE & ADMI TTI NG (ACCUM. COST)	Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION O PLANT (SQUARE FEET)		HOUSEKEEPI NG (SQUARE FEET)	22.00
1.00 Administrative and Conserve	5.02	5A. 03	5.03	7.00	8.00	9.00	1 00
 Administrative and General OO Skilled Nursing Care OO Physical Therapy OO Occupational Therapy OO Speech Pathology OO Medical Social Services OO Home Health Aide OO Drugs OO Drugs OO Prives Aide Services OO Respiratory Therapy OO Private Duty Nursing OO Clinic OO Day Care Program OO Home Delivered Meals Program OO All Others (specify) So Telemedicine OO Total (sum of lines 1-19) OO Total cost multiplier 			103, 496 262, 524 32, 868 40, 387 1, 691 4, 349 36, 350 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0	949 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21.00

Heal th Financial Systems			MMUNITY HOSPITA			u of Form CMS-2	
ALLOCATION OF GENERAL SERVICE COSTS T BASIS	U HHA CUSI CENI	iers statistic	AL Provider CC HHA CCN:	N: 15-1327 15-7542	Period: From 01/01/2018 To 12/31/2018		pared [.]
					Home Health Agency I	PPS	<u>o piii</u>
Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	
	10.00	11.00	13.00	14.00	15.00	16.00	
 Administrative and General OSkilled Nursing Care OPhysical Therapy OCcupational Therapy OCcupational Therapy OO Speech Pathology OO Medical Social Services OO Home Health Aide OO Drugs OO DME OO ME OO Home Dialysis Aide Services OO Respiratory Therapy OO Private Duty Nursing OO Lainic OO Home Delivered Meals Program OO Home Activities OD All Others (specify) OT Telemedicine OO Total (sum of lines 1-19) OO Total cost to be allocated OU Unit cost multiplier 			12, 443 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 44 1, 44 42 0. 29562	0 0 26 0	390, 615 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 20.\ 00\\ 21.\ 00\\ 21.\ 00\end{array}$
Cost Center Description	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME) 19.00	0.00000	3. 173371	0.27302		0.007304	
 Administrative and General OO Skilled Nursing Care OO Physical Therapy OO Occupational Therapy OO Speech Pathology OO Medical Social Services OO Home Health Aide OO Drugs OO DME OO ME OO Medical Services OO DME OO DME OO Private Duty Nursing OO Clinic OO Aga Care Program OO Home Delivered Meals Program OO All Others (specify) OO Total (sum of lines 1-19) OO Total cost to be allocated 							$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 22.\ 00\\ \end{array}$

	Financial Systems		IVAN COUNTY CO		CN: 15-1327	Peri od:	u of Form CMS-2 Worksheet H-3	
		0		HHA CCN:	15-7542	From 01/01/2018 To 12/31/2018	Part I	pared:
				Title	e XVIII	Home Health Agency I	PPS	•
	Cost Center Description		Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
		0	1.00	Part II) 2.00	3.00	4.00	4) 5.00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	418, 682		418, 68			
2.00	Physical Therapy	3.00	52, 419	C			75.97	
3.00	Occupational Therapy	4.00	64, 411	C	,		255.60	3.00
4.00	Speech Pathol ogy	5.00	2, 697	C				
5.00	Medical Social Services	6.00	6, 935		6, 93			
6.00	Home Health Aide	7.00	57, 973		57, 97		94. 73	
7.00	Total (sum of lines 1-6)		603, 117	C				7.00
			1		Program Visit			-
			0DCA N (1)	D		art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject 1 Deductibles			
					Coi nsurance			
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation		1.00	2.00	0.00	1.00	0.00	
8.00	Skilled Nursing Care		45460	C	54	5		8.00
8. 01	Skilled Nursing Care		99915	C	6	5		8.01
9.00	Physical Therapy		45460	C	49	7		9.00
9.01	Physical Therapy		99915	C	5	5		9.01
10.00	Occupational Therapy		45460	C	18	32		10.00
10. 01	Occupational Therapy		99915	C	2	5		10.01
11.00	Speech Pathol ogy		45460	C		6		11.00
11. 01	Speech Pathol ogy		99915	C		0		11.01
12.00	Medical Social Services		45460	C		7		12.00
12.01	Medical Social Services		99915	C		1		12.01
13.00	Home Health Aide		45460	C				13.00
13.01	Home Health Aide		99915	C		27		13.01
14.00	Total (sum of lines 8-13)			C	., , , ,			14.00
	Cost Center Description				Total HHA		Ratio (col. 3	
		Part I, col.	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (col s.	1 (from HHA Records)	÷ col. 4)	
		28, line	n-z, Parti)	Part II)	+ 2)	Records)		
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computa	-		2100	0.00		0100	
15.00		8.00	0	C		0 0	0. 000000	15.00
16.00	Cost of Drugs	9.00	0	C)	0 0	0. 000000	16.00
			Program Visits		Cost of			
			_		Servi ces			
			Par			Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
			Deductibles &			Deductibles &	Deductibles &	
		(00	Coi nsurance	Coi nsurance	0.00	Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	RUGRAM CUSI, A	GGREGATE OF TF	IE PROGRAM LIN	ITATION COST, OF	K	
	Cost Per Visit Computation]
1.00	Skilled Nursing Care	0	630			0 290, 493		1.00
1.00	Physi cal Therapy	0	552			0 41, 935		2.00
2.00		-	207		1	0 52,909		3.00
2.00	Occupational Therapy	0	207			JZ, 707		0.00
	Occupational Therapy Speech Pathology	0	207			0 952		
2.00 3.00								4.00
2.00 3.00 4.00	Speech Pathology	0	6			0 952		4.00 5.00 6.00

APPORT	Financial Systems IONMENT OF PATIENT SERVICE COST	S		Provider CC	CN: 15-1327	Peri od:	u of Form CMS-2 Worksheet H-3	
				HHA CCN:	15-7542	From 01/01/2018 To 12/31/2018	Part I Date/Time Pre 5/30/2019 2:3	pareo
				Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation	0.00	7.00	8.00	9.00	10.00	11.00	
2. 01 3. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Health Aide Home Health Aide							8. 8. 9. 10. 10. 11. 11. 12. 12. 13. 13.
	Total (sum of lines 8-13)							14.
		Progi	ram Covered Cha	rges	Cost of Servi ces			
			Part	B		Part B		
	Cost Center Description	Part A	Not Subject to Deductibles &	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles &	Subject to Deductibles &	
		6.00	Coi nsurance 7.00	8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
	Supplies and Drugs Cost Computa							
	Cost of Medical Supplies	0	961	0		0 0	0	
6.00	Cost of Drugs Cost Center Description	Total Program	0	0		0	0	16.
	cost center bescription	Cost (sum of cols. 9-10) 12.00				-		
	PART I - COMPUTATION OF LESSER		ROGRAM COST, AC	GREGATE OF THE	E PROGRAM LI	MITATION COST, OR		
	BENEFICIARY COST LIMITATION							-
. 00	Cost Per Visit Computation Skilled Nursing Care	290, 493						1 1.
. 00	Physical Therapy	41, 935						2.
. 00	Occupational Therapy	52, 909						3.
. 00	Speech Pathology	952						4.
. 00	Medical Social Services	3, 468						5.
. 00	Home Health Aide	52, 196 441, 953						6. 7.
. 00	Total (sum of lines 1-6) Cost Center Description	441, 955						/.
	cost conter beschiption	12.00				-		1
	Limitation Cost Computation							
	Skilled Nursing Care							8.
. 00	Skilled Nursing Care							8.
. 00 . 01								9. 9.
. 00 . 01 . 00	Physical Therapy							
. 00 . 01 . 00 . 01	Physical Therapy Physical Therapy							1 10
. 00 . 01 . 00 . 01 0. 00	Physi cal Therapy Physi cal Therapy Occupati onal Therapy							10.
. 00 . 01 . 00 . 01 0. 00 0. 01	Physical Therapy Physical Therapy							10.
. 00 . 01 . 00 . 01 0. 00 0. 01 1. 00	Physi cal Therapy Physi cal Therapy Occupati onal Therapy Occupati onal Therapy							10. 11.
. 00 . 01 . 00 . 01 0. 00 0. 01 1. 00 1. 01	Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology							10. 11. 11.
3. 00 3. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 12. 01	Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services							10. 11. 11. 12. 12.
3.00 3.01 9.00 9.01 10.00 10.01 11.00 11.01 12.00 12.01 13.00	Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide							10. 11. 11. 12. 12. 13.
3.00 3.01 3.01 0.00 0.01 1.00 1.01 2.00 2.01 3.00 3.01	Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services							10 11 11 12 12

Heal th	Financial Systems	SULL	IVAN COUNTY CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider C	CN: 15-1327	Period: From 01/01/2018	Worksheet H-3 Part II	
				HHA CCN:	15-7542	To 12/31/2018		
				Titl€	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00	Physical Therapy	66.00	0. 569124	C)	0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 502499	C		Ocol. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	1. 111161	C		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 149857	C		0 col. 2, line 1	5.00	4.00
5.00	Cost of Drugs	73.00	0. 512356	C		0 col. 2, line 1	6. 00	5.00

	Financial Sullivan County County <thcounty< th=""> <thcounty< th=""> <thcount< th=""><th>Provider CC</th><th></th><th>Peri</th><th>od:</th><th>u of Form CMS-2 Worksheet H-4</th><th></th></thcount<></thcounty<></thcounty<>	Provider CC		Peri	od:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	15-7542		01/01/2018 12/31/2018	Part I-II Date/Time Pre 5/30/2019 2:3	
		Ti tl e	XVIII		ome Health Agency I	PPS	<u>o p</u>
			Part A	Not	Par Subject to		
			Fait A	De		Deductibles & Coinsurance	
		-	1.00		2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MARY CHARGES	5				
00	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0	0	0	1 1
00	Total charges			0	0	0	
00	Customary Charges Amount actually collected from patients liable for payment for			0	0	0	3
00	on a charge basis (from your records)	Services		0	0	0	
00	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in a			0	0	0	4
00	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	000	0. 000000	0.000000	5
00	Total customary charges (see instructions)		0.0000	0	0.000000	0.000000	
00	Excess of total customary charges over total reasonable cost (complete		0	0	0	7
00	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	yifline		0	0	0	8
00	Primary payer amounts			0	0	0	9
					Part A Services	Part B Servi ces	
					1.00	2.00	
00	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				0	0	1 10
. 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				0	0 265, 077	
. 00	Total PPS Reimbursement - Full Episodes with Outliers				0	3, 806	
. 00	Total PPS Reimbursement - LUPA Episodes				0	4, 348	
. 00	Total PPS Reimbursement - PEP Episodes				0	9, 873	
. 00 . 00	Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes				0	354 0	
. 00	Total Other Payments				0	0	
. 00	DME Payments				0	0	
. 00	Oxygen Payments				o	0	
. 00	Prosthetic and Orthotic Payments				0	0	20
. 00	Part B deductibles billed to Medicare patients (exclude coinsu	rance)				0	21
. 00	Subtotal (sum of lines 10 thru 20 minus line 21)				0	283, 458	
. 00	Excess reasonable cost (from line 8)				0	0	
. 00	Subtotal (line 22 minus line 23)				0	283, 458	
. 00	Coinsurance billed to program patients (from your records)				0	0 283, 458	
. 00 . 00	Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)				0	283, 458	20
	Reimbursable bad debts for dual eligible beneficiaries (see in	structions)					28
. 00	Total costs - current cost reporting period (line 26 plus line				0	283, 458	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	0	
. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	0	30
. 99	Demonstration payment adjustment amount before sequestration				0	0	
. 00	Subtotal (see instructions)				0	283, 458	
. 01	Sequestration adjustment (see instructions)				0	5, 669	
. 02	Demonstration payment adjustment amount after sequestration				0	0	
2.00	Interim payments (see instructions)				0	277, 789	
3.00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32, a	nd 33)			0	0	
1 00		10 33/			0	0	1 34
4.00 5.00	Protested amounts (nonallowable cost report items) in accordan		Pub. 15-2		0	0	35

	SIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider CC	CN: 15-1327		eriod:	Worksheet H-5	
PRO	IGRAM BENEFI CI ARI ES	HHA CCN:	15-7542	To	rom 01/01/2018 0 12/31/2018	Date/Time Prep 5/30/2019 2:35	
					Home Health Agency I	PPS	<u>, piii</u>
		I npati en	t Part A		Par	t B	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
00	Total interim novmente neid te previder	1.00	2.00	0	3.00	4.00	1.
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0		277,789 0	1. 2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						3.
1				0		0	3
2				0		0	3
)3				0		0	3
)4				0		0	3
5	Provider to Program			0		0	3
0				0		0	3
1				0		0	3
2				0		0	3
3				0		0	3
54				0		0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		0	3
0	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		277, 789	4
	TO BE COMPLETED BY CONTRACTOR						
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5
	Program to Provider						
1				0		0	5
)2)3				0 0		0	5 5
3	Provider to Program			0		0	C
0				0		0	5
1				0		0	5
2				0		0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		0	5
0	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)						6
)1	SETTLEMENT TO PROVIDER			0		0	6
)2	SETTLEMENT TO PROGRAM			0		0	6
00	Total Medicare program liability (see instructions)			0		277, 789	7
					Contractor	NPR Date	
					Number	(Mo/Day/Yr)	