Health Financia	al Systems	HENDRICKS REGIONAL	HEALTH	In Lie	u of Form CMS-2552-10	
This report is	required by law (42 USC 1395	g; 42 CFR 413.20(b)). Failu	re to report can re	esult in all interim	FORM APPROVED	
payments made	since the beginning of the co	st reporting period being d	eemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY  PART I - COST REPORT STATUS  Provider CCN: 150005 From 01/01/2015 To 12/31/2015 Date 5/26						
PART I - COST	REPORT STATUS					
Provi der	1. [ X ] Electronically filed	cost report		Date: 5/26/20	016 Time: 11:24 am	
use only	2. [ ] Manually submitted co	ost report				
	3. [ 0 ] If this is an amended 4. [ F ] Medicare Utilization.	l report enter the number of Enter "F" for full or "L"	times the provide for low.	er resubmitted this c	ost report	
Contractor use only	5. [ 1 ]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened		this Provider CCN			

## PART II - CERTIFICATION

(5) Amended

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

## CERTIFICATION BY 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 HENDRICKS REGIONAL HEALTH (150005) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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.

(Si gned)	
	Officer or Administrator of Provider(s)
Title	
Date	

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	137, 419	120, 686	0	163, 359	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	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	137, 419	120, 686	0	163, 359	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.

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150005 Peri od: Worksheet S-2 From 01/01/2015 Part I 12/31/2015 Date/Time Prepared: 5/26/2016 11:23 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1000 EAST MAIN STREET 1.00 PO Box: 1.00 State: IN Zip Code: 46122-1409 County: HENDRICKS 2.00 City: DANVILLE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Туре 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal HENDRICKS REGIONAL 150005 26900 07/01/1966 N 3.00 HFAI TH Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15 00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2015 12/31/2015 Type of Control (see instructions) 21.00 21.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate γ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Υ Υ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the

	1, circle i i adite of dami saron, 2 ii census days, or							
	method of identifying the days in this cost reporting	g period di	fferent fro	om the metho	od			
	used in the prior cost reporting period? In column 2	2, enter "Y	for yes c	r "N" for r	no.			
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medicaid		days	
			unpai d	paid days	eligible			
			days		unpai d			
		1. 00	2. 00	3. 00	4. 00	5. 00	6.00	
24. 00	If this provider is an IPPS hospital, enter the	498	1, 143	0	2	1, 727	0	24. 00
	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		^	_	_			25. 00
		١	U	"	٥			25.00
	Medicaid paid days in column 1, the in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid							
	HMO paid and eligible but unpaid days in column 5.							
				•		•	•	•

Ν

23.00

cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with

1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the

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

42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

	Financial Systems HENDRICI TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		ONAL HEALTH Provi der (		eri od:		Workshe		2552-10
					com 01/01/		Part I Date/Ti	me Pre	nared:
							5/26/20	16 11:	
					Urban/Rui 1.00		Date of 2.0		
26. 00	Enter your standard geographic classification (not wa			inning of the	1.00	1	2. (	,,,	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa			of the cost		1			27. OC
27.00	reporting period. Enter in column 1, "1" for urban or	"2" fc	or rural. If ap			1			27.00
35 00	enter the effective date of the geographic reclassifilf this is a sole community hospital (SCH), enter the			H etatue in		0			35. OC
	effect in the cost reporting period.	Hulliber	or perrous sc	ii status iii		U			33.00
					Begi nni		Endi		
36. 00	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for number	1. 00		2. (	)()	36. 00
	of periods in excess of one and enter subsequent date	S.	·						07.00
37. 00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the nu	imber of period	S MDH STATUS		0			37.00
38. 00	If line 37 is 1, enter the beginning and ending dates								38. 00
	greater than 1, subscript this line for the number of enter subsequent dates.	peri oc	ds in excess of	one and					
	Subsequent dutes.				Y/N		Υ/		
39. 00	Does this facility qualify for the inpatient hospital	navmor	at adjustment f	or Low volume	1. 00 N		2. ( N		39. 00
37.00	hospitals in accordance with 42 CFR §412.101(b)(2)(ii	)? Ente	er in column 1	"Y" for yes	IN IN		IN		39.00
	or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	ui remer	nts in accordan	ce with 42					
40. 00	Is this hospital subject to the HAC program reduction				N		N		40.00
	"N" for no in column 1, for discharges prior to Octob			es or "N" for					
	no in column 2, for discharges on or after October 1.	(See I	nstructions)			V	XVIII	XIX	
						1. 00	2. 00	3. 00	
45. 00	Prospective Payment System (PPS)-Capital  Does this facility qualify and receive Capital paymen	t for o	li sproporti onat	e share in acc	ordance	N	Υ	N	45. 00
	with 42 CFR Section §412.320? (see instructions)								
46. 00	Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst	ption f	for extraordina - III and Wkst	ry circumstanc	es hrough	N	N	N	46. 00
	Pt. III.								
	Is this a new hospital under 42 CFR §412.300 PPS capils the facility electing full federal capital payment				10.	N N	N N	N N	47. 00 48. 00
46.00	Teaching Hospitals	: LIILE	n ror yes	or in roi no.		IV	I IN	I IV	40.00
56. 00	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y" f	or yes	N			56. 00
57. 00	or "N" for no. If line 56 is yes, is this the first cost reporting p	eriod o	during which re	sidents in app	roved				   57. 00
	GME programs trained at this facility? Enter "Y" for	yes or	"N" for no in	column 1. If	column 1				
	is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y								
F0 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II								F0 00
58. 00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ns services a	IS	N			58. 00
	Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,			N			59. 00
60.00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"				tions)	N			60.00
		Y/N	IME	Direct GME	IME		Di rect	GME	
		1. 00	2. 00	3. 00	4.00	)	5. (	00	
61. 00	Did your hospital receive FTE slots under ACA	50	2.00	5. 00	4. 00	0.00	5. (		61. 00
	section 5503? Enter "Y" for yes or "N" for no in	i l				[			
	Icolumn 1 (see instructions)								
61. 01	column 1. (see instructions) Enter the average number of unweighted primary care		0. 00	0. 00					61. 01
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports		0. 00	0.00					61. 01
61. 01	Enter the average number of unweighted primary care		0. 00	0.00					61. 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 instructions) Enter the current year total unweighted primary care		0. 00 0. 00	0. 00					
	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 instructions)								
61. 02	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 instructions)  Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0. 00	0. 00					61. 02
61. 02	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 instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care								61. 02
61. 02	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 instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0. 00	0. 00					61. 02
61. 02 61. 03	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 instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0. 00	0. 00					61. 02 61. 03
61. 02 61. 03	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 instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0. 00	0. 00					61. 02 61. 03
61. 02 61. 03 61. 04	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 instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0. 00 0. 00 0. 00	0. 00 0. 00 0. 00					61. 02 61. 03 61. 04
61. 02 61. 03 61. 04	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 instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0. 00	0. 00					61. 02 61. 03 61. 04 61. 05
61. 02 61. 03 61. 04	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 instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 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		0. 00 0. 00 0. 00	0. 00 0. 00 0. 00					61. 02 61. 03 61. 04
61. 02 61. 03 61. 04 61. 05	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 instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0. 00 0. 00 0. 00	0. 00 0. 00 0. 00					61. 02 61. 03 61. 04

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150005 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/26/2016 11:23 am Program Name Program Code Unweighted IME Unwei ghted Direct ĞME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 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)

Health Financial Systems HENDRICKS REG HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			In Lie eriod: com 01/01/2015	eu of Form CMS- Worksheet S-2 Part I	
		To		Date/Time Pre	
			V	5/26/2016 11: XI X	23 am
			1. 00	2.00	
95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yeapplicable column.			O. 00 N	O. OC N	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the ap Rural Providers	oplicable column	n.	0. 00	0.00	97. 00
105.00 Does this hospital qualify as a critical access hospital (0 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		hod of payment	N N		105. 00 106. 00
107.00 If this facility qualifies as a CAH, is it eligible for costraining programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.	nn 1. (see insti	ructions) If	N		107. 00
108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108. 00
	Physi cal 1.00	0ccupati onal 2.00	Speech 3.00	Respiratory 4.00	+
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N N	N N	N N	109. 00
				1.00	_
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)for	1. 00 N	110. 00
			1. 00	0 2.00 3.00	
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or	or "N" for no ::	n column 1 lf	column 1 N	0	115. 00
is yes, enter the method used (A, B, or E only) in column 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, chapter 22, §2208.1.	2. If column 2 i ent for long tea	is "E", enter i rm care (includ	n column les		115.00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu	•		N" for Y		116. 00 117. 00
no.  118.00 Is the malpractice insurance a claims-made or occurrence policy is occurrence.	olicy? Enter 1 i	if the policy i	s 1		118. 00
crafill-lilade. Litter 2 ff the portey is occurrence.		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 847, 310	2. 00 C	3.00	0 118. 01
			1. 00	2.00	-
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.			N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments.	n column 1, "Y' qualifies for th	" for yes or he Outpatient	N	N	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 imples patients? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Y		121. 00
Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.	for yes and "N"	for no. If	N		125. 00
126.00 If this is a Medicare certified kidney transplant center, ein column 1 and termination date, if applicable, in column	2.				126. 00
127.00  f this is a Medicare certified heart transplant center, er  in column 1 and termination date, if applicable, in column   128.00  f this is a Medicare certified liver transplant center, er	2.				127. 00 128. 00
in column 1 and termination date, if applicable, in column 129.00 olf this is a Medicare certified lung transplant center, ent	2.				129. 00
column 1 and termination date, if applicable, in column 2.  130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in co		ti fi cati on			130. 00
	olumn 2.				
131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in co	er, enter the co olumn 2.				
131.00 If this is a Medicare certified intestinal transplant center	er, enter the co blumn 2. nter the certifi 2.	ication date			131. 00 132. 00 133. 00

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLEX		FGI ONAL HEALTH Provi der	CCN: 15000		:	u of Form CMS Worksheet S	
				From O	1/01/2015 2/31/2015	Part I Date/Time P 5/26/2016 1	repared
					1. 00	2.00	
All Providers					1.00	2.00	
40.00 Are there any related organization of chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the h	for no in column 1. I	If yes, and home	office co		N		140. 0
1.00		2. 00	1 110 11		3.00	6.11	
If this facility is part of a chain home office and enter the home office				e name and	d address	of the	
41. 00 Name:	Contractor's Name:	CONTRIGUED HAMB		actor's Nu	mber:		141. (
12.00 Street:	PO Box:		7: 0				142.
3. 00 Ci ty:	State:		Zi p Co	oae:			143.
						1.00	
14.00 Are provider based physicians' costs	included in Workshee	t A?				Y	144.
					1. 00	2.00	$\dashv$
45.00 f costs for renal services are clai					Y		145. (
inpatient services only? Enter "Y" f				5			
no, does the dialysis facility incluperiod? Enter "Y" for yes or "N" for		on for this cost	reporting				
16.00 Has the cost allocation methodology	changed from the previ				N		146.
Enter "Y" for yes or "N" for no in c yes, enter the approval date (mm/dd/		. 15-2, chapter 4	40, §4020)	lf			
yes, enter the approvar date (IIIII/dd/	yyyy) iii corullii 2.						
L						1.00	
7.00 Was there a change in the statistica 8.00 Was there a change in the order of a						N N	147. 148.
9.00 Was there a change to the simplified		,		for no.		N N	149.
<u> </u>	<u> </u>	Part A	Part	3 T	itle V	Title XIX	
Does this facility contain a provide	un that muslifies for	1.00	2.00	i ooti on ot	3.00	4.00	
or charges? Enter "Y" for yes or "N"							
55.00 Hospi tal	•	N	N		N	N	155.
6.00 Subprovider - IPF 7.00 Subprovider - IRF		N N	N N		N N	N N	156. 157.
88. 00 SUBPROVI DER		IV.	"		IV	14	158.
59. 00 SNF		N	N		N	N	159.
50.00HOME HEALTH AGENCY 51.00CMHC		N	N N		N N	N N	160. 161.
51. OO CWITC			I IV		IN	IV	101.
						1.00	
Multicampus 55.00 s this hospital part of a Multicamp	us hospital that has o	one or more campi	isas in di	fforent CE	25/15/2	N	165.
Enter "Y" for yes or "N" for no.	us nospitai that has t	one or more campo	ases III ui	rrerent c	JONG :	14	105.
	Name	County	State	Zip Code	CBSA	FTE/Campus	
66.00 If line 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5.00	00 166.
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)						5.	
						1 00	
Health Information Technology (HIT)	incentive in the Amer	ican Recovery an	d Reinvest	ment Act		1.00	
7.00 Is this provider a meaningful user u 8.00 If this provider is a CAH (line 105 reasonable cost incurred for the HIT	nder §1886(n)? Enter is "Y") and is a meani	"Y" for yes or ' ingful user (line	'N" for no		the	N	167. 0168.
8.01 If this provider is a CAH and is not	a meaningful user, do	oes this provider			lshi p		168.
1 0440 70( ) (() (1) 0 5					enter the	0.	00169.
exception under §413.70(a)(6)(ii)? E 69.00 If this provider is a meaningful use transition factor. (see instructions							
				Ве	gi nni ng	Endi ng	
69.00 If this provider is a meaningful use	5)			Ве	gi nni ng 1. 00	Endi ng 2. 00	170.

Health Financial Systems	HENDRI CKS	REGI ONAL	HEALTH			In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	FICATION DATA		Provi der (	CCN: 150005		od: n 01/01/2015	Worksheet S-: Part I	2
					То	12/31/2015	Date/Time Pro 5/26/2016 11	
							3/20/2010 11	23 alli
							1. 00	
171.00 If line 167 is "Y", does this provider ha	N	171. 00						
Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no.								
(see instructions)								

	Financial Systems	HENDRICKS REGIONAL				eu of Form CMS	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period: From 01/01/2015	Worksheet S-: Part II	2
					o 12/31/2015		
					Y/N	Date	. 23 alli
					1. 00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for	all NO re	esponses. Enter	all dates in	the	
	Provider Organization and Operation					1	
1. 00	Has the provider changed ownership immediately reporting period? If yes, enter the date of				N		1.00
	reporting perrous in yes, enter the date of	the change in corum	1 2. (366	Y/N	Date	V/I	
				1. 00	2. 00	3. 00	
2.00	Has the provider terminated participation in yes, enter in column 2 the date of termination voluntary or "I" for involuntary.	on and in column 3,	"V" for	N			2.00
3.00	Is the provider involved in business transaction contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or relationships? (see instructions)	., chain home office d to the provider o l, or members of the	es, drug its board	N			3.00
				Y/N	Type	Date	
	Einancial Data and Donorto			1.00	2. 00	3. 00	
4.00	Financial Data and Reports  Column 1: Were the financial statements prepared Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Co enter date availabl	ompiled,	Y	A		4.00
5. 00	column 3. (see instructions) If no, see instr Are the cost report total expenses and total		from	l N			5.00
	those on the filed financial statements? If						
					Y/N	Legal Oper.	
	Approved Educational Activities				1. 00	2. 00	
6.00	Column 1: Are costs claimed for nursing school the legal operator of the program?	•		ne provider is	N		6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs' Were nursing school and/or allied health programs reporting period? If yes, see instruction	grams approved and/o		during the	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents i	in an approved grad	uate medic	cal education	N		9. 00
10. 00	program in the current cost report? If yes, s Was an approved Intern and Resident GME progr		newed in t	he current	N		10.00
	cost reporting period? If yes, see instructions are GME cost directly assigned to cost center	ons. rs other than I & R			N		11. 00
	Teaching Program on Worksheet A? If yes, see	instructions.				Y/N	
						1.00	
	Bad Debts					11.00	
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy.				t reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments w	vaived? If	yes, see inst	ructi ons.	N	14.00
15. 00	Did total beds available change from the price	or cost reporting po	eriod? If			N Deset D	15. 00
		Descriptio	n	Y/N	Tt A Date	Part B Y/N	
		0		1.00	2. 00	3.00	
	PS&R Data						
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see			Y	04/20/2016	Y	16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is			N		N	17. 00
18. 00	yes, enter the paid-through date in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not			N		N	18. 00
19. 00	included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see			N		N	19. 00
20. 00	instructions.  If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N		N	20. 00

Health Financial Systems		HENDRI CKS REC	GLONAL HEALTH	In Lie	u of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CAR	E REIMBURSEMENT	QUESTI ONNAI RE	Provider CCN: 150005	Peri od:	Worksheet S-2
				From 01/01/2015	Part II
				To 10/01/001E	Doto/Time Dronored

21.00 Was the cost report prepared only using the provider's resported only using the cost reporting period? If yes, see instructions.  25.00 Ware there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.  26.00 Ware there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.  27.00 Ware there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.  28.00 Ware there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.  28.00 Ware there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.  28.00 Ware the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.  28.00 Ware the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 2 2 00 treated as a funded depreciation account? If yes, see instructions.  29.00 If the provider have a funded depreciation account? If yes, see instructions.  29.00 Ware the provider have a funded depreciation account? If yes, see instructions.  29.00 If yes, see instructions.  29.00 Ware the provider have a funded depreciation account? If yes, see instructions.  29.00 Ware the provider have a funded d						From To	01/01/2015 12/31/2015	Part II Date/Time Pre 5/26/2016 11:	
21.00 Was the cost report prepared only using the provider's records? If yes, see Instructions.    COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					P	art A			
21.00   Nas the cost report propaged only using the provider's records? If yes, see   1.00			Descri pt	tion	Y/N		Date	Y/N	
Provider's records?   if yes, see			0		1.00		2. 00	3. 00	
COMPLETED BY COST RELIMBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capit Tall Related Cost  22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have assets been relifed for Medicare depreciation expense due to appraisals made during the cost 23.00 Have assets been relifed for Medicare depreciation expense due to appraisals made during the cost 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see 25.00 Have there been new capit all zed Leases entered into during the cost reporting period? If yes, see 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit 28.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, submit 29.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 29.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 29.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 39.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 39.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 39.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 39.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 39.00 Instructions. 39.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 39.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 39.00 Were home office costs claimed on the cost report? 39.00 Were home office costs claimed on the cost report? 39.00 Were home office costs claimed on the c	21. 00	provider's records? If yes, see			N			N	21. 00
Capital Related Cost   22.00   Notes assets been relifed for Medicare purposes? If yes, see instructions   N   23.00								1. 00	
22.00   Have assets been relifed for Medicare purposes? If yes, see instructions   N   22.00   N   23.00   Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost   N   23.00   Ware changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period?   N   24.00   Ware new leases and/or amendments to existing leases entered into during this cost reporting period?   N   24.00   Ware see instructions   N   24.00   Ware assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see   N   25.00   Ware assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see   N   26.00   Instructions   N   27.00   Copy.   Instructions   N   27.00   Copy.   Instructions   N   27.00   Copy.   Instructions   N   28.00   Ware assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see   N   27.00   Copy.   Instructions   N   28.00   Ware assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see   N   27.00   Copy.   Instructions   N   28.00   Ware new loans, nortgage agreements or letters of credit entered into during the cost reporting   N   28.00   Ware new loans, nortgage agreements or letters of credit entered into during the cost reporting   N   29.00   Ware new loans, nortgage agreements or letters of credit entered into during the cost reporting   N   29.00   Ware to provide depreciation account? If yes, see Instructions   N   29.00   Ware to provide depreciation account? If yes, see Instructions   N   29.00   Ware to provide depreciation account? If yes, see Instructions   N   31.00   Instructions   N   31.00   Instructions   N   32.00   Ware to require the provider facility without issuance of new debt? If yes, see   N   31.00   Instructions   N   32.00   Ware changes or new agreements occurred in patient care services furnished through contractual   N   32.00   Variation   Variation   N   33.00   Variation   Varia		COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCEPT	CHILDRENS HO	OSPI TALS)				
1.   23.00   Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions   N   24.00		Capital Related Cost							
24.00 Were new Jeases and/or amendments to existing Jeases entered into during this cost reporting period? N 24.00 If yes, see Instructions S 1 25.00 Have there been new capital zed Jeases entered into during the cost reporting period? If yes, see N 25.00 Instructions.  25.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Instructions.  27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 CODY.  28.00 Were new Jeans, mortgage agreements or letters of credit entered into during the cost reporting Period? If yes, see instructions.  29.00 Were new Jeans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions.  29.00 Id the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 Were asset as funded depreciation account? If yes, see Instructions of N 29.00 Were asset as funded depreciation account? If yes, see Instructions of N 29.00 Were asset as funded depreciation account? If yes, see Instructions of N 29.00 Were asset as funded depreciation account? If yes, see Instructions of N 29.00 Were asset as funded depreciation account? If yes, see Instructions of N 29.00 Were asset Provided Depreciation account? If yes, see Instructions of N 20.00 Were changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  31.00 If fine 32 is yes, were the requirements of Sec. 2135. 2 applied pertaining to competitive bidding? If N 33.00 Were-Based Physicians?  32.00 If yes, see Instructions.  33.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians? N 11 yes, see instructions.  35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 Physicians during the cost reporting period? If yes, see instructi		Have changes occurred in the Medicare deprec			als made duri	ing t	he cost		
instructions.  26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see	24. 00	Were new leases and/or amendments to existing	g leases entered	into during	this cost rep	porti	ng period?	N	24. 00
instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Copy. Interest Expense  28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.  29.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.  30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 instructions.  31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 instructions.  32.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 31.00 instructions.  32.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 instructions.  32.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 instructions.  32.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 instructions.  32.00 Has existing debt the provider scheduled maturity without issuance of new debt? If yes, see N 31.00 instructions.  32.00 Has existence of the scheduled maturity without issuance of new debt? If yes, see N 31.00 instructions.  32.00 Has existing agreements with suppliers of services? If yes, see instructions.  32.00 If yes, see wore the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 3.00 if yes, see instructions.  33.00 If Jine 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 if Jine 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 if Jine 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 if Jine 34 is yes, were the year of the home office different from that of N 36.00 if Jine 36 is yes, has a home office	25. 00	Have there been new capitalized leases enter	ed into during th	ne cost repor	ting period?	lf y	es, see	N	25. 00
Copy.   Interest Expense	26. 00		uired during the	cost reporti	ng period? I1	f yes	, see	N	26. 00
28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.  29.00 If d the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)  10.00 It reated as a funded depreciation account? If yes, see instructions.  30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see  10.00 Instructions.  30.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see  10.00 Instructions.  30.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  30.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.00 no, see instructions.  30.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?  30.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 physicians during the cost reporting period? If yes, see instructions.  30.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 physicians during the cost reporting period? If yes, see instructions.  30.00 If line 36 is yes, was the fiscal year end of the home office?  30.00 If line 36 is yes, did the provider render services to other chain components? If yes, see Instructions.  30.00 If line 36 is yes, did the provider render services to the home office? If yes, see Instructions.  30.00 If line 36 is yes, did the provider render services to the home office? If yes, see Instructions.  30.00 If line 36 is yes, did the provider render services to the home office? If yes, see Instructions.  30.00 Enter the first name, last name and the title/position held by the cost report perparer	27. 00	copy.	submit	N	27. 00				
29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)  10.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see  10.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see  10.00 Has existing debt been recalled before scheduled maturity without issuance of new debt? If yes, see  10.00 Name of the provider scheduled maturity without issuance of new debt? If yes, see  10.00 Has existing debt been recalled before scheduled maturity without issuance of new debt? If yes, see  10.00 Has existing debt been recalled before scheduled maturity without issuance of new debt? If yes, see  10.00 Has existing debt been recalled before scheduled maturity without issuance of new debt? If yes, see  10.00 Has existing debt been recalled before scheduled maturity without issuance of new debt? If yes, see  10.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see  10.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see  10.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see  10.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.  10.10 If line 34 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Name arrangement with provider-based physicians?  10.00 If line 34 is yes, were ther enew agreements or amended existing agreements with the provider-based physicians?  10.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians?  10.00 If line 36 is yes, has a home office cost statement been prepared by the home office?  10.00 If line 36 is yes, has a home office cost statement been prepared by the home office.  10.00 If line 36 is yes, and a home office cost statement been prepared by the home office.  10.00 If line 36 is yes, and a home offi	28. 00	Were new loans, mortgage agreements or lette	rs of credit ente	ered into dur	ing the cost	repo	rting	N	28. 00
30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see    N 30.00 instructions.  31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see    N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see    N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see    N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see    N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see    N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see    N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see    N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see    N 31.00 If line 36 is yes, were the requirements of sec. 2135.2 applied pertaining to competitive bidding? If N 32.00 Have changes of the services furnished through contractual N 32.00 Have changes or new agreements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.00 Has a rangements with supplied pertaining to competitive bidding? If N 33.00 Has a rangements with supplied pertaining to competitive bidding? If N 33.00 Has a rangements with supplied pertaining to competitive bidding? If N 34.00 Has a rangements with supplied pertaining to competitive bidding? If N 34.00 Has a rangements with supplied pertaining to competitive bidding? If N 34.00 Has a rangement with provider-based physicians P N 34.00 Has a rangements with supplied pertaining to competitive bidding? If N 34.00 Has a rangements with supplied pertaining to competitive bidding? If N 34.00 Has a rangements with supplied pertaining to competitive bidding? If N 34.00 Has a see instructions.  N 34.00 Has a services furnished the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 34.00 Has a s	29. 00	Did the provider have a funded depreciation a	e Fund)	N	29. 00				
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see	30. 00	Has existing debt been replaced prior to its		N	30. 00				
32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.00 Provider-Based Physicians  34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.  35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.  36.00 Were home office Costs  36.00 Were home office costs claimed on the cost report?  37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 37.00 If line 36 is yes, was the fiscal year end of the home office different from that of N the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions.  41.00 Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report BLUE & CO., LLC Preparer.  42.00 Enter the employer/company name of the cost report BLUE & CO., LLC Preparer.  43.00 Enter the telephone number and email address of the cost 317.713.7959 MALESSANDRINI @BLUEANDCO.COM 43.00	31. 00	Has debt been recalled before scheduled matu instructions.		N	31.00				
33.00   If Iine 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If No. 33.00   No. see instructions.   No. see instructions.   No.   Are services furnished at the provider facility under an arrangement with provider-based physicians?   No.   34.00   If Iine 34 is yes, were there new agreements or amended existing agreements with the provider-based   No.   N	32. 00	Have changes or new agreements occurred in pa			d through cor	ntrac	tual	N	32. 00
34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? N  35.00 If ine 34 is yes, were there new agreements or amended existing agreements with the provider-based N  35.00 physicians during the cost reporting period? If yes, see instructions.    Home Office Costs	33. 00	If line 32 is yes, were the requirements of			g to competi	tive	bidding? If	N	33. 00
If yes, see instructions.   35.00   If line 34 is yes, were there new agreements or amended existing agreements with the provider-based   N   35.00		Provi der-Based Physi ci ans							
physicians during the cost reporting period? If yes, see instructions.    Y/N   Date   1.00   2.00		If yes, see instructions.	•	· ·	•				
Home Office Costs  36.00 Were home office costs claimed on the cost report?  37.00 If line 36 is yes, has a home office cost statement been prepared by the home office?  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N  40.00 Cost Report Preparer Contact Information  41.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  42.00 Enter the employer/company name of the cost report preparer.  43.00 Enter the telephone number and email address of the cost 317.713.7959 MALESSANDRINI **BLUEANDCO.COM** 43.00	35. 00				ts with the p	provi	der-based	N	35.00
Home Office Costs    Home Office Costs   Home Office costs claimed on the cost report?   Statement been prepared by the home office?   N   Statement of the provider of the provider?   Statement of the provider of the home office of the home office.   Statement of the provider?   Statement of the provider of the home office.   Statement of the provider of the home office.   Statement of the home offic		physicians during the cost reporting period:	TT yes, see Thst	i uctions.			Y/N	Date	
36.00 Were home office costs claimed on the cost report?  37.00 If line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see  1.00 2.00  Cost Report Preparer Contact Information  41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  42.00 Enter the employer/company name of the cost report preparer.  43.00 Enter the telephone number and email address of the cost 317.713.7959  MALESSANDRINI @BLUEANDCO.COM 43.00									
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office?  N 37.00 If yes, see instructions.  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  N 38.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Instructions.  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  42.00 Enter the employer/company name of the cost report preparer.  BLUE & CO., LLC  MI CHAEL  ALESSANDRINI   ALESSANDRINI   ALESSANDRINI   ALESSANDRINI   BLUE ALCO., LLC  42.00   Enter the telephone number and email address of the cost 317.713.7959  MALESSANDRINI   BLUEANDCO. COM 43.00		Home Office Costs							
38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  N 39.00 If line 36 is yes, did the provider render services to the home office? If yes, see  N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see  N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see  N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see  N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see  N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see  N 40.00 If line 36 is yes, did the provider render services to the home office.  N 40.00 If line 36 is yes, did the provider render services to the home office.  N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If ye		If line 36 is yes, has a home office cost sta		pared by the	home office?				1
39.00   If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00   If line 36 is yes, did the provider render services to the home office? If yes, see   N   40.00	38. 00	If line 36 is yes , was the fiscal year end (	of the home offic	ce different	from that of		N		38. 00
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions.  1.00 2.00  Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  42.00 Enter the employer/company name of the cost report preparer.  43.00 Enter the telephone number and email address of the cost 317.713.7959  MALESSANDRINI @BLUEANDCO. COM 43.00	39. 00	If line 36 is yes, did the provider render s				,	N		39. 00
Cost Report Preparer Contact Information  41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  42.00 Enter the employer/company name of the cost report preparer.  43.00 Enter the telephone number and email address of the cost 317.713.7959  MALESSANDRINI @BLUEANDCO.COM 43.00	40. 00	If line 36 is yes, did the provider render se	ervices to the ho	ome office?	If yes, see		N		40. 00
Cost Report Preparer Contact Information  41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  42.00 Enter the employer/company name of the cost report preparer.  43.00 Enter the telephone number and email address of the cost 317.713.7959  MALESSANDRINI @BLUEANDCO.COM 43.00			_	1 /	<u> </u>		2 1	00	_
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  42.00 Enter the employer/company name of the cost report preparer.  43.00 Enter the telephone number and email address of the cost 317.713.7959  MALESSANDRINI  41.00  42.00  42.00  MALESSANDRINI  MI CHAEL  ALESSANDRINI  41.00  42.00		Cost Report Preparer Contact Information	<u> </u>		30		2. '	00	
42.00 Enter the employer/company name of the cost report preparer.  43.00 Enter the telephone number and email address of the cost 317.713.7959  BLUE & CO., LLC  MALESSANDRINI@BLUEANDCO.COM 43.00	41. 00	Enter the first name, last name and the title held by the cost report preparer in columns		CHAEL		ALE	SSANDRI NI		41. 00
43.00 Enter the telephone number and email address of the cost 317.713.7959 MALESSANDRINI@BLUEANDCO.COM 43.00	42. 00	Enter the employer/company name of the cost	report BL	UE & CO., LLC	2				42. 00
	43. 00	Enter the telephone number and email address		7. 713. 7959		MAL	ESSANDRI NI @E	BLUEANDCO. COM	43. 00

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Health Financial Systems	HENDRI CKS R	EGI UNAL	HEALIH		in Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	ESTI ONNAI RE		Provi der	CCN: 150005	Peri od: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Pre 5/26/2016 11:	pared:
	Part B						
	Date						
	4.00						

				To 12/31/2015 Date/Time Pro 5/26/2016 11:	
		Part B		0, 20, 2010 111	
		Date			
		4. 00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R	04/20/2016			16. 00
	Report only? If either column 1 or 3 is yes,				
	enter the paid-through date of the PS&R				
	Report used in columns 2 and 4 (see				
47.00	instructions)				17.00
17. 00	Was the cost report prepared using the PS&R				17. 00
	Report for totals and the provider's records for allocation? If either column 1 or 3 is				
	yes, enter the paid-through date in columns				
	2 and 4. (see instructions)				
18. 00	If line 16 or 17 is yes, were adjustments				18.00
.0.00	made to PS&R Report data for additional				1 .0.00
	claims that have been billed but are not				
	included on the PS&R Report used to file				
	this cost report? If yes, see instructions.				
19.00	If line 16 or 17 is yes, were adjustments				19. 00
	made to PS&R Report data for corrections of				
	other PS&R Report information? If yes, see				
	instructions.				
20. 00	If line 16 or 17 is yes, were adjustments				20. 00
	made to PS&R Report data for Other? Describe				
21. 00	the other adjustments: Was the cost report prepared only using the				21. 00
21.00	provider's records? If yes, see				21.00
	instructions.				
	The trader one.				
			3. 00		
	Cost Report Preparer Contact Information				
41. 00	Enter the first name, last name and the title		SENI OR MANAGER		41. 00
	held by the cost report preparer in columns 1	I, 2, and 3,			
	respecti vel y.				
42. 00	Enter the employer/company name of the cost r	report			42. 00
42.00	preparer.	of the cost			12.00
43. 00	Enter the telephone number and email address				43. 00
	report preparer in columns 1 and 2, respective	vei y.	I		1

 
 Heal th Financial
 Systems
 HENDRIC

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provi der CCN: 150005

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part I | To 12/31/2015 | Date/Time Prepared:

Component   Worksheet A   No. of Beds   Bed Days   Available   CAH Hours   Trips						1	0 12/31/2015	5/26/2016 11:	
Component   Worksheet A   No. of Beds   Bed Days   CAH Hours   Title V									25 4111
Component									
1.00   Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)   2.00   HM0 and other (see instructions)   2.00   1.00   2.00   3.00   41,975   0.00   0   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.		Component	Workshoot A	No	of Rods	Red Dave	CAH Hours		
1.00		Component		IVO.	or beas	,	CAIT HOURS	II LIE V	
1.00					2 00		4 00	5.00	
8 exclude Swing Bed. Observation Bed and Hospice days (see instructions for col. 2 for the portion of LDP room available beds)   2	1 00	Hospital Adults & Dods (columns 5 6 7 and							1 00
Hospice days)(see Instructions for col. 2   For the portion of LDP room available beds)   2.00   HMC and other (see instructions)   3.00   MC IPS Subprovider   3.30   MC IPS Subprovider   4.00   4	1.00		30.00		113	41, 7/3	0.00	0	1.00
For the portion of LIP room available beds)   2.00   MMO and other (see instructions)   2.00   3.00   1.0									
2.00									
3.00	2 00								2.00
4. 00		, ,							
5.00   Hospital Adults & Peds. Swing Bed SNF   0   6.00   Hospital Adults and Peds. Swing Bed NF   0   0   6.00   7.00   Total Adults and Peds. (exclude observation beds) (see instructions)   115   41,975   0.00   0   7.00   100   115   115   41,975   0.00   0   8.00   115									
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 10.00 BURNI INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 THER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 15.00 CAH visits 16.00 SUBPROVIDER - IPF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER FACILITY 20.00 NURSING FACILITY 20.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.10 HOSPICE (non-distinct part) 25.00 CAR VISIT (SURGICAL CENTER (D.P.) 24.10 HOSPICE (non-distinct part) 25.00 CAR VISIT (SURGICAL CENTER (D.P.) 26.00 RURAL HEALTH CLINIC 27.00 Description of the part of the par		•							
7.00   Total Adults and Peds. (exclude observation beds) (see instructions)   115   41,975   0.00   0 7.00									
beds) (see instructions)								ł	
8. 00 INTENSIVE CARE UNIT	7. 00				115	41, 975	0.00	0	7. 00
9.00   CORONARY CARE UNIT   9.00   10.00   BURN INTENSIVE CARE UNIT   11.00   11.00   SURGICAL INTENSIVE CARE UNIT   11.00   12.00   OTHER SPECIAL CARE (SPECIFY)   12.00   13.00   NURSERY   43.00   14.00   Total (see instructions)   127   46,355   0.00   15.00   CAH visits   15.00   16.00   SUBPROVIDER - IPF   16.00   17.00   SUBPROVIDER - IRF   19.00   18.00   SUBPROVIDER - IRF   19.00   19.00   SKILLED NURSING FACILITY   20.00   20.00   NURSING FACILITY   20.00   21.00   OTHER LONG TERM CARE   21.00   22.00   AMBULATORY SURGICAL CENTER (D.P.)   22.00   24.00   HOSPICE (non-distinct part)   30.00   25.00   CMHC - CMHC   25.00   26.05   FEDERALLY QUALIFIED HEALTH CENTER   27.00   27.00   Total (sum of lines 14-26)   27.00   28.00   Observation Bed Days   29.00   29.00   Ambul ance Trips   30.00   30.00   Employee discount days (see instruction)   31.00   31.00   Employee discount days - IRF   30.00   32.01   Total ancillary labor & delivery room outpatient days (see instructions)   32.01   32.01   Total ancillary labor & delivery room outpatient days (see instructions)   32.01   32.01   Total ancillary labor & delivery room outpatient days (see instructions)   32.01   33.00   33.01   33.00   33.01   34.00   34.00   34.00   34.00   35.00   Complex descount days (see instructions)   33.00   35.01   Total ancillary labor & delivery room outpatient days (see instructions)   32.01   35.00   Complex descount days (see instructions)   33.00   35.01   Total ancillary labor & delivery room outpatient days (see instructions)   33.01   35.00   Complex descount days (see instructions)   33.00   35.01   Total ancillary labor & delivery room outpatient days (see instructions)   33.00   35.01   Total ancillary labor & delivery room outpatient days (see instructions)   33.00		, ,							
10. 00   BURN INTENSIVE CARE UNIT   11. 00   SURGICAL INTENSIVE CARE UNIT   12. 00   OTHER SPECIAL CARE (SPECIFY)   12. 00   OTHER SPECIAL CARE (SPECIFY)   12. 00   OTHER SPECIAL CARE (SPECIFY)   13. 00   OTHER SPECIAL CARE (SPECIFY)   143. 00   OTHER SPECIAL CARE (SPECIFY)   143. 00   OTHER SPECIAL CARE (SPECIFY)   OTHER SPECIFY   OTHER SPECIF			31. 00		12	4, 380	0.00	0	
11. 00 12. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 16. 00 SUBPROVIDER - IFF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 SUBCRACT (Sum of lines 14-26) 27. 00 Total (sum of lines 14-26) 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01	9.00								9. 00
12. 00 0 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 43. 00 14. 00 15. 01 15. 00 16. 00 18. 00 18. 00 19. 0	10.00	BURN INTENSIVE CARE UNIT							10. 00
13. 00 NURSERY	11.00	SURGICAL INTENSIVE CARE UNIT							11. 00
14.00 Total (see instructions) 15.00 CAH visits 0 CAH visits 0 15.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D. P.) 24.10 HOSPICE 24.10 HOSPICE 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 27.00 Observation Bed Days 29.00 Ambul ance Tri ps 20.00 Ambul ance Tri ps 20.00 Employee discount days (see instruction) 28.00 Employee discount days (see instructions) 29.00 Total (sum of lines 14-26) 30.00 Employee discount days (see instruction) 29.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)	12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 19. 00 SUBPROVIDER 19. 00 SVILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 OBservation Bed Days 27. 00 Observation Bed Days 28. 00 Observation Bed Days 29. 00 Ambul ance Tri ps 30. 00 31. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancil lary labor & delivery room outpatient days (see instructions) 32. 01	13.00	NURSERY	43. 00					0	13. 00
16. 00 SUBPROVIDER - I PF 17. 00 SUBPROVIDER - I RF 18. 00 SUBPROVIDER 18. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 19. 00 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P. ) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 25 27. 00 Total (sum of lines 14-26) 27. 00 Total (sum of lines 14-26) 28. 00 29. 00 Ambul ance Trip s 30. 00 31. 00 Employee discount days (see instruction) 31. 00 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 32. 01	14.00	Total (see instructions)			127	46, 355	0.00	0	14.00
17. 00   SUBPROVIDER - IRF   17. 00   18. 00   SUBPROVIDER   19. 00   SUBLED NURSING FACILITY   19. 00   20. 00   NURSING FACILITY   20. 00   NURSING FACILITY   21. 00   22. 00   22. 00   24. 00   HOME HEALTH AGENCY   23. 00   AMBULATORY SURGICAL CENTER (D.P.)   23. 00   24. 10   HOSPICE (non-distinct part)   30. 00   24. 10   25. 00   CMHC - CMHC   26. 00   RURAL HEALTH CLINIC   26. 00   RURAL HEALTH CLINIC   26. 00   Cobservation Bed Days   27. 00   28. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00   29. 00   30. 00	15.00	CAH visits						0	15. 00
18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.10 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 control outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)	16.00	SUBPROVIDER - IPF							16. 00
18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.10 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 control outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)	17.00	SUBPROVIDER - IRF							17. 00
19.00   SKILLED NURSING FACILITY   19.00   20.00   20.00   21.00   21.00   21.00   21.00   21.00   21.00   21.00   21.00   21.00   21.00   21.00   21.00   21.00   21.00   22.00   22.00   22.00   23.00   24.00   24.00   24.00   24.00   24.00   24.00   25.00   24.00   25.00   26.00   26.00   26.00   26.00   26.00   26.00   26.25   27.00   26.00   26.25   27.00   28.	18.00	1							18. 00
20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.00 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)		1							
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 29.00 Employee discount days (see instructions) 30.00 Employee discount days (see instructions) 30.00 Journal outpatient days (see instructions)	20.00	1							20.00
22.00 23.00 24.00 HOME HEALTH AGENCY 23.00 HOSPICE 24.00 HOSPICE (non-distinct part) 25.00 RURAL HEALTH CLINIC 25.00 RURAL HEALTH CLINIC 25.00 Total (sum of lines 14-26) 27.00 28.00 Deservation Bed Days 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)									
23. 00		1							
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26. 00 26. 25 27. 00 70			30.00						
26. 25 27. 00 28. 00 0bservation Bed Days 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total (sum of lines 14-26) 27. 00 28. 00 29. 00 29. 00 29. 00 30. 00 30. 00 31. 00 31. 00 32. 01		1							
27.00   Total (sum of lines 14-26)   27.00   28.00   29.00   28.00   29.00   2		1							
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)					127				
29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)		,			127			_	
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)		,						U	
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)  31.00 0 0 0 32.00									
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)  32.00									
32.01 Total ancillary labor & delivery room outpatient days (see instructions)					_	_			
outpatient days (see instructions)					0	C			
	32. 01								32. 01
33.00   LICH non-covered days             33.00		1 .							
	33.00	LICH non-covered days				l			33.00

Provider CCN: 150005

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 5/26/2016 | 11: 23 am

						5/26/2016 11:	23 am_
		I/P Days	3 / O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	6, 964	489	16, 271			1. 00
2.00	HMO and other (see instructions)	2, 622	2, 714				2. 00
3.00	HMO IPF Subprovider	o	O				3. 00
4.00	HMO IRF Subprovider	o	o				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	o	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		o	0			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	6, 964	489	16, 271			7. 00
8.00	INTENSIVE CARE UNIT	1, 084	o	2, 030			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		o	3, 067			13. 00
14.00	Total (see instructions)	8, 048	489	21, 368	0.00	1, 261. 85	14. 00
15.00	CAH visits	o	o	0			15. 00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27.00	Total (sum of lines 14-26)				0.00	1, 261. 85	27. 00
28.00	Observation Bed Days		o	3, 521			28. 00
29.00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	o	167	458			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00

| Period: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 150005

Full Time   Equivalents   Nonpaid						To	12/31/2015	Date/Time Prep 5/26/2016 11::	
Component				<b>'</b>		Di scha	arges	0, 20, 20, 10, 11, 1	20 4
No.   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)   February   Febr		Component		Ti tla V	- 1	Title YVIII	Ti tla YIY	Total All	
1.00		Component		TI LIE V		TI LIE XVIII	TI LI G XIX		
1.00				12.00	_	13. 00	14.00		
Hospice days)(see instructions for col. 2	1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and			0				1. 00
MM I PF Subprovider		Hospice days) (see instructions for col. 2				·			
4.00	2.00	HMO and other (see instructions)			İ	679	632		2. 00
5.00	3.00	HMO IPF Subprovider			İ		О		3. 00
6. 00 Hospital Adults & Peds. Swing Bed NF 7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) 8. 00 INTENSIVE CARE UNIT 9. 00 10. 00 BURN INTENSIVE CARE UNIT 11. 00 OUTHER SPECIAL CARE (SPECIFY) 13. 00 OUTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 10. 00 All visits 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER - IRF 10. 00 OUTHER LENG TERM CARE 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 HOME HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 23. 00 HOME HEALTH AGENCY 24. 10 HOSPICE (non-distinct part) 25. 00 CAMP OF CEPTALLY OUALIFIED HEALTH CLINIC 26. 05 TOTAL (sum of lines 14-26) 27. 00 OSSERVALION (see instructions) 28. 00 OSSERVALION (see instruction) 29. 00 Employee discount days (see instructions) 32. 01 Total adultary (see instructions) 32. 01 Total adults and Peds (see instructions) 32. 01 Total adults and Peds (see instructions) 32. 01 Total adults and Peds (see instructions) 32. 01 Total adults and Peds (see instructions) 32. 01 Total part of the peds (see instructions) 32. 01 Total adults and Peds (see instructions) 32. 01 Total adults and Peds (see instructions) 32. 01 Total part of the peds (see instructions)	4.00	HMO IRF Subprovider			1		o		4. 00
7.00	5.00	Hospital Adults & Peds. Swing Bed SNF							5. 00
beds) (see instructions)	6.00								6. 00
9.00   CORONARY CARE UNIT   9.00   10.00   BURN INTENSIVE CARE UNIT   11.00   11.00   SURGICAL INTENSIVE CARE UNIT   11.00   12.00   OTHER SPECIAL CARE (SPECIFY)   12.00   13.00   NURSERY   15.00   15.00   CAH visits   15.00   16.00   SUBPROVIDER - IPF   15.00   17.00   SUBPROVIDER - IRF   16.00   18.00   SUBPROVIDER - IRF   18.00   18.00   SUBPROVIDER - IRF   19.00   19.00   SKILLED NURSING FACILITY   18.00   20.00   NURSING FACILITY   20.00   21.00   OTHER LONG TERM CARE   22.00   22.00   HOME HEALTH ACENCY   22.00   23.00   AMBULATORY SURGICAL CENTER (D.P.)   24.00   10.00   COMMC - CMHC   24.00   24.00   HOSPICE (non-distinct part)   25.00   26.05   FEDERALLY QUALIFIED HEALTH CENTER   26.00   27.00   OTHER LONG BERN CARE   27.00   28.00   Observation Bed Days   28.00   29.00   Ambul ance Trips   30.00   32.01   Labor & delivery days (see instructions)   32.01   32.01   Total (auniform) labor & delivery room outpatient days (see instructions)   32.01   32.01   Control of the con		beds) (see instructions)							
10. 00 BURN INTENSIVE CARE UNIT									
11. 00   SURGICAL INTENSIVE CARE UNIT   11. 00   12. 00   OTHER SPECIAL CARE (SPECIFY)   13. 00   13. 00   NURSERY   15. 00   14. 00   Total (see instructions)   0. 00   0   1, 965   87   5, 347   14. 00   15. 00   CAH visits   16. 00   SUBPROVIDER - IPF   16. 00   SUBPROVIDER - IRF   18. 00   SUBPROVIDER - IRF   19. 00   SKILLED NURSING FACILITY   19. 00   SKILLED NURSING FACILITY   20. 00   NURSING FACILITY   20. 00   NURSING FACILITY   20. 00   NURSING FACILITY   20. 00   HOME HEALTH AGENCY   22. 00   23. 00   AMBULATORY SURGICAL CENTER (D.P.)   23. 00   AMBULATORY SURGICAL CENTER (D.P.)   24. 00   HOSPICE (non-distinct part)   25. 00   CMHC - CMHC   25. 00   CMRC - CMHC   25. 00   26. 25   FEDERALLY QUALIFIED HEALTH CENTER   26. 25   27. 00   Total (sum of lines 14-26)   0. 00   CMPC - CMPC   29. 00   29. 00   Ambul ance Trips   29. 00   29. 00   Ambul ance Trips   29. 00   29. 00   29. 00   Cmpl oyee discount days (see instruction)   31. 00   29. 00   Cmpl oyee discount days (see instructions)   31. 00   20. 01   Total ancillary labor & delivery room   20. 01   Total ancillary labor & delivery room   20. 01   20. 00   20. 0									
12. 00 13. 00 13. 00 13. 00 13. 00 14. 00 15. 00 15. 00 15. 00 15. 00 16. 00 15. 00 16. 00 18. 00 18. 00 19					ł				
13. 00 14. 00 10 Total (see instructions) 15. 00 16. 00 17. 00 18. 00 19					ł				
14. 00 Total (see instructions)		, ,			ł				
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 19. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 19. 00 OTHER LONG TERM CARE 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 Observation Bed Days 27. 00 Observation Bed Days 28. 00 29. 00 Ambul ance Trip ps 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01		4	0.00			1 065	07	5 247	
16.00 SUBPROVI DER - I PF 17.00 SUBPROVI DER - I RF 18.00 SUBPROVI DER 19.00 SKILLED NURSING FACILITY 19.00 OTHER LONG TERM CARE 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 27.00 Total (sum of lines 14-26) 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - I RF 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01		, ,	0.00		۷	1, 705	67	5, 547	
17. 00 18. 00 18. 00 19. 00 SUBPROVIDER - IRF 19. 00 SUBLED NURSING FACILITY 19. 00 20. 00 NURSING FACILITY 20. 00 POTHER LONG TERM CARE 21. 00 22. 00 POTHER LONG TERM CARE 22. 00 POTHER LONG TERM CARE 23. 00 POTHER LONG TERM CARE 24. 00 POSPICE		4			ł				
18. 00 19. 00 19. 00 19. 00 20. 00 19. 00 20. 00 19. 00 20. 00 21. 00 22. 00 19. 00 22. 00 23. 00 24. 00 19. 00 24. 00 19. 00 24. 00 19. 00 25. 00 26. 00 27. 00 28. 00 28. 00 29. 00 20		4			l				
19. 00 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 40. 00 HOSPICE 40. 00 CMHC - CMHC 25. 00 CMHC - CMHC 26. 20 CMHC - CMHC 27. 00 CMSPALLY QUALIFIED HEALTH CENTER 28. 00 CMSPALLY QUALIFIED HEALTH CENTER 29. 00 CMSPALLY QUALIFIED HEALTH CENTER 20. 00 CMSPALLY QUALIFIED HEALTH CENTER 21. 00 CMSPALLY QUALIFIED HEALTH CENTER 22. 00 CMSPALLY QUALIFIED HEALTH CENTER 23. 00 CMSPALLY QUALIFIED HEALTH CENTER 24. 10 CMSPALLY QUALIFIED HEALTH CENTER 25. 00 CMSPALLY QUALIFIED HEALTH CENTER 26. 25 CMSPALLY QUALIFIED HEALTH CENTER 27. 00 CMSPALLY QUALIFIED HEALTH CENTER 28. 00 CMSPALLY QUALIFIED HEALTH CENTER 29. 00 CMSPALLY QUALIFIED HEALTH CENTER 29. 00 CMSPALLY QUALIFIED HEALTH CENTER 20. 00 CMSPALLY QUALIFIED HEALTH CENTER 21. 00 CMSPALLY QUALIFIED HEALTH CENTER 22. 00 CMSPALLY QUALIFIED HEALTH CENTER 23. 00 CMSPALLY QUALIFIED HEALTH CENTER 24. 10 CMSPALLY QUALIFIED HEALTH CENTER 25. 00 CMSPALLY QUALIFIED HEALTH CENTER 26. 25 CMSPALLY QUALIFIED HEALTH CENTER 26. 25 CMSPALLY QUALIFIED HEALTH CENTER 27. 00 CMSPALLY QUALIFIED HEALTH CENTER 28. 00 CMSPALLY QUALIFIED HEALTH CENTER 29. 00		4			i				
21. 00 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 29. 00 Employee discount days (see instruction) Employee discount days (see instructions) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)					İ				
22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Observation Bed Days 29.00 Ambul ance Trips 29.00 Ambul ance Trips 29.00 Employee discount days (see instruction) 29.00 Employee discount days - IRF 20.00 Total ancillary labor & delivery room outpatient days (see instructions)		4			i				
23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 26.27.00 Total (sum of lines 14-26) 27.00 Observation Bed Days 29.00 Ambulance Trips 29.00 28.00 Employee discount days (see instruction) 29.00 Employee discount days - IRF 20.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01	21.00	OTHER LONG TERM CARE			1				21. 00
24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 Employee discount days (see instruction) 29. 00 Employee discount days (see instructions) 20. 00 Labor & delivery days (see instructions) 31. 00 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)	22.00	HOME HEALTH AGENCY							22. 00
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)	23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)									
26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Observation Bed Days Ambulance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01									
26. 25 7. 00   Total (sum of lines 14-26)   0. 00   27. 00 28. 00   Observation Bed Days   28. 00 29. 00   Ambul ance Trips   29. 00 30. 00   Employee discount days (see instruction)   31. 00   Employee discount days - IRF   32. 00   Labor & delivery days (see instructions)   32. 01   Total ancillary labor & delivery room outpatient days (see instructions)   32. 01		1							
27.00 Total (sum of lines 14-26) 0.00 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01									
28.00 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01			0.00						
29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF  Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)		,	0.00						
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)  30.00 31.00 32.01					ł				
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)  31.00 32.01									
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)  32.00									
32.01 Total ancillary labor & delivery room outpatient days (see instructions)									
outpati ent days (see instructions)									
	02.01								52.01
	33.00								33. 00

Provider CCN: 150005

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 5/26/2016 | 11: 23 am

Line Number   Reported on of Salaries   Salaries   Related to   Wage	60. 80 0. 00 93. 25 0. 00	4 ÷  0.65 1.  0.00 2.  0.00 3.  0.00 4.  0.00 4.  0.00 6.  0.00 7.  0.00 7.  0.00 8.  0.00 9.
PART II - WAGE DATA   SALARIES     1.00   2.00   3.00   4.00   5.00	6. 00  35. 65  0. 00  0. 00  0. 00  0. 00  0. 00  0. 00  0. 00  0. 00  0. 00  0. 00  0. 00  93. 25	3. 65 1. 3. 00 2. 3. 00 3. 3. 00 4. 3. 00 4. 3. 00 6. 3. 00 7. 3. 00 7. 3. 00 9. 3. 55 10. 3. 00 12.
PART II - WAGE DATA   1.00   2.00   3.00   4.00   5.00	6. 00  35. 65  0. 00  0. 00  0. 00  0. 00  0. 00  0. 00  0. 00  0. 00  48. 55	0. 00 2. 0. 00 3. 0. 00 4. 0. 00 4. 0. 00 5. 0. 00 7. 0. 00 7. 0. 00 7. 0. 00 9. 0. 00 12. 0. 00 12.
PART II - WAGE DATA   SALARIES	35. 65 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 48. 55 60. 80 0. 00 93. 25	0. 00 2. 0. 00 3. 0. 00 4. 0. 00 4. 0. 00 5. 0. 00 7. 0. 00 7. 0. 00 7. 0. 00 9. 0. 00 12. 0. 00 12.
SALARIES	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 48. 55	0. 00 2. 0. 00 3. 0. 00 4. 0. 00 4. 0. 00 5. 0. 00 7. 0. 00 7. 0. 00 7. 0. 00 9. 0. 00 12. 0. 00 12.
1.00   Total salaries (see   200.00   93,570,159   0   93,570,159   2,624,644.00   1   1   1   1   1   1   1   1   1	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 48. 55	0. 00 2. 0. 00 3. 0. 00 4. 0. 00 4. 0. 00 5. 0. 00 7. 0. 00 7. 0. 00 7. 0. 00 9. 0. 00 12. 0. 00 12.
Instructions   Non-physic an anesthetist Part   Non-physic an anesthetist   Non-physic anestheti	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 48. 55	0. 00 2. 0. 00 3. 0. 00 4. 0. 00 4. 0. 00 5. 0. 00 7. 0. 00 7. 0. 00 7. 0. 00 9. 0. 00 12. 0. 00 12.
2.00	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 48. 55	0. 00 3. 0. 00 4. 0. 00 4. 0. 00 5. 0. 00 6. 0. 00 7. 0. 00 7. 0. 00 9. 0. 00 9. 0. 00 12.
## A. 00 Physician-Part A - Administrative ## A. 00	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 48. 55 60. 80 0. 00 93. 25	0. 00 4. 0. 00 4. 0. 00 5. 0. 00 7. 0. 00 7. 0. 00 8. 0. 00 9. 0. 55 10. 0. 80 11. 0. 00 12.
## A. 00 Physician-Part A - Administrative ## A. 00	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 48. 55 60. 80 0. 00 93. 25	0. 00 4. 0. 00 4. 0. 00 5. 0. 00 7. 0. 00 7. 0. 00 8. 0. 00 9. 0. 55 10. 0. 80 11. 0. 00 12.
Administrative	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 48. 55	1. 00 4. 00 5. 00 6. 00 7. 00 7. 00 8. 00 9. 11. 0. 80 11. 0. 00 12. 0. 00 1
Administrative	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 48. 55	1. 00 4. 00 5. 00 6. 00 7. 00 7. 00 8. 00 9. 11. 0. 80 11. 0. 00 12. 0. 00 1
4.01   Physicians - Part A - Teaching   0   0   0   0   0   0   0   0   0	0. 00 0. 00 0. 00 0. 00 0. 00 48. 55 60. 80 0. 00	0. 00
1.00	0. 00 0. 00 0. 00 0. 00 0. 00 48. 55 60. 80 0. 00	0. 00 6. 0. 00 7. 0. 00 8. 0. 00 9. 0. 80 11. 0. 80 12.
Interns & residents (in an approved program)	0. 00 0. 00 0. 00 0. 00 48. 55 60. 80 0. 00 93. 25	0.00 7. 0.00 7. 0.00 8. 0.00 9. 0.55 10. 0.80 11. 0.00 12.
approved program   Contracted interns and residents (in an approved programs)   8.00   Home office personnel   44.00   0   0   0   0   0   0   0   0   0	0. 00 0. 00 0. 00 48. 55 60. 80 0. 00 93. 25	0. 00 7. 1. 00 8. 1. 00 9. 1. 55 10. 1. 00 12. 1. 25 13.
7. 01 Contracted interns and residents (in an approved programs) 8. 00 Home office personnel 9. 00 SNF 44. 00 9. 00 SNF 44. 00 9. 00 O O O O O O O O O O O O O O O O O O	0. 00 0. 00 48. 55 60. 80 0. 00	0. 00 8. 0. 00 9. 10. 80 11. 0. 00 12.
Residents (in an approved programs)	0. 00 0. 00 48. 55 60. 80 0. 00	0. 00 8. 0. 00 9. 10. 80 11. 0. 00 12.
8.00   Home office personnel   44.00   0   0   0   0   0.00   9.00   SNF   44.00   0   0   0   0   0.00   10.00   Excluded area salaries (see instructions)   29,074,048   319,813   29,393,861   605,391.00	0. 00 48. 55 60. 80 0. 00 93. 25	0. 00 9. 0. 55 10. 0. 80 11. 0. 00 12. 0. 25 13.
9.00 SNF	0. 00 48. 55 60. 80 0. 00 93. 25	0. 00 9. 0. 55 10. 0. 80 11. 0. 00 12. 0. 25 13.
10.00   Excluded area salaries (see instructions)   29,074,048   319,813   29,393,861   605,391.00   10.00	48. 55 60. 80 0. 00 93. 25	1. 55 10. 1. 80 11. 1. 00 12. 1. 25 13.
Instructions   OTHER WAGES & RELATED COSTS	60. 80 0. 00 93. 25	0. 80 11. 0. 00 12. 3. 25 13.
OTHER WAGES & RELATED COSTS	93. 25 0. 00	). 00 12. 3. 25 13.
Care   Contract Labor: Top Level   O	93. 25 0. 00	). 00 12. 3. 25 13.
12.00   Contract Labor: Top Level   0   0   0   0   0   0   0   0   0	93. 25	3. 25 13.
management and other   management and administrative   services	93. 25	3. 25 13.
management and administrative   services	0. 00	
13.00   Contract Labor: Physician-Part   288, 149   0   288, 149   3,090.00     A - Administrative   0   0   0   0   0.00     14.00   Home office salaries &   0   0   0   0   0.00     15.00   Home office: Physician Part A   0   0   0   0   0     - Administrative   0   0   0   0   0     Home office and Contract   0   0   0   0   0     Physicians Part A - Teaching   WAGE-RELATED COSTS     17.00   Wage-related costs (core) (see instructions)   18.00   Wage-related costs (other)   0   0   0   0     18.00   Wage-related costs (other)   0   0   0   0     19.00   0   0   0   0   0     19.00   0   0   0   0   0     19.00   0   0   0   0   0     19.00   0   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0   0     19.00   0   0   0     19.00   0   0   0   0     19.00   0   0   0     1	0. 00	
A - Administrative	0. 00	
14.00       Home office salaries & wage-related costs       0       0       0       0.00         15.00       Home office: Physician Part A - Administrative       0       0       0       0       0.00         16.00       Home office and Contract Physicians Part A - Teaching       0       0       0       0       0.00         WAGE-RELATED COSTS       Wage-related costs (core) (see instructions)       21,925,458       0       21,925,458       0         18.00       Wage-related costs (other)       0       0       0       0		0. 00 14.
Wage-related costs   Home office: Physician Part A   O   O   O   O   O   O   O   O   O		, 00 14.
15.00 Home office: Physician Part A		
16. 00 Home office and Contract 0 0 0 0 0.00  Physicians Part A - Teaching  WAGE-RELATED COSTS  17. 00 Wage-related costs (core) (see instructions)  18. 00 Wage-related costs (other) 0 0 0	0.00	0. 00 15.
Physicians Part A - Teaching		
WAGE-RELATED COSTS           17. 00         Wage-related costs (core) (see instructions)         21, 925, 458         0         21, 925, 458           18. 00         Wage-related costs (other)         0         0         0	0. 00	0. 00 16.
17. 00     Wage-rel ated costs (core) (see instructions)     21,925,458     0     21,925,458       18. 00     Wage-rel ated costs (other)     0     0     0		
18.00   Wage-related costs (other)   0   0   0		17.
(see instructions)	'	18.
19. 00 Excluded areas 6, 774, 008 0 6, 774, 008		19.
20. 00   Non-physici an anesthetist Part   0   0   0		20.
A A		
21.00 Non-physician anesthetist Part 0 0 0		21.
32 00 Physician Part A		1 22
22. 00   Physician Part A - 0 0 0   O   O   O   O   O   O   O   O	1 '	22.
22. 01 Physician Part A - Teaching 0 0 0	1:	22.
23.00 Physician Part B 0 0 0		23.
24.00         Wage-related costs (RHC/FQHC)         0         0         0		24.
25.00 Interns & residents (in an approved program) 0 0 0	:	25.
OVERHEAD COSTS - DIRECT SALARIES		
26. 00 Employee Benefits Department 4. 00 2, 476, 170 -1, 495, 285 980, 885 31, 733. 00	30. 91	0. 91 26.
27. 00 Administrative & General 5. 00 7, 987, 769 132, 123 8, 119, 892 233, 847. 00	34. 72	. 72 27.
28.00   Administrative & General under   4,770,853   0   4,770,853   23,994.00	198. 84	8. 84 28.
contract (see inst.)	0.00	00 00
29. 00   Maintenance & Repairs   6. 00   0   0   0   0. 00   30. 00   Operation of Plant   7. 00   2, 252, 569   46, 020   2, 298, 589   92, 198. 00		
31. 00 Laundry & Li nen Servi ce 8. 00 294, 105 9, 419 303, 524 21, 252. 00		
32. 00 Housekeepi ng 9. 00 1, 748, 463 68, 896 1, 817, 359 122, 746. 00		
33.00   Housekeepi ng under contract   0   0   0   0.00	0.00	0. 00 33.
(see instructions)	10.00	
34. 00   Di etary   10. 00   1, 464, 840   -1, 062, 675   402, 165   21, 285. 00   35. 00   Di etary under contract (see   0   0   0   0. 00	•	
35.00 Di etary under contract (see 0 0 0 0.00 i nstructi ons)	0.00	0. 00 35.
36. 00 Cafeteri a 11. 00 0 1, 124, 574 1, 124, 574 70, 368. 00	15. 98	. 98 36.
37. 00 Maintenance of Personnel 12. 00 0 0 0 0. 00		
38. 00 Nursi ng Admini strati on 13. 00 1, 815, 634 36, 808 1, 852, 442 56, 988. 00		. 511 38
39.00   Central Services and Supply   14.00   611,112   17,224   628,336   28,694.00   40.00   Pharmacy   15.00   1,806,283   30,556   1,836,839   49,615.00	32. 51	
40.00   Pharmacy   15.00   1,806,283   30,556   1,836,839   49,615.00	21. 90	

Heal th	Financial Systems		HENDRI CKS REG	I ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der	1	Period: From 01/01/2015 Fo 12/31/2015		pared:
		Worksheet A	Amount	Recl assi fi cati	Adj usted		Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
41. 00	Medical Records & Medical Records Library	16. 00	1, 220, 329	33, 102	1, 253, 43	55, 375. 00	22. 64	41. 00
42.00	Soci al Servi ce	17. 00	1, 585, 176	32, 026	1, 617, 202	2 47, 154. 00	34. 30	42.00
43.00	Other General Service	18. 00	0	0		0.00	0. 00	43.00

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part III | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/201

					'	0 12/31/2013	5/26/2016 11: 2	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		98, 341, 012	0	98, 341, 012	2, 648, 638. 00	37. 13	1.00
	instructions)							
2.00	Excluded area salaries (see		29, 074, 048	319, 813	29, 393, 861	605, 391. 00	48. 55	2.00
	instructions)							
3.00	Subtotal salaries (line 1		69, 266, 964	-319, 813	68, 947, 151	2, 043, 247. 00	33. 74	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 470, 955	0	1, 470, 955	22, 543. 00	65. 25	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		21, 925, 458	0	21, 925, 458	0.00	31. 80	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		92, 663, 377	-319, 813	92, 343, 564	2, 065, 790. 00	44. 70	6.00
7.00	Total overhead cost (see		28, 033, 303	-1, 027, 212	27, 006, 091	855, 249. 00	31. 58	7.00
	instructions)							

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150	005 Period: Worksheet S-3 From 01/01/2015 Part IV
		To 12/31/2015 Date/Time Prepared:

PART I V - WAGE RELATED COSTS   1.00   1.0		To 12/31/2015	Date/Time Prep 5/26/2016 11:	
PART IV - WAGE RELATED COSTS   Part A - Core List   RETIREMENT COST			Amount	
PART IV - WAGE RELATED COSTS   Part A - Core List   RETIREMENT COST   401K Empl oyer Contributions   0   1.00   2.00   7.00			Reported	
Part A - Core List   RETIREMENT COST			1.00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00				
2.00		RETI REMENT COST		
3.00   Nongualified Defined Benefit Plan Cost (see instructions)   0.00   0.0	1.00		0	1. 00
A. 00	2.00		0	2. 00
PLAM ADMINISTRATIVE COSTS (Paid to External Organization)   401K/TSA Plan Administration fees   0   0   0   0   0   0   0   0   0	3.00		665, 598	3. 00
5.00       401K/TSA PI an Administration fees       0       5.00         6.00       Legal /Account in g/Management Fees-Pensi on PI an       0       6.00         7.00       Employee Managed Care Program Administration Fees       0       7.00         8.00       Heal th Insurance (Purchased or Self Funded)       13, 069, 597       8.00         9.00       Prescription Drug Plan       0       9.00         10.00       Dental, Hearing and Vision Plan       0       10.00         12.00       Accident Insurance (If employee is owner or beneficiary)       227, 53       11.00         13.00       Disability Insurance (If employee is owner or beneficiary)       0       12.00         14.00       Long-Term Care Insurance (If employee is owner or beneficiary)       0       14.00         15.00       Workers' Compensation Insurance       192, 131       15.00         16.00       Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.       0       16.00         17.00       FICA-Employers Portion Only       4, 289, 693       17.00         18.00       Medicare Taxes - Employers Portion Only       0       18.00         19.00       Unemployment Insurance       11, 124       19.00         20.00       State or Federal Unempl	4.00		0	4. 00
Legal / Accounting / Management Fees-Pension Plan				
Employee Managed Care Program Administration Fees   0   7.00   HEALTH AND INSURANCE COST   13,069,597   8.00   9.00   10.00   13,069,597   8.00   10			0	
HEALTH AND INSURANCE COST   8. 00   Heal th Insurance (Purchased or Self Funded)   13,069,597   8. 00   9. 00   10. 00			0	
8.00   Heal th Insurance (Purchased or Self Funded)   13,069,597   8.00   9.00   Prescription Drug Plan   0 9.00   10.00   Dental, Hearing and Vision Plan   0 10.00   10.00	7.00		0	7. 00
9.00       Prescription Drug Plan       0       9.00         10.00       Dental, Hearing and Vision Plan       0       10.00         11.00       Life Insurance (If employee is owner or beneficiary)       227,533       11.00         12.00       Accident Insurance (If employee is owner or beneficiary)       0       12.00         13.00       Disability Insurance (If employee is owner or beneficiary)       0       13.00         14.00       Long-Term Care Insurance (If employee is owner or beneficiary)       0       14.00         15.00       Workers' Compensation Insurance       192.131       15.00         16.00       Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.       0       16.00         Non cumulative portion)       4, 289, 693       17.00         18.00       Medicare Taxes - Employers Portion Only       0       18.00         19.00       State or Federal Unemployment Taxes       0       20.00         OTHER         21.00       Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))       3, 264, 934       21.00         22.00       Day Care Cost and Allowances       0       22.00         23.00       Tuit tion Reimbursement       204, 848       23.00 <td></td> <td></td> <td></td> <td></td>				
10.00   Dental, Hearing and Vision Plan			13, 069, 597	8. 00
11.00   Life Insurance (If employee is owner or beneficiary)   227,533   11.00   12.00   Accident Insurance (If employee is owner or beneficiary)   0   12.00   13.00   13.00   15.3	9.00		0	
12.00	10.00		0	10.00
13. 00 Disability Insurance (If employee is owner or beneficiary)  14. 00 Long-Term Care Insurance (If employee is owner or beneficiary)  15. 00 'Workers' Compensation Insurance  16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17. 00 FICA-Employers Portion Only  18. 00 Medicare Taxes - Employers Portion Only  19. 00 Unemployment Insurance  20. 00 State or Federal Unemployment Taxes  17. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22. 00 Day Care Cost and Allowances  20. 00 Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost	11. 00		227, 533	11. 00
Long-Term Care Insurance (If employee is owner or beneficiary)  14. 00 15. 00 16. 00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17. 00 Redicare Taxes - Employers Portion Only 18. 00 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes  17. 00 THER  21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) Day Care Cost and Allowances Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00		0	12.00
15.00 'Workers' Compensation Insurance 192, 131 15.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only 4, 289, 693 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 11, 124 19.00 20.00 State or Federal Unemployment Taxes 0 20.00  OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 3, 264, 934 1.00 instructions)) 22.00 Day Care Cost and Allowances 0 20.00 23.00 Tuition Reimbursement 2 204, 848 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 21, 925, 458 24.00 Part B - Other than Core Related Cost			0	
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion) TAXES  17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes  11. 124 19. 00  OTHER  21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 3, 264, 934 instructions)  22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	14.00		0	14.00
Non cumulative portion   TAXES   TAXES   TO   TO   Taxes   To   To   To   To   To   To   To   T	15. 00		192, 131	15. 00
TAXES	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
17. 00   FICA-Employers Portion Only   4, 289, 693   17. 00   18. 00   Medicare Taxes - Employers Portion Only   0   18. 00   19. 00   Unemployment Insurance   11, 124   19. 00   20. 00   OTHER   21. 00   Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see   3, 264, 934   21. 00   instructions))   22. 00   Day Care Cost and Allowances   0   22. 00   23. 00   Tuition Reimbursement   204, 848   23. 00   24. 00   Total Wage Related cost (Sum of Lines 1 -23)   21, 925, 458   24. 00   Part B - Other than Core Related Cost   24. 00   25				
18. 00       Medi care Taxes - Employers Portion Only       0       18. 00         19. 00       Unemployment Insurance       11, 124       19. 00         20. 00       State or Federal Unemployment Taxes       0       20. 00         OTHER         21. 00       Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))       3, 264, 934       21. 00         22. 00       Day Care Cost and Allowances       0       22. 00         23. 00       Tuition Reimbursement       204, 848       23. 00         24. 00       Total Wage Related cost (Sum of Lines 1 -23)       21, 925, 458       24. 00         Part B - Other than Core Related Cost       20. 00       21, 925, 458       24. 00				
19.00   Unemployment Insurance   11,124   19.00   20.00   State or Federal Unemployment Taxes   0   20.00   OTHER   21.00   Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see   3,264,934   21.00   instructions))   22.00   Day Care Cost and Allowances   0   22.00   Tuition Reimbursement   204,848   23.00   24.00   Total Wage Related cost (Sum of Lines 1 -23)   21,925,458   24.00   Part B - Other than Core Related Cost   24.00   25			4, 289, 693	
20.00 State or Federal Unemployment Taxes 0 20.00 OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 3, 264, 934 21.00 instructions))  22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 2 204, 848 23.00 Total Wage Related cost (Sum of Lines 1 -23) 21, 925, 458 24.00 Part B - Other than Core Related Cost				
OTHER  21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22. 00 Day Care Cost and Allowances  23. 00 Tuition Reimbursement  24. 00 Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost			11, 124	
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  Tuition Reimbursement  204,848 23.00  Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost	20.00		0	20. 00
instructions))  22.00 Day Care Cost and Allowances  10 22.00 23.00 Tuition Reimbursement  204,848 23.00  24.00 Total Wage Related cost (Sum of lines 1 -23)  Part B - Other than Core Related Cost				
22. 00       Day Care Cost and Allowances       0       22. 00         23. 00       Tuition Reimbursement       204, 848       23. 00         24. 00       Total Wage Related cost (Sum of lines 1 -23)       21, 925, 458       24. 00         Part B - Other than Core Related Cost       204. 00       204. 00	21. 00		3, 264, 934	21. 00
23. 00 Tuition Reimbursement 204, 848 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 21, 925, 458 Part B - Other than Core Related Cost				
24.00 Total Wage Related cost (Sum of lines 1 -23)  Part B - Other than Core Related Cost  21,925,458 24.00			-	
Part B - Other than Core Related Cost				
	24. 00		21, 925, 458	24. 00
25. 00   OTHER WAGE RELATED COSTS (SPECIFY)   0   25. 00				
	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150005	Peri od: From 01/01/2015 To 12/31/2015		pared:
Cost Center Description		Contract Labor	Benefit Cost	

			3/20/2010 11.	zs alli
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2. 00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12. 00
13.00	Hospi tal -Based Hospi ce			13. 00
14.00	Hospital-Based Health Clinic RHC			14. 00
15. 00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16. 00
17.00	Renal Di al ysi s	0	0	17. 00
18.00	Other	0	0	18. 00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA    Provider CCN: 150005   Port od: From 01/01/2015   For 01/2015   Fo	Heal th	Financial Systems HENDRICKS REGION.	AL HEALTH		In Lie	u of Form CMS-2	2552-10
Uncompensated and indigent care cost computation  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 8)  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 8)  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 8)  1.00 Cost to medical down and sale with a supplemental payments from Medical C  1.00 Cost to line 4 is "no", then enter DSH or supplemental payments from Medical C  1.00 Cost to line 4 is "no", then enter DSH or supplemental payments from Medical C  1.00 Cost to line 4 is "no", then enter DSH or supplemental payments from Medical C  1.00 Cost to line 4 is "no", then enter DSH or supplemental payments from Medical C  1.00 Cost to line 4 is "no", then enter DSH or supplemental payments from Medical C  1.00 Cost to line 4 is "no", then enter DSH or supplemental payments from Medical C  1.00 Cost to line 4 is "no", then enter DSH or supplemental payments from Medical C  1.00 Cost to line 4 is "no", then enter DSH or supplemental payments from Medical C  1.00 Cost to line 4 is "no", then enter SH or Medical C  1.00 Cost to line 4 is "no", then enter SH or Medical C  1.00 Cost to line 4 is "no", then enter SH or Medical C		<del></del>		CCN: 150005			
Uncompensated and indigent care cost computation   1.00							
Uncompensated and indigent care cost computation  1.00 Sost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  Medicaid (see Instructions for each line)  2.00 Net revenue From Medicaid  4.00 If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?  4.00 If line 4 is "no", then enter DSH or supplemental payments from Medicaid?  5.00 If line 4 is "no", then enter DSH or supplemental payments from Medicaid?  6.00 Medicaid charges  7.654,505  8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if 2 cero then enter zero)  7.654,505  8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if 2 cero then enter zero)  8.00 Net revenue From stand-alone SCHIP  9.00 Net revenue From Stand-alone SCHIP (see instructions for each line)  11.00 Stand-alone SCHIP cost (line 1 times line 10)  12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (See instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (Ine 15 minus line 13; if < zero then enter zero)  17.00 Medicaid cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 2 cost indigent care programs (sum of lines 2 cost indigent care programs (sum of lines 2 cost indigent care programs (sum of lines 2 cost indigent care programs (sum of lines 2 cost indigent care programs (sum of lines 2 cost indigent care programs (sum of lines 2 cost cost indigent care programs (sum of lines 2 cost cost indigent care programs (sum of lines 2 cost cost						072072010 11.	20 4111
Cost to charge ratio (Worksheet C, Part   Line 202 column 3 divided by line 202 column 8)   0.317119						1. 00	
Medicaid (see instructions for each line)							
2.00 Net revenue from Medicaid 3.00 Did you receive DSH or supplemental payments from Medicaid? 4.00 If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? 4.00 If line 4 is "no", then enter DSH or supplemental payments from Medicaid 2.00 Did you receive DSH or supplemental payments from Medicaid 2.00 Did you receive DSH or supplemental payments from Medicaid 2.00 Did you receive DSH or supplemental payments from Medicaid 2.00 Did you receive DSH or supplemental payments from Medicaid 2.00 Did you receive DSH or supplemental payments from Medicaid 2.00 Did you receive DSH or supplemental payments from Medicaid 2.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 2.00 Difference Detween net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 2.00 Difference Detween net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 2.00 Difference DSH you have revenue from Stand-alone SCHIP (see instructions for each line)  9.00 Net revenue from Stand-alone SCHIP (line 11 minus line 9; if 2.00 Difference Detween net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if 2.00 Difference Detween net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if 2.00 Difference Detween net revenue and costs for stand-alone SCHIP (line 11 minus line 2.00 Difference Detween net revenue and costs for state or local indigent care program (Not included in lines 6 or 10 Difference Detween net revenue and costs for state or local indigent care program (line 15 minus line 11 Difference Detween net revenue and costs for state or local indigent care program (line 15 minus line 11 Difference Detween net revenue and costs for state or local indigent care program (line 15 minus line 11 Difference Detween net revenue and costs for state or local indigent care program (line 15 minus line 11 Difference Detween net revenue and costs for state or local indigent care program (line 15 minus line 1			vided by lir	ne 202 colum	า 8)	0. 317119	1. 00
3.00 Did you receive DSH or supplemental payments from Medicaid? 4.00 Iffline 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? 5.00 Iffline 4 is "no", then enter DSH or supplemental payments from Medicaid 6.00 Medicaid charges 7,654,505 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if care then enter zero) 8.00 Net revenue from stand-al one SCHIP (see instructions for each line) 9.00 Net revenue from Stand-al one SCHIP cost (line 1 times line 10) 11.00 Stand-al one SCHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10) 17.00 Private grants, donations, or endowment income restricted to funding charity care (line 15 minus line 13; if < zero then enter zero)  Uncompensated care (see Instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  20.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 10, 2, 20 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,				0.00/.070	
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1.00   If line 4 is "no", then enter DSH or supplemental payments from Medicaid d   24, 137, 643   643   7, 654, 505   7, 644, 505   7, 645, 645, 645   7, 645, 645, 645, 645, 645, 645, 645, 645	4				10		3. 00
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8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if  9.00 Net revenue from stand-al one SCHIP 10.00 Stand-al one SCHIP cost (line 1 times line 10) 11.00 Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero)  11.00 Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero)  12.00 Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 lines 13; if < zero then enter zero)  17.00 Private grants, donations, or endowment income restricted to funding charity care 0 lines line 20 lines 0 lines 1 lines line 20 lines 1 lines line 20 lines l	4	9					7. 00
<pre></pre>	4	,	(line 7 minu	ıs sum of Liu	nes 2 and 5 if		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)  9.00 Net revenue from stand-alone SCHIP 10.00 Stand-alone SCHIP charges 10.11 11.00 Stand-alone SCHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9: if < zero then 12  13.00 Net revenue from state or local indigent care program (see instructions for each line) 14.00 Charges for patients covered under state or local indigent care program (Not included on lines 2, 5 or 9) 16.00 State or local indigent care program cost (line 1 times line 14) 17.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)  18.00 Incompensated care (see instructions for each line) 19.00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 0 16 17 18 100 2 00 3 00 20 00 Total initial obligation of patients approved for charity care (at full patients pa			(11116 7 1111116	23 3uii 01 111	ics 2 and 5, 11	O	0.00
10.00 Stand-alone SCHIP charges 11.00 Stand-alone SCHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)  Uncompensated care (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations  19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 0 15 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	5	State Children's Health Insurance Program (SCHIP) (see instruc	ctions for ea	ach line)			
11.00 Stand-alone SCHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then 0 12 enter zero)  Other state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16 13; if < zero then enter zero)  Uncompensated care (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 0 16 17 18 1.00 2.00 3.00 2.00 3.00 2.00 Total initial obligation of patients approved for charity care (at full 8, 109, 629 0 8, 109, 629 20 0 8, 109, 629 10 0 2, 571, 717 0 2, 571, 717 0 2, 571, 717 0 2, 571, 717 0 2, 571, 717 0 2, 571, 717 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	9.00	Net revenue from stand-alone SCHIP				0	9. 00
12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)  Uncompensated care (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care (socyernment grants, appropriations or transfers for support of hospital operations 0 18; 12 and 16)  18.00 Government grants, appropriations or transfers for support of hospital operations 0 18; 12 and 16)  Uninsured patients patients 0 10 10 10 10 10 10 10 10 10 10 10 10 1	10.00	Stand-alone SCHIP charges				0	10.00
enter zero) Other state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)  Uncompensated care (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care  18.00 Government grants, appropriations or transfers for support of hospital operations  19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 0 16 17 18, 12 and 16)  20.00 Total initial obligation of patients approved for charity care (at full 8, 109, 629 0 8, 109, 629 20 18, 109, 629 20 19, 571, 717 21 19	11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0	11. 00
Other state or local government indigent care program (see instructions for each line)  13. 00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14. 00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15. 00 State or local indigent care program cost (line 1 times line 14)  16. 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)  17. 00 Private grants, donations, or endowment income restricted to funding charity care 18. 00 Government grants, appropriations or transfers for support of hospital operations 19. 00 Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 19. 00 Insured patients patients 19. 00 Insured 19. 00 Insured 19. 00 Insu			P (line 11 mi	nus line 9;	if < zero then	0	12.00
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0 1.0)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 1.0)  17.00 Difference detween net revenue and costs for state or local indigent care program (line 15 minus line 0 1.0)  17.00 Private grants, donations, or endowment income restricted to funding charity care 0 1.00 Government grants, appropriations or transfers for support of hospital operations 0 1.00 Government grants, appropriations or transfers for support of hospital operations 0 1.00 Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 0 1.00 English (sum of lines 1.00 English (sum of li							
14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16 17 18 18 18 19 19 19 19 19 19 19 19 19 19 19 19 19						0	12.00
10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)  Uncompensated care (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients   Total (col. 1 patients   pat		3 1 3 1			,	-	
State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)  Uncompensated care (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care  8.00 Government grants, appropriations or transfers for support of hospital operations  19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients   Total (col. 1 patients   patients   patients   patients   patients   patients   patients   patients   2.00   3.00    20.00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility  21.00 Cost of initial obligation of patients approved for charity care (line 1   2,571,717   0   2,571,717   2.571,71							
16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)  Uncompensated care (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients + col. 2)  1.00 2.00 3.00  20.00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility  21.00 Cost of initial obligation of patients approved for charity care (line 1 2, 571, 717 0 2, 571, 717 2.	4						
13; if < zero then enter zero) Uncompensated care (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care  18.00 Government grants, appropriations or transfers for support of hospital operations  19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 0 10 10 10 10 10 10 10 10 10 10 10 10 1	4						
17.00 Private grants, donations, or endowment income restricted to funding charity care  18.00 Government grants, appropriations or transfers for support of hospital operations  19.00 Total unrelimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients + col. 2)  1.00 2.00 3.00  20.00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility  21.00 Cost of initial obligation of patients approved for charity care (line 1 2, 571, 717 0 2, 571, 717 2.		13; if < zero then enter zero)					
18.00 Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 0 19 19 19 19 19 19 19 19 19 19 19 19 19	l	Uncompensated care (see instructions for each line)					
19.00 Total unrel mbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients   Insured patients   Total (col. 1 + col. 2)			9	,		-	17. 00
8, 12 and 16)  Uninsured patients   Insured patients   Total (col. 1 + col. 2)    1.00   2.00   Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility    21.00   Cost of initial obligation of patients approved for charity care (line 1   2,571,717   0   2,571,717   2.571,717		3 . 11 1					
Uninsured patients		·	cal indigent	care prograi	ns (sum of lines	0	19. 00
20.00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility 21.00 Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1	8, 12 and 16)		Uni neurod	Incured	Total (col 1	
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20.00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility 21.00 Cost of initial obligation of patients approved for charity care (line 1 2,571,717 0 2,571,717 2.							
21.00 Cost of initial obligation of patients approved for charity care (line 1 2,571,717 0 2,571,717 2 times line 20)	20.00	Total initial obligation of patients approved for charity care	e (at full	8, 109, 6	29 0		20. 00
times line 20)	].	charges excluding non-reimbursable cost centers) for the entire	re facility				
		3 1 11	are (line 1	2, 571, 7	17 0	2, 571, 717	21. 00
						_	
			-	0 574 7	-	-	
23. 00   Cost of charity care (line 21 minus line 22)   2, 571, 717   0 2, 571, 717   23	23.00	Cost of charity care (line 21 minus line 22)		2,5/1,/	17] 0	2,5/1,/1/	23. 00
1.00						1 00	
	24 00	Does the amount in line 20 column 2 include charges for patier	nt days beyon	nd a Length	of stav limit		24. 00
imposed on patients covered by Medicaid or other indigent care program?				a a rongen	or oray c	.,	2 00
25.00   If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit   0   29	25. 00	If line 24 is "yes," charges for patient days beyond an indig	gent care pro	ogram's Leng	th of stay limit	0	25. 00
26.00 Total bad debt expense for the entire hospital complex (see instructions) 11,301,442 20	26. 00	Total bad debt expense for the entire hospital complex (see in	nstructions)	· ·	<u>-</u>	11, 301, 442	26. 00
27.00 Medicare bad debts for the entire hospital complex (see instructions) 425,542 2	27. 00	Medicare bad debts for the entire hospital complex (see instru	uctions)			425, 542	27. 00
		, ,		,			
20 00 Cost of non Modicaro and non roimburgable Modicaro had dobt expense (Line 1 times Line 20)	4	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	xpense (line	1 times line	e 28)	3, 448, 955	
	4	, , ,					
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,020,672 30		Total unreimbursed and uncompensated care cost (line 19 plus I	Line 30)			6, 020, 672	1 31 NN

Health Financial Systems	HENDRICKS REGIONAL HEALTH			In Lieu of Form CMS-2552-10		
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der		Peri od:	Worksheet A	
				rom 01/01/2015		
			1	To 12/31/2015	Date/Time Pre	
	0.1.1	0.11		5	5/26/2016 11:	23 am
Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Reclassi fied	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT		19, 827, 131	19, 827, 131	0	19, 827, 131	1. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 476, 170	3, 643, 556			4, 629, 476	4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	7, 987, 769	27, 862, 541	35, 850, 310		36, 035, 443	5. 00
7. 00   00700   OPERATION OF PLANT		6, 250, 769				7. 00
	2, 252, 569				8, 563, 175	
8. 00   00800 LAUNDRY & LINEN SERVICE	294, 105	339, 962			675, 175	8. 00
9. 00   00900   HOUSEKEEPI NG	1, 748, 463	1, 162, 330			2, 979, 646	9. 00
10. 00  01000  DI ETARY	1, 464, 840	1, 652, 455	3, 117, 295		774, 787	10. 00
11. 00   01100   CAFETERI A	0	0	(	2, 404, 386	2, 404, 386	11. 00
13.00 O1300 NURSING ADMINISTRATION	1, 815, 634	853, 097	2, 668, 731	34, 898	2, 703, 629	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	611, 112	488, 792	1, 099, 904	10, 355	1, 110, 259	14. 00
15. 00 01500 PHARMACY	1, 806, 283	10, 206, 964			3, 697, 384	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	1, 220, 329	1, 423, 619			2, 677, 050	16. 00
17. 00 01700 SOCIAL SERVICE	1, 585, 176	708, 884			2, 342, 810	17. 00
	1, 365, 176	700, 004	2, 274, 000	40,730	2, 342, 010	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.100.202	4 050 501	12 240 003	202 207	12 047 50/	20.00
30. 00   03000   ADULTS & PEDI ATRI CS	9, 199, 382	4, 050, 521			13, 047, 596	30.00
31. 00 03100 INTENSIVE CARE UNIT	1, 641, 059	799, 863			2, 349, 136	31. 00
43. 00 04300 NURSERY	699, 578	205, 731	905, 309	-70, 519	834, 790	43. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	1, 446, 658	8, 430, 329	9, 876, 987	1, 091, 453	10, 968, 440	50.00
50. 01   05001 ENDOSCOPY	823, 780	674, 181	1, 497, 961	-233, 980	1, 263, 981	50. 01
51.00 05100 RECOVERY ROOM	1, 163, 790	482, 244			1, 569, 660	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 833, 218	289, 618		I	2, 082, 831	52. 00
53. 00   05300   ANESTHESI OLOGY	4, 533, 021	1, 655, 280			6, 028, 918	53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	3, 612, 265	2, 160, 740			5, 529, 381	54.00
54. 01   05401   RADI ATI ON-ONCOLOGY	968, 139	12, 095, 744			12, 911, 928	54. 01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	126, 679	211, 421	338, 100		339, 097	56. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	473, 116	826, 116	1, 299, 232	-1, 572, 467	-273, 235	59. 00
60. 00  06000 LABORATORY	2, 389, 690	4, 501, 819	6, 891, 509	75, 542	6, 967, 051	60.00
64. 00 06400 I NTRAVENOUS THERAPY	827, 067	297, 559	1, 124, 626	38, 238	1, 162, 864	64. 00
65. 00 06500 RESPIRATORY THERAPY	1, 432, 466	802, 660	2, 235, 126	-33, 359	2, 201, 767	65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 727, 519	1, 839, 621			5, 414, 833	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	314, 669	104, 633			422, 229	67. 00
68. 00 06800 SPEECH PATHOLOGY	287, 501	110, 100			401, 907	68. 00
· · · · · · · · · · · · · · · · · · ·						
69. 00 06900 ELECTROCARDI OLOGY	458, 291	390, 727			857, 790	69. 00
69. 01   06901   CARDI AC   REHAB	377, 281	111, 183			491, 433	
70. 00 07000 ELECTROENCEPHALOGRAPHY	94, 735	46, 897	141, 632	2, 667	144, 299	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(	4, 026, 321	4, 026, 321	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	ol	0	(	11, 149, 827	11, 149, 827	73. 00
73. 01 07301 ULTRA SOUND	449, 869	137, 314	587, 183	-36, 582	550, 601	73. 01
74.00 07400 RENAL DIALYSIS	0	136, 631		1 ' 1	135, 376	74.00
OUTPATIENT SERVICE COST CENTERS	5	1007001	100,00	., ., 200	100,070	7 00
90. 00 09000 CLI NI C	1, 565, 423	4, 638, 299	6, 203, 722	-415, 682	5, 788, 040	90. 00
91. 00 09100 EMERGENCY	2, 788, 465	1, 949, 396			4, 508, 808	91. 00
	2, 700, 403	1, 949, 390	4, 737, 60	-229, 003	4, 300, 606	
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)						92. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	64, 496, 111	121, 368, 727	185, 864, 838	3, 431, 182	189, 296, 020	118. 00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	24, 422, 979	16, 938, 856	41, 361, 835	-3, 350, 894	38, 010, 941	192. 00
192. 01 19201 HEALTH TRACKS	2, 800, 012	1, 109, 418			3, 881, 825	
194. 00 07950 PRIMARY CARE CLINIC	422, 684	159, 458			582, 981	
194. 01 07951 PARTNERS IN CARE	583, 868	262, 232	1		823, 939	
194. 02 07952 OCCUPATI ONAL MEDI CI NE	181, 692	582, 951	764, 643		724, 683	
194. 03 07953 FOUNDATION	167, 478	63, 304			235, 088	
194. 04 07954 SCHOOL & TOWN CLINICS	495, 335	148, 723			648, 351	
200.00   TOTAL (SUM OF LINES 118-199)	93, 570, 159	140, 633, 669	234, 203, 828	8  0	234, 203, 828	200. OO

Heal th FinancialSystemsHENDRICKSRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 150005 

			5/26/2016 11:	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
OFNEDAL CERVILOE COCT OFNITERS	6.00	7. 00		
GENERAL SERVICE COST CENTERS	1 (50 105	10 1/0 02/		1 00
1.00   00100   NEW CAP REL COSTS-BLDG & FIXT 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	-1, 658, 195 -86, 334	18, 168, 936 4, 543, 142		1.00 4.00
5. 00   00500   ADMI NI STRATI VE & GENERAL	-6, 519, 824	29, 515, 619		5.00
7. 00 00700 OPERATION OF PLANT	-40, 934	8, 522, 241		7.00
8. 00   00800 LAUNDRY & LINEN SERVICE	0	675, 175		8.00
9. 00   00900   HOUSEKEEPI NG	0	2, 979, 646		9. 00
10. 00   01000   DI ETARY	-369, 781	405, 006		10.00
11. 00   01100   CAFETERI A	-752, 441	1, 651, 945		11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-11, 188			13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	-140	1, 110, 119		14. 00
15. 00 01500 PHARMACY	0	3, 697, 384		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	-1, 961	2, 675, 089		16.00
17. 00 01700 SOCIAL SERVICE	0	2, 342, 810		17. 00
INPATIENT ROUTINE SERVICE COST CENTERS				1
30. 00 03000 ADULTS & PEDIATRICS	-2, 217, 675	10, 829, 921		30. 00
31.00 03100 INTENSIVE CARE UNIT	0	2, 349, 136		31. 00
43. 00 04300 NURSERY	0	834, 790		43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	10, 968, 440		50. 00
50. 01   05001   ENDOSCOPY	0	1, 263, 981		50. 01
51. 00   05100   RECOVERY ROOM	0	1, 569, 660		51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	2, 082, 831		52.00
53. 00 05300 ANESTHESI OLOGY	-5, 325, 112	703, 806		53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	-83, 063	5, 446, 318		54.00
54. 01   05401   RADI ATI ON-ONCOLOGY	0	12, 911, 928		54. 01
56.00   03450   NUCLEAR MEDICINE - DIAGNOSTIC 59.00   05900   CARDIAC CATHETERIZATION	0	339, 097		56. 00 59. 00
60. 00   06000   LABORATORY	-2, 180	-273, 235 6, 964, 871		60.00
64. 00   06400   NTRAVENOUS THERAPY	-2, 180	1, 162, 864		64. 00
65. 00 06500 RESPIRATORY THERAPY	0	2, 201, 767		65.00
66. 00   06600   PHYSI CAL THERAPY	-410, 801	5, 004, 032		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	-50, 582	371, 647		67.00
68. 00 06800 SPEECH PATHOLOGY	-792	401, 115		68. 00
69. 00 06900 ELECTROCARDI OLOGY	-109, 185	748, 605		69. 00
69. 01   06901 CARDI AC REHAB	0	491, 433		69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	144, 299		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	O		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	4, 026, 321		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	11, 149, 827		73. 00
73. 01   07301   ULTRA SOUND	0	550, 601		73. 01
74. 00 07400 RENAL DIALYSIS	0	135, 376		74. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00  09000   CLI NI C	-90, 080			90. 00
91. 00   09100   EMERGENCY	-450, 064	4, 058, 744		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
SPECIAL PURPOSE COST CENTERS	40 400 000	474 445 (00		140.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	-18, 180, 332	171, 115, 688		118. 00
NONREI MBURSABLE COST CENTERS  192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES		20 010 041		102.00
· · · · · · · · · · · · · · · · · · ·	0	38, 010, 941		192. 00 192. 01
192. 01 19201 HEALTH_TRACKS 194. 00 07950 PRIMARY_CARE_CLINIC	0 0	3, 881, 825 582, 981		194. 00
194.00 07930 PRIMARY CARE CLINIC	0	823, 939		194. 00
194. 02 07952  OCCUPATI ONAL MEDI CI NE	0	724, 683		194. 01
194. 03 07953 FOUNDATION	0	235, 088		194. 02
194. 04 07954 SCHOOL & TOWN CLINICS	0	648, 351		194. 04
200.00 TOTAL (SUM OF LINES 118-199)	-18, 180, 332			200.00

Health Financial Systems HENDRICKS REGIONAL HEALTH				In Lie	u of Form Cl	MS-2552-10		
RECLASS	SIFICATIONS			Provi der	CCN: 150005	Peri od: From 01/01/2015	Worksheet	A-6
						To 12/31/2015	Date/Time	
		Increases				I	5/26/2016	11: 23 am
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3.00	4. 00	5. 00				
1 00	A - DRUG RECLASS	72.00	al	11 140 007				1 00
1. 00 2. 00	DRUGS CHARGED TO PATIENTS INTRAVENOUS THERAPY	73. 00 64. 00	0	11, 149, 827 84, 206				1. 00 2. 00
3. 00	THE TOTAL TO	0.00	Ö	01, 200				3. 00
4.00		0. 00	О	0				4. 00
5.00		0.00	0	0				5. 00
6. 00 7. 00		0. 00 0. 00	0	0				6. 00 7. 00
8. 00		0.00	Ö	0				8. 00
9.00		0.00	О	0				9. 00
10.00		0.00	0	0				10.00
11. 00 12. 00		0. 00 0. 00	0	0				11. 00 12. 00
13. 00		0.00	o	0				13. 00
14.00		0.00	О	0				14. 00
15. 00		0.00	0	0				15. 00
16. 00 17. 00		0. 00 0. 00	0	0				16. 00 17. 00
18. 00		0.00	o	0				18. 00
19. 00		0.00	0	0				19. 00
20.00		0.00	0	0				20.00
21. 00 22. 00		0. 00 0. 00	0	0				21. 00 22. 00
23. 00		0.00	0	0				23. 00
24. 00		0.00	0	0				24. 00
25. 00		0.00	0	0				25. 00
26. 00				<u> 0</u> 11, 234, 033				26. 00
	B - MOB PLANT RECLASS		UU	11, 234, 033				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6, 016				1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	54, 111				2. 00
3.00	OPERATION OF PLANT	7. 00	0	13, 862				3. 00
4. 00 5. 00	LAUNDRY & LINEN SERVICE SOCIAL SERVICE	8. 00 17. 00	0	31, 690 16, 724				4. 00 5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	70, 520				6. 00
7.00	LABORATORY	60.00	O	18, 913				7. 00
8. 00	CLINIC	90.00		17 <u>7, 0</u> 5 <u>5</u> 388, 891				8. 00
	C - CAFETERIA RECLASS		O <sub>1</sub>	300, 091				
1.00	CAFETERI A	11. 00	1, 124, 574	1, 279, 812				1. 00
	O DE LANGUANTARI E REVUESES		1, 124, 574	1, 279, 812				
1. 00	D - IMPLANTABLE DEVICES IMPL. DEV. CHARGED TO	72.00	0	4, 026, 321				1.00
1.00	PATI ENT	72.00		4, 020, 321				1.00
2.00		0.00	О	0				2. 00
3.00		0.00	0	0				3. 00
4. 00 5. 00		0. 00 0. 00	0	0				4. 00 5. 00
6. 00		0.00	•	0				6. 00
	0		0	4, 026, 321				
1 00	E - BONUS RECLASS	E 00	122 122					1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	132, 123 46, 020	0				1. 00 2. 00
3.00	LAUNDRY & LINEN SERVICE	8.00	9, 419	0				3. 00
4.00	HOUSEKEEPI NG	9. 00	68, 896	0				4. 00
5.00	DI ETARY	10.00	61, 899	0				5. 00
6. 00 7. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13. 00 14. 00	36, 808 17, 224	0				6. 00 7. 00
8. 00	PHARMACY	15. 00	30, 556	0				8. 00
9.00	MEDICAL RECORDS & LIBRARY	16. 00	33, 102	0				9. 00
10.00	SOCI AL SERVI CE	17. 00	32, 026	0				10.00
11. 00 12. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	192, 881 34, 862	0				11. 00 12. 00
13. 00	OPERATING ROOM	50.00	29, 604	0				13. 00
14. 00	ENDOSCOPY	50. 01	15, 216	0				14. 00
15. 00	RECOVERY ROOM	51. 00	19, 108	0				15. 00
16.00	ANESTHESI OLOGY	53.00	19, 886	0				16.00
17. 00 18. 00	RADI OLOGY-DI AGNOSTI C RADI ATI ON-ONCOLOGY	54. 00 54. 01	74, 009 17, 493	0				17. 00 18. 00
19. 00	NUCLEAR MEDICINE -	56. 00	2, 153	0				19. 00
	DI AGNOSTI C							
20.00	CARDI AC CATHETERI ZATI ON	59.00	8, 488	0				20.00
21. 00 22. 00	LABORATORY INTRAVENOUS THERAPY	60. 00 64. 00	59, 353 12, 918	0				21. 00 22. 00
	1	51.50	, , , , ,		1			1 22.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 150005

					5/26/2016 11	: 23 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4.00	5. 00		
23. 00	RESPIRATORY THERAPY	65.00	27, 720	0		23. 00
24.00	PHYSI CAL THERAPY	66.00	70, 718	0		24. 00
25.00	OCCUPATI ONAL THERAPY	67.00	6, 728	0		25. 00
26.00	SPEECH PATHOLOGY	68.00	4, 306	0		26. 00
27. 00	ELECTROCARDI OLOGY	69.00	11, 842	0		27. 00
28. 00	CARDI AC REHAB	69. 01	6, 190	0		28. 00
29. 00	ELECTROENCEPHALOGRAPHY	70.00	2, 691	Ö		29. 00
30. 00	ULTRA SOUND	73. 01	4, 844	Ö		30.00
31. 00	CLINIC	90.00	30, 680	Ö		31. 00
32. 00	EMERGENCY	91.00	55, 709	o		32. 00
33. 00	PHYSICIANS' PRIVATE OFFICES	192.00	253, 158	Ö		33. 00
34. 00	HEALTH TRACKS	192.00	39, 743	o		34. 00
35. 00	PRIMARY CARE CLINIC	194. 00	2, 691	o		35. 00
36. 00	PARTNERS IN CARE	194.00	9, 150	0		36. 00
37. 00			4, 306	0		37. 00
	OCCUPATIONAL MEDICINE	194. 02				
38. 00	FOUNDATION	194. 03	4, 306	0		38. 00
39. 00	SCHOOL & TOWN CLINICS	194. 04	6, 459	0		39. 00
	U STATE OF THE STA		1, 495, 285	0		_
1 00	F - MEDICAL SUPPLY RECLASS	F0.00	ما	11 0/0 412		1 00
1.00	OPERATING ROOM	50.00	0	11, 069, 413		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5. 00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10. 00		0.00	0	0		10. 00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17.00		0.00	0	0		17. 00
18.00		0.00	0	0		18. 00
19.00		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00
21.00		0.00	0	0		21. 00
22.00		0.00	0	0		22. 00
23.00		0.00	O	0		23. 00
24.00		0.00	O	0		24. 00
25.00		0.00	O	0		25. 00
26.00		0.00	O	0		26. 00
27.00		0.00	0	0		27. 00
28.00		0.00	0	0		28. 00
29.00		0.00	o	0		29. 00
30.00		0.00	O	0		30.00
31. 00		0.00	o	Ö		31. 00
32. 00		0.00	o	o		32. 00
33. 00		0.00	n	o		33. 00
34. 00		0.00	0	Ö		34. 00
35. 00		0.00	o	n		35. 00
36. 00		0.00	0	Ö		36. 00
37. 00		0.00	0	0		37. 00
38. 00		0.00	0	0		38. 00
50.00				11, 069, 413		30.00
500 00	Grand Total: Increases		2, 619, 859	27, 998, 470		500.00
500.00	prana rotar. Thereases		2,017,007	21, 770, 410		1 300. 00

Peri od: From 01/01/2015 To 12/31/2015 Provi der CCN: 150005 Date/Time Prepared: 5/26/2016 11:23 am

	Cont Conton	Decreases Li ne #	Calami	O+box	Wko+ A 7 Dof		
	Cost Center 6.00	7. 00	8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - DRUG RECLASS						
1.00	NURSING ADMINISTRATION	13. 00	0	, , ,	0		1. 00
2. 00 3. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	0				2. 00 3. 00
4.00	ADULTS & PEDIATRICS	30.00	0				4. 00
5. 00	INTENSIVE CARE UNIT	31.00	0	538			5. 00
6.00	NURSERY	43.00	0	71			6. 00
7.00	OPERATING ROOM	50. 00	0	.,			7. 00
8.00	ENDOSCOPY	50. 01	0	1, 022			8. 00
9. 00 10. 00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	51. 00 52. 00	0	361 841	0		9. 00 10. 00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	0				11. 00
12. 00	RADI ATI ON-ONCOLOGY	54. 01	0	56			12. 00
13.00	LABORATORY	60.00	0				13. 00
14.00	RESPIRATORY THERAPY	65.00	0	337			14. 00
15. 00 16. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00	0	70, 909 29			15. 00 16. 00
17. 00	CARDI AC REHAB	69. 01	0	9			17. 00
18. 00	RENAL DIALYSIS	74.00	0	349			18. 00
19. 00	CLINIC	90.00	0	728			19. 00
20. 00	EMERGENCY	91.00	0				20. 00
21. 00	PHYSICIANS' PRIVATE OFFICES HEALTH TRACKS	192.00	0	2, ,20, 0,0			21. 00
22. 00 23. 00	PRIMARY CARE CLINIC	192. 01 194. 00	0	34, 403 1, 423			22. 00 23. 00
24. 00	PARTNERS IN CARE	194. 01	0	13, 189	-		24. 00
25. 00	OCCUPATIONAL MEDICINE	194. 02	0	1			25. 00
26. 00	SCHOOL & TOWN CLINICS	1 <u>94.</u> 04	0	1, 147			26. 00
	D MOD DIANT DECLASS		0	11, 234, 033			-
1. 00	B - MOB PLANT RECLASS PHYSICIANS' PRIVATE OFFICES	192.00	0	388, 891	0		1. 00
2. 00	I THISTOTANS THE VALE OF FICES	0.00	0				2. 00
3.00		0.00	0	0	0		3. 00
4.00		0.00	0	0			4. 00
5.00		0.00	0	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	0		0		6. 00 7. 00
8. 00		0.00	0	Ö	o		8. 00
	0			388, 891		<u> </u>	
1 00	C - CAFETERIA RECLASS	10.00	1 104 574	1 270 012			1.00
1. 00	DI ETARY	1000	<u>1, 124, 5</u> 74 1, 124, 574				1. 00
	D - IMPLANTABLE DEVICES		1, 121, 071	1,277,012			1
1.00	OPERATING ROOM	50.00	0	2, 353, 429			1. 00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	,			2. 00
3. 00 4. 00	CARDIAC CATHETERIZATION RENAL DIALYSIS	59. 00 74. 00	0				3. 00 4. 00
5.00	CLINIC	90.00	0	622, 592			5. 00
6. 00	EMERGENCY	91.00	0	204			6. 00
	0 — — — — —			4, 026, 321		I .	
	E - BONUS RECLASS		4 405 005		1		
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 0. 00	1, 495, 285 0	0			1. 00 2. 00
3.00		0.00	0				3. 00
4. 00		0.00	0				4. 00
5.00		0.00	0				5. 00
6.00		0.00	0				6. 00
7. 00 8. 00		0. 00 0. 00	0				7. 00 8. 00
9. 00		0.00	0				9. 00
10. 00		0.00	0				10.00
11. 00		0.00	0	0			11. 00
12.00		0.00	0				12. 00
13.00		0.00	0				13.00
14. 00 15. 00		0. 00 0. 00	0				14. 00 15. 00
16. 00		0.00	0				16. 00
17. 00		0.00	0		0		17. 00
18. 00		0.00	0				18. 00
19. 00		0.00	0				19. 00
20. 00 21. 00		0. 00 0. 00	0				20. 00 21. 00
22. 00		0.00	0				22. 00
23. 00		0.00	0	0	0		23. 00
24. 00		0. 00	0	0	0		24. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 5/26/2016 11:23 am Provider CCN: 150005

						5/26/2016 11:	23 am_
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8.00	9. 00	10.00		
25. 00		0.00	0	0	0		25. 00
26.00		0.00	0	0	0		26. 00
27.00		0.00	0	0	0		27. 00
28. 00		0.00	0	0	0		28. 00
29. 00		0.00	0	0	0		29. 00
30. 00		0.00	0	0	0		30.00
		0.00	0	0	0		31. 00
31. 00			0				1
32.00		0.00	0	0			32.00
33. 00		0. 00	0	0	0		33. 00
34. 00		0. 00	0	0	0		34. 00
35. 00		0. 00	0	0	0		35. 00
36.00		0.00	0	0	0		36. 00
37.00		0.00	0	0	0		37. 00
38. 00		0.00	0	0	0		38. 00
39.00		0.00	0	0	0		39. 00
			1, 495, 285	— — <u> </u>			
	F - MEDICAL SUPPLY RECLASS		17 1707 200			l .	i
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	981	0		1. 00
	•		0		0		1
2.00	ADMINISTRATIVE & GENERAL	5.00	-	1, 101			2.00
3. 00	OPERATION OF PLANT	7. 00	0	45	0		3. 00
4.00	LAUNDRY & LINEN SERVICE	8. 00	0	1	0		4. 00
5.00	HOUSEKEEPI NG	9. 00	0	43	0		5. 00
6.00	DI ETARY	10.00	0	21	0		6. 00
7.00	NURSING ADMINISTRATION	13. 00	0	1, 169	0		7. 00
8.00	CENTRAL SERVICES & SUPPLY	14. 00	0	6, 839	0		8. 00
9. 00	PHARMACY	15. 00	0	11, 124	0		9. 00
10. 00	ADULTS & PEDIATRICS	30.00	0	392, 559	0		10. 00
11. 00	INTENSIVE CARE UNIT	31.00	0	126, 110	0		11. 00
12. 00	NURSERY	43. 00	0	70, 448	0		12. 00
	OPERATING ROOM		0	·			1
13.00		50.00	U	7, 650, 029	0		13.00
14. 00	ENDOSCOPY	50. 01	0	248, 174	0		14. 00
15. 00	RECOVERY ROOM	51. 00	0	95, 121	0		15. 00
16. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	39, 164	0		16. 00
17. 00	ANESTHESI OLOGY	53. 00	0	179, 269	0		17. 00
18.00	RADI OLOGY-DI AGNOSTI C	54.00	0	297, 895	0		18. 00
19.00	RADI ATI ON-ONCOLOGY	54. 01	0	169, 392	0		19. 00
20.00	NUCLEAR MEDICINE -	56.00	0	1, 156	0		20.00
	DI AGNOSTI C			·			
21. 00	CARDIAC CATHETERIZATION	59. 00	0	618, 367	0		21. 00
22. 00	LABORATORY	60.00	0	2, 700	0		22. 00
23. 00	INTRAVENOUS THERAPY	64.00	0	58, 886	0		23. 00
24. 00	RESPIRATORY THERAPY	65. 00	0	60, 742	0		24. 00
	PHYSI CAL THERAPY		-		0		4
25. 00	1	66.00	0	152, 116			25. 00
26. 00	OCCUPATI ONAL THERAPY	67. 00	0	3, 801	0		26. 00
27. 00	ELECTROCARDI OLOGY	69. 00	0	3, 041	0		27. 00
28. 00	CARDI AC REHAB	69. 01	0	3, 212	0		28. 00
29. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	24	0		29. 00
30.00	ULTRA SOUND	73. 01	0	41, 426	0		30.00
31.00	CLINIC	90.00	0	97	0		31. 00
32.00	EMERGENCY	91.00	0	283, 635	0		32. 00
33. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	490, 083			33. 00
34. 00	HEALTH TRACKS	192.00	0	32, 945	0		34. 00
35. 00	PRIMARY CARE CLINIC	194. 00	0	429	0		35. 00
			0		_		36.00
36.00	PARTNERS IN CARE	194. 01	0	18, 122	0		
37. 00	OCCUPATIONAL MEDICINE	194. 02	0	8, 127	0		37. 00
38. 00	SCHOOL & TOWN CLINICS	1 <u>94.</u> 04	0	<u>1, 0</u> 19			38. 00
	0		0	11, 069, 413			
500.00	Grand Total: Decreases		2, 619, 859	27, 998, 470			500. 00

					rom 01/01/2015		
				1	o 12/31/2015	Date/Time Prep 5/26/2016 11:	
				Acqui si ti ons		37 207 2010 11.	25 4111
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances	. a. c.iaccc	5011411 011	. o ca.	Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
-	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	16, 407, 702	166, 500	0	166, 500	0	1.00
2.00	Land Improvements	6, 174, 137	0	0	0	0	2. 00
3.00	Buildings and Fixtures	247, 576, 654	0	0	0	822, 786	3. 00
4.00	Building Improvements	463, 498	197, 383	0	197, 383	2, 686	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	73, 001, 218	15, 358, 410	0	15, 358, 410	6, 355, 886	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	343, 623, 209	15, 722, 293	0	15, 722, 293	7, 181, 358	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	343, 623, 209	15, 722, 293	0	15, 722, 293	7, 181, 358	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	16, 574, 202	0				1. 00
2.00	Land Improvements	6, 174, 137	0				2. 00
3.00	Buildings and Fixtures	246, 753, 868	0				3. 00
4.00	Building Improvements	658, 195	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	82, 003, 742	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	352, 164, 144	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	352, 164, 144	0				10. 00

Heal th	Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
					From 01/01/2015 To 12/31/2015		nared·
					10 12/01/2010	5/26/2016 11:	
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	instructions)	
		9. 00	10.00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	14, 536, 109	0	5, 125, 95	2 165, 070	0	1. 00
3.00	Total (sum of lines 1-2)	14, 536, 109	0	5, 125, 95	2 165, 070	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	19, 827, 131				1. 00
3.00	Total (sum of lines 1-2)	0	19, 827, 131				3. 00

Heal th	Financial Systems	HENDRI CKS REG	IONAL HEALTH		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
					From 01/01/2015 To 12/31/2015	Part III Date/Time Prep	nared:
						5/26/2016 11: 2	
		COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Coot Contan Decemintion	Gross Assets	Conitalizad	Gross Assets	Datio (coo	Insurance	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	for Ratio	Ratio (see instructions)	Trisurance	
			Leases	(col. 1 - col			
				2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	0		0 1. 000000	0	1. 00
3.00	Total (sum of lines 1-2)	0	0		0 1.000000		3. 00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DADT 111 DESCRIPTION OF SARITAL SOCTO OF	6.00	7. 00	8. 00	9. 00	10.00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS			0 44 505 000		4 00
1. 00 3. 00	NEW CAP REL COSTS-BLDG & FIXT Total (sum of lines 1-2)	0	0		0 14, 525, 380 0 14, 525, 380		1. 00 3. 00
3.00	Total (Suil of Titles 1-2)	U	<u> </u>	L JMMARY OF CAPI		U	3.00
			30	DWINART OF CALL	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate		
					d Costs (see	through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	DART III DECONCILIATION OF CARLTAL COCTO OF	11. 00	12.00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CI		1/5 070			10.1/0.00/	1 00
1.00	NEW CAP REL COSTS-BLDG & FIXT	3, 478, 486			0	18, 168, 936	1.00
3.00	Total (sum of lines 1-2)	3, 478, 486	165, 070		0	18, 168, 936	3.00

| Peri od: | Worksheet A-8 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

				T T	0 12/31/2015	Date/Time Prep 5/26/2016 11:2	
				Expense Classification on		3/20/2010 11.2	23 aiii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref.	
1. 00	Investment income - NEW CAP	1. 00 B		NEW CAP REL COSTS-BLDG &	1.00	5. 00 11	1. 00
	REL COSTS-BLDG & FLXT (chapter 2)			FLXT			
2.00	Investment income - CAP REL		0	*** Cost Center Deleted ***	2.00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)						
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5. 00	Refunds and rebates of		0		0.00	0	5. 00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
7.00	stations excluded) (chapter		O		0.00	Ĭ	7.00
8. 00	21) Television and radio service		0		0.00	0	8. 00
	(chapter 21)						
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-8, 482, 924		0.00	0 0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11. 00
	(chapter 23)		O		0.00		
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12. 00
13.00	Laundry and linen service		0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee	1	-738, 843 0	CAFETERI A	11. 00 0. 00	0 0	14. 00 15. 00
	and others						
16. 00	Sale of medical and surgical supplies to other than		U		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
	patients		O				
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing school (tuition, fees,		0		0. 00	О	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
	repay Medicare overpayments				45.00		
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
24.00	therapy costs in excess of	A-0-3	O	THISTORE THERALT	00.00		24.00
25. 00	limitation (chapter 14) Utilization review -		0	  *** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	o	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL			FIXT *** Cost Center Deleted ***	2. 00	0	27. 00
	COSTS-MVBLE EQUIP						
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
	Depreciation and Interest	1		I	I	ı	

From 01/01/2015 | Worksheet A-8 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

				To	12/31/2015	Date/Time Prep 5/26/2016 11:	pared:
				Expense Classification on	Worksheet A	3/20/2010 11.	23 4111
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	cost center beserver on	1.00	2. 00	3.00	4. 00	5. 00	
33. 00	ADMITTING TELEPHONE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
	(EQUI PMENT)						
33. 01	ADMITTING TELEPHONE (SALARY)	A	·	ADMINISTRATIVE & GENERAL	5. 00		
33. 02	MARKETING DEPARTMENT	A		ADMINISTRATIVE & GENERAL	5. 00		33. 02
34. 00	STAFF EDUCATION ED DEPT COURSES	В	-11, 188	NURSING ADMINISTRATION	13. 00	0	34. 00
35. 00	CBC - OB UNIT ED DEPT COURSES	В	-6 660	ADULTS & PEDIATRICS	30.00	0	35. 00
36. 00	EMS PROGRAM ED DEPT COURSES	В	·	EMERGENCY	91. 00		36. 00
37. 00	LABORATORY MISC. SERVICES	В		LABORATORY	60.00		37. 00
38. 00	RADIOLOGY SALE OF X-RAYS	В	-1, 471	RADI OLOGY-DI AGNOSTI C	54.00	0	38. 00
39. 00	PHYSICAL THERAPY SUPPLIES SOLD	В	-5, 580	PHYSI CAL THERAPY	66. 00	0	39. 00
40.00	TO OT	В	22 104	DUVCI CAL THEDADY	// 00		40.00
40. 00	SPORTS MEDICINE ED DEPT.	В	-32, 194	PHYSI CAL THERAPY	66. 00	0	40. 00
41. 00	PLAINFIELD PT SUPPLIES SOLD TO	В	-7 795	PHYSI CAL THERAPY	66.00	0	41. 00
11.00	OTHER		7,770	THE STORE THE WITT	00.00	J	11.00
43.00	DIETARY CATERING	В	-13, 598	CAFETERI A	11. 00	0	43.00
44.00	REGISTRATION ANSWERING SERVICE		-3, 796	ADMINISTRATIVE & GENERAL	5.00	0	44. 00
45. 00	ACCOUNTING MISCELLANEOUS/OTHER	l I		ADMINISTRATIVE & GENERAL	5. 00		
45. 01	ACCOUNTING PURCHASE DISCOUNTS	В	-47, 228	ADMINISTRATIVE & GENERAL	5. 00	0	45. 01
45. 02	TAKEN GUEST ROOM RENTAL	В	1 170	ADMINISTRATIVE & GENERAL	5. 00	0	45. 02
45. 02	HEALTH INFO MGMT MEDICAL	В		MEDICAL RECORDS & LIBRARY	16. 00		ı
10.00	RECORDS TRA		1, 701	INCOME RECORDS & ELDIVIN	10.00	J	10.00
45.04	HUMAN RESOURCES JURY DUTY	В	-173	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45. 04
	RECEI PTS	_				_	
45. 05	MATERIALS MGMT. SUPPLIES SOLD	В	-140	CENTRAL SERVICES & SUPPLY	14. 00	0	45. 05
45. 06	TO OTH PLAINFIELD PT ED DEPT COURSES	В	250	PHYSI CAL THERAPY	66.00	0	45. 06
45. 07	AVON ORTH/SPORT MISC. /OTHER	В		PHYSICAL THERAPY	66.00		
45. 08	OCC THERAPY REHAB SUPPLIES	В		OCCUPATI ONAL THERAPY	67. 00		45. 08
	SOLD TO 0						
45. 09	HRH WELLNESS ED DEPARTMENT	В	-86, 161	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	45. 09
45. 10	COURSES	Δ.	240 701	DIETADY	10. 00	0	45. 10
45. 10 45. 11	MEALS ON WHEELS 1993 CARRYFORWARD	A A	-369, 781 -14, 017	NEW CAP REL COSTS-BLDG &	1. 00		45. 10
45. 11	1773 CARRITORWARD	^		FIXT	1.00	7	45.11
45. 12	1994 CARRYFORWARD	A		NEW CAP REL COSTS-BLDG &	1.00	9	45. 12
				FIXT			
45. 13	PHYSI CI AN RECRUI TMENT	A		ADMI NI STRATI VE & GENERAL	5. 00	0	
45. 14	I HA LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5.00	1	45. 14
45. 15 45. 16	AHA LOBBYING EXPENSE HOSPITAL ASSESSMENT FEE	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	
	WOUND OSTOMY LEASE REVENUE	В		PHYSICAL THERAPY	66. 00		45. 16
45. 21	B' BURG PT SUPPLIES SOLD T	В		PHYSI CAL THERAPY	66. 00		1
45. 22	AVON PHYS THRPY SUPPLIES	В		PHYSI CAL THERAPY	66. 00	0	1
45. 24	OCC THER ED DEPT CO	В	-50, 396	OCCUPATIONAL THERAPY	67.00	0	45. 24
45. 25	ACCOUNTING NON-OP REVENUE	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	
45. 28	HI BBELN SUR CNT MI SCELLANEOUS	В	-90, 080	1	90.00	0	
45. 29	AVON PHYS THRPY MISCELLAN	В		PHYSI CAL THERAPY	66.00	0	
45. 30 45. 31	B' BURG PT LEASE REVENUE AVON PHYS THRPY LEASE REV	B B		PHYSI CAL THERAPY PHYSI CAL THERAPY	66. 00 66. 00	0	
45. 31	SPEECH THERAPY ED DEPT CO	В	·	SPEECH PATHOLOGY	68. 00		1
46. 00	MAINTENANCE MISC. REVENUE	В		OPERATION OF PLANT	7. 00		46. 00
50. 00	TOTAL (sum of lines 1 thru 49)	1	-18, 180, 332	1		]	50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

Description - all chapter references in this column pertain to CMS Pub. 15-1.
 Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

						0 12/31/2015	5/26/2016 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	30.00	ADULTS & PEDIATRICS	2, 211, 015	2, 211, 015	0	179, 000	0	1. 00
2.00	91. 00	EMERGENCY	93, 750	0	93, 750	179, 000	1, 100	2. 00
3.00	91. 00	EMERGENCY	123, 303	0	123, 303	179, 000	1, 447	3. 00
4.00	60.00	LABORATORY	71, 096	0	71, 096	260, 300	686	4. 00
5.00	66. 00	PHYSI CAL THERAPY	353, 495	353, 495	0	179, 000	0	5. 00
6.00	69. 00	ELECTROCARDI OLOGY	109, 185	109, 185	0	179, 000	0	6. 00
7.00	54.00	RADI OLOGY-DI AGNOSTI C	81, 592	81, 592	0	179, 000	0	7. 00
8.00		EMERGENCY	402, 525			179, 000	0	8. 00
9. 00	53. 00	ANESTHESI OLOGY	5, 325, 112	5, 325, 112	0	239, 400	0	9. 00
10.00	0.00		0			0	0	10.00
200.00			8, 771, 073	8, 482, 924	288, 149		3, 233	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &		of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14. 00	
1.00		ADULTS & PEDIATRICS	0		_	_	0	
2.00		EMERGENCY	94, 663			0	0	
3.00		EMERGENCY	124, 525			0	0	
4.00		LABORATORY	85, 849	1	0	0	0	1
5.00		PHYSI CAL THERAPY	0	0	0	0	0	0.00
6.00		ELECTROCARDI OLOGY	0	0	0	0	0	0.00
7.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	7.00
8.00		EMERGENCY	0	0	0	0	0	8. 00
9.00		ANESTHESI OLOGY	0	0	0	0	0	,
10. 00	0. 00		0	0	0	0	0	1
200.00			305, 037			0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	13.00			2, 211, 015		1. 00
2. 00		EMERGENCY		1		2,211,019		2. 00
3. 00		EMERGENCY	1 0			0		3. 00
4. 00		LABORATORY				0		4. 00
5. 00		PHYSI CAL THERAPY	1 0	00,017		353, 495		5. 00
6. 00		ELECTROCARDI OLOGY	1 0		0	109, 185		6. 00
7. 00		RADI OLOGY-DI AGNOSTI C	1 0		0	81, 592		7. 00
8. 00		EMERGENCY	1 0		0	402, 525		8. 00
9. 00		ANESTHESI OLOGY	0		0	5, 325, 112		9. 00
10. 00	0.00				0	0,020,112		10.00
200.00	3. 00		0		_	8, 482, 924		200. 00
			1	1 2227 007	,	-//	1	

| Peri od: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150005

				Ť	o 12/31/2015		pared:
			CAPI TAL			5/26/2016 11:	23 am
			RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		for Cost	FLXT	BENEFITS		& GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		col. 7)	1.00	4.00	4A	5. 00	
	GENERAL SERVICE COST CENTERS		1.00	4.00	471	3.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	18, 168, 936	18, 168, 936				1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 543, 142	145, 617	4, 688, 759			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	29, 515, 619	1, 410, 931	411, 191	31, 337, 741	31, 337, 741	5. 00
7.00	00700 OPERATION OF PLANT	8, 522, 241	2, 048, 169			1, 813, 221	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	675, 175					8.00
9.00	00900 HOUSEKEEPI NG	2, 979, 646					9.00
10. 00 11. 00	01000   DI ETARY   01100   CAFETERI A	405, 006 1, 651, 945					1
13. 00	01300 NURSI NG ADMI NI STRATI ON	2, 692, 441	229, 337				13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 110, 119					
15. 00	01500 PHARMACY	3, 697, 384					
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 675, 089	175, 916	63, 474			16. 00
17. 00	01700 SOCIAL SERVICE	2, 342, 810	54, 110	81, 895	2, 478, 815	420, 578	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	T			T		
30.00	03000 ADULTS & PEDI ATRI CS	10, 829, 921					1
31. 00 43. 00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	2, 349, 136 834, 790					31. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	034, 790	44, 170	33, 427	714, 373	155, 144	43.00
50. 00	05000 OPERATING ROOM	10, 968, 440	440, 823	74, 758	11, 484, 021	1, 948, 482	50.00
50. 01	05001 ENDOSCOPY	1, 263, 981	142, 597				50. 01
51.00	05100 RECOVERY ROOM	1, 569, 660	725, 991	59, 902	2, 355, 553	399, 664	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 082, 831	149, 828				52. 00
53. 00	05300 ANESTHESI OLOGY	703, 806					1
54.00	05400 RADI OLOGY - DI AGNOSTI C	5, 446, 318					
54. 01 56. 00	05401   RADI ATI ON-ONCOLOGY   03450   NUCLEAR   MEDI CI NE   - DI AGNOSTI C	12, 911, 928 339, 097	434, 493 13, 958				54. 01 56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	-273, 235					59.00
60. 00	06000 LABORATORY	6, 964, 871	342, 377			l e	1
64. 00	06400 I NTRAVENOUS THERAPY	1, 162, 864					1
65.00	06500 RESPIRATORY THERAPY	2, 201, 767	184, 789	73, 944	2, 460, 500	417, 471	65. 00
66. 00	06600 PHYSI CAL THERAPY	5, 004, 032					66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	371, 647					1
68. 00	06800 SPEECH PATHOLOGY	401, 115					
69. 00 69. 01	06900  ELECTROCARDI OLOGY   06901  CARDI AC REHAB	748, 605 491, 433				149, 865 108, 695	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	144, 299				37, 372	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	, , , , , ,			0,,0,2	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	4, 026, 321	o			683, 142	
73.00	07300 DRUGS CHARGED TO PATIENTS	11, 149, 827	0	0			
73. 01	07301 ULTRA SOUND	550, 601	18, 063			100, 392	1
74.00	07400 RENAL DIALYSIS	135, 376	0	0	135, 376	22, 969	74. 00
00.00	OUTPATIENT SERVICE COST CENTERS	F (07.0/0	F24 0F2	00.007	/ 212 020	1 071 002	00.00
90. 00 91. 00	09000   CLI NI C   09100   EMERGENCY	5, 697, 960 4, 058, 744					1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,030,744	370, 741	144, 029	4, 801, 714		92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		171, 115, 688	13, 153, 634	3, 200, 219	164, 611, 846	22, 614, 810	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	38, 010, 941					
	19201 HEALTH TRACKS	3, 881, 825				738, 859	
	07950 PRIMARY CARE CLINIC	582, 981	147, 285			127, 558	
	07951   PARTNERS IN CARE   07952   OCCUPATIONAL MEDICINE	823, 939 724, 683					
	07952 CCCOPATIONAL MEDICINE	235, 088					
	07954 SCHOOL & TOWN CLINICS	648, 351	15, 203				
200.00		2.5,501	.5, 250		000, 700		200. 00
201.00	1 1		0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	216, 023, 496	18, 168, 936	4, 688, 759	216, 023, 496	31, 337, 741	202. 00

Provider CCN: 150005

				12/31/2013	5/26/2016 11:	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10.00	11.00	
GENERAL SERVICE COST CENTERS				•		
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT	12, 500, 032					7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE	0	1, 102, 383				8.00
9. 00   00900   HOUSEKEEPI NG	184, 781	0 1, 102, 000				9. 00
10. 00   01000 DI ETARY	724, 931	0		1, 880, 708		10.00
11. 00   01100   CAFETERI A	128, 741	0	137, 207	1, 000, 700	2, 219, 743	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	374, 712	0	32, 339	0	84, 466	13.00
14. 00   01400   CENTRAL SERVICES & SUPPLY	670, 448	257		0		
		l .		0	31, 465	
15. 00   01500   PHARMACY	295, 866	1, 288		0	91, 249	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	234, 893	l		0	102, 710	16.00
17. 00 01700 SOCI AL SERVI CE	0	0	3, 069	0	36, 380	17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1	. 1		
30. 00   03000   ADULTS & PEDI ATRI CS	3, 024, 047	l		1, 441, 508		30. 00
31.00 03100 INTENSIVE CARE UNIT	381, 290		1	174, 922	97, 041	31. 00
43. 00 04300 NURSERY	72, 181	16, 311	12, 983	264, 278	35, 061	43. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	1, 200, 428	72, 858	288, 687	0	97, 526	50.00
50. 01  05001 ENDOSCOPY	232, 989	32, 801	7, 081	0	49, 670	50. 01
51.00   05100   RECOVERY ROOM	706, 020	75, 426	52, 403	0	61, 225	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	244, 803	61, 305	6, 137	o	87, 717	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	6, 609	O	61, 348	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	850, 512	105, 390	176, 092	0	178, 490	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0	9, 614	1	o	55. 750	54. 01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	22, 806			0	5, 696	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	384, 189	0	0	0	24, 739	59.00
60. 00   06000   LABORATORY	352, 599	451	113, 067	o l	138, 739	60.00
64. 00 06400 I NTRAVENOUS THERAPY	58, 637	4, 157		o o	41, 653	64.00
65. 00 06500 RESPIRATORY THERAPY	274, 965			o o	88, 595	•
66. 00   06600   PHYSI CAL THERAPY	322, 913	l e		0	66, 404	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0			0	13, 190	67.00
68. 00 06800 SPEECH PATHOLOGY	102, 776	1	7, 081	0	14, 874	68.00
		l e		o o		•
69. 00 06900 ELECTROCARDI OLOGY	181, 146	l		0	38, 302	69.00
69. 01   06901   CARDI AC   REHAB	127, 919			U	16, 578	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	116, 062	1, 334	39, 420	0	6, 147	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	이	0	0	73. 00
73.01  07301 ULTRA SOUND	29, 513		8, 026	0	18, 390	73. 01
74. 00 07400 RENAL DIALYSIS	0	237	11, 094	0	0	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	0	61, 752	163, 582	0	0	90.00
91. 00  09100 EMERGENCY	978, 604	137, 039	311, 820	0	173, 031	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	12, 278, 771	1, 064, 042	3, 425, 538	1, 880, 708	2, 219, 743	118. 00
NONREI MBURSABLE COST CENTERS		,		*		
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	49, 419	30, 187	288, 687	0	0	192. 00
192. 01 19201 HEALTH TRACKS	0	l		0		192. 01
194. 00 07950 PRIMARY CARE CLINIC	0	l	1	0		194. 00
194. 01 07951 PARTNERS IN CARE	171, 842	١	26, 673	ol ol		194. 01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	171,542	1, 045		ol		194. 02
194. 03 07953 FOUNDATION	0	1,043	1, 652	o o		194. 03
194. 04 07954 SCHOOL & TOWN CLINICS		326		0		194. 04
200.00 Cross Foot Adjustments		320	2, 124	٩		200.00
201.00   Negative Cost Centers		_	0			200.00
	12 500 022	1 100 000	-	1 000 700		
202.00   TOTAL (sum lines 118-201)	12, 500, 032	1, 102, 383	3, 909, 908	1, 880, 708	2, 219, 743	12U2. UU

Provider CCN: 150005

| Period: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 5/26/2016 | 11: 23 am

						5/26/2016 11:	23 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
		13.00	14. 00	15. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	10.00	10.00	17.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION	4, 018, 754					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	2, 596, 995				14. 00
15. 00	01500 PHARMACY	0	0				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0		3, 781, 042	l .	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	2, 938, 842	17. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 007 400			22/ /25	0.050.400	00.00
30.00	03000 ADULTS & PEDIATRICS	1, 337, 188	0		336, 625		
31.00	03100 I NTENSI VE CARE UNI T	257, 819	0		102, 332	l	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	93, 151	0	0	0	0	43. 00
50. 00	05000 OPERATING ROOM	259, 106	2, 596, 995	0	0	0	50.00
50. 00	05001 ENDOSCOPY	131, 963	2, 340, 443		0		50.00
51. 00	05100 RECOVERY ROOM	162, 663	0		187, 408	_	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	233, 047	0	-	107, 400	Ö	52.00
53. 00	05300 ANESTHESI OLOGY	162, 988	0	0	0	ő	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	474, 211	0	0	925, 773		54. 00
54. 01	05401 RADI ATI ON-ONCOLOGY	0	0	o	0	Ō	1
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	1
59.00	05900 CARDI AC CATHETERI ZATI ON	65, 727	0	0	0	0	59. 00
60.00	06000 LABORATORY	0	0	0	795, 182	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	235, 378	0	0	62, 848	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0	301, 763	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	38, 531	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	101, 760	0	0	196, 606	l .	69. 00
69. 01	06901 CARDI AC REHAB	44, 045	0	0	0	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00		0	0	0	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
73. 01 74. 00	07301   ULTRA SOUND   07400   RENAL DI ALYSI S	0	0		0	0	
74.00	OUTPATIENT SERVICE COST CENTERS	U	0	0		0	74.00
90. 00		0	0	0	0	0	90.00
91. 00	09100 EMERGENCY	459, 708			833, 974		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1077 700	Ŭ		000, 77 1	555, 151	92. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		4, 018, 754	2, 596, 995	5, 052, 136	3, 781, 042	2, 924, 525	118. 00
	NONREI MBURSABLE COST CENTERS						
192.00	0 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	14, 317	192. 00
192. 01	1 19201 HEALTH TRACKS	0	0	0	0	0	192. 01
	0 07950 PRIMARY CARE CLINIC	0	0	0	0		194. 00
	1 07951 PARTNERS IN CARE	0	0	_	0		194. 01
	2 07952 OCCUPATI ONAL MEDI CI NE	0	0		0		194. 02
	3 07953 FOUNDATION	0	0	0	0		194. 03
	4 07954 SCHOOL & TOWN CLINICS	0	0	0	0	0	194. 04
200.00			_		_		200.00
201.00		4 010 754	2 504 005	E 053 134	2 701 042		201. 00
202.00	U TOTAL (Suill LITIES 118-201)	4, 018, 754	2, 596, 995	5, 052, 136	3, 781, 042	2, 938, 842	J2U2. UU

HENDRICKS REGIONAL HEALTH

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150005

					To 12/31/2015	Date/Time Prepared:
	Cost Center Description	Subtotal	Intern &	Total		5/26/2016 11: 23 am
	<b>'</b>		sidents Cost			
			& Post Stepdown			
		A	dj ustments			
		24. 00	25. 00	26. 00		
1 00	GENERAL SERVICE COST CENTERS					1.00
1. 00 4. 00	OO100   NEW CAP REL COSTS-BLDG & FIXT   OO400   EMPLOYEE BENEFITS DEPARTMENT					1. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					5. 00
7.00	00700 OPERATION OF PLANT					7. 00
8. 00 9. 00	O0800   LAUNDRY & LINEN SERVICE   O0900   HOUSEKEEPING					8. 00 9. 00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13.00	01300 NURSING ADMINISTRATION					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 16. 00	O1500   PHARMACY   O1600   MEDI CAL RECORDS & LI BRARY					15. 00 16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	25, 846, 284	0	25, 846, 28		30.00
31. 00 43. 00	03100   INTENSIVE CARE UNIT   04300   NURSERY	4, 517, 120	0	4, 517, 12		31. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	1, 563, 504	<u> </u>	1, 563, 50	4	43.00
50.00	05000 OPERATI NG ROOM	17, 948, 103	0	17, 948, 10	3	50.00
50. 01	05001 ENDOSCOPY	2, 149, 430	0	2, 149, 43		50. 01
51.00	05100 RECOVERY ROOM	4, 000, 362	0	4, 000, 36		51.00
52. 00 53. 00	05200   DELI VERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY	3, 353, 066 1, 323, 843	0	3, 353, 06 1, 323, 84		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	10, 183, 596	o	10, 183, 59		54. 00
54. 01	05401 RADI ATI ON-ONCOLOGY	15, 828, 586	0	15, 828, 58	6	54. 01
56. 00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	456, 408	0	456, 40		56. 00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	460, 945 10, 092, 162	0	460, 94 10, 092, 16		59. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY	1, 564, 842	o	1, 564, 84		64. 00
65.00	06500 RESPIRATORY THERAPY	3, 554, 628	0	3, 554, 62		65. 00
66. 00	06600 PHYSI CAL THERAPY	7, 509, 305	0	7, 509, 30		66. 00
67. 00 68. 00	O6700   OCCUPATI ONAL THERAPY   O6800   SPEECH PATHOLOGY	545, 522	0	545, 52		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	684, 763 1, 666, 108	o	684, 76 1, 666, 10		69. 00
69. 01	06901 CARDI AC REHAB	957, 211	o	957, 21		69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	420, 602	0	420, 60		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	4, 709, 463 18, 093, 743	0	4, 709, 46 18, 093, 74		72. 00 73. 00
73. 01	07301 ULTRA SOUND	748, 012	o	748, 01		73. 01
74.00	07400 RENAL DIALYSIS	169, 676	0	169, 67	6	74. 00
00.00	OUTPATIENT SERVICE COST CENTERS	7 (00 2//		7 (00 0)	,	00.00
	09000   CLI NI C   09100   EMERGENCY	7, 609, 266 9, 174, 076	0	7, 609, 26 9, 174, 07		90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 174, 070	o	7, 174, 07		92. 00
	SPECIAL PURPOSE COST CENTERS					
118.00		155, 130, 626	0	155, 130, 62	6	118. 00
102 00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES	51, 272, 461	ol	51, 272, 46	1	192. 00
	19201 HEALTH TRACKS	5, 200, 202	0	5, 200, 20		192. 00
194.00	07950 PRIMARY CARE CLINIC	884, 322	ō	884, 32	2	194. 00
	07951 PARTNERS IN CARE	1, 405, 710	0	1, 405, 71		194. 01
	07952 OCCUPATIONAL MEDICINE 07953 FOUNDATION	1, 000, 923 320, 941	o	1, 000, 92 320, 94		194. 02 194. 03
	07953 FOUNDATION 07954 SCHOOL & TOWN CLINICS	808, 311	0	320, 94 808, 31		194. 03
200.00		0	o		o o	200. 00
201.00		0	o		0	201. 00
202.00	TOTAL (sum lines 118-201)	216, 023, 496	0	216, 023, 49	6	202. 00

| Peri od: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150005

				Ť	o 12/31/2015		pared:
			CAPITAL			5/26/2016 11:	23 alli
			RELATED COSTS				
	Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
		Assigned New	FLXT		BENEFI TS	& GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs 0	1.00	2A	4.00	5. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	ZA	4. 00	5.00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	145, 617	145, 617	145, 617		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	1, 410, 931				5. 00
7.00	00700 OPERATION OF PLANT	0	2, 048, 169		3, 616	82, 374	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	251, 929				8. 00
9.00	00900 HOUSEKEEPI NG	0	113, 093				9.00
10.00	01000 DI ETARY		443, 684				10.00
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON		78, 794 229, 337				11. 00 13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY		410, 338				14. 00
15. 00	01500 PHARMACY		181, 081				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	175, 916				16. 00
17. 00	01700 SOCIAL SERVICE	0	54, 110	54, 110	2, 544	19, 107	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1				1	
30.00	03000 ADULTS & PEDI ATRI CS	0	,				30.00
31. 00 43. 00	03100   INTENSI VE CARE UNIT   04300   NURSERY	0			1		31.00
43.00	ANCI LLARY SERVI CE COST CENTERS		44, 178	44, 178	1, 100	7, 048	43. 00
50. 00	05000 OPERATI NG ROOM		440, 823	440, 823	2, 322	88, 519	50. 00
50. 01	05001 ENDOSCOPY		142, 597				50. 01
51.00	05100 RECOVERY ROOM	0	725, 991	725, 991	1, 861	18, 157	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	149, 828	149, 828			52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		,		53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	756, 105		1		54.00
54. 01 56. 00	05401   RADIATION-ONCOLOGY   03450   NUCLEAR   MEDICINE - DIAGNOSTIC		434, 493 13, 958				54. 01 56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		235, 137				59. 00
60.00	06000 LABORATORY		342, 377				60.00
64.00	06400 I NTRAVENOUS THERAPY	0	35, 888				64. 00
65.00	06500 RESPIRATORY THERAPY	0	184, 789	184, 789	2, 297	18, 966	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	475, 731				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	18, 911				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	62, 903				68. 00
69. 00 69. 01	06900   ELECTROCARDI OLOGY   06901   CARDI AC REHAB		110, 868 129, 778				69. 00 69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY		71, 034				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	0	31, 035	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	85, 943	73. 00
73. 01	07301 ULTRA SOUND	0	18, 063				73. 01
74. 00	07400 RENAL DIALYSIS	0	0	C	0	1, 043	74. 00
90 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	0	534, 052	534, 052	2, 511	48, 659	
	09100 EMERGENCY				4, 474		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0,0,,11	0,0,,,,		07,012	92.00
	SPECIAL PURPOSE COST CENTERS		·		1		
118.00		0	13, 153, 634	13, 153, 634	99, 409	1, 027, 384	118. 00
400.00	NONREI MBURSABLE COST CENTERS	Τ	1 017 050	1 4 047 050	00 707		
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	., ,				•
	19201 HEALTH TRACKS  07950 PRIMARY CARE CLINIC	0	329, 081 147, 285				194. 00
	07951 PARTNERS IN CARE		178, 114				194. 00
	07952 OCCUPATI ONAL MEDI CI NE		69, 074				194. 02
	07953 FOUNDATI ON	0	29, 187	29, 187	270	2, 104	194. 03
	07954 SCHOOL & TOWN CLINICS	0	15, 203				194. 04
200.00	, ,		_	C			200. 00
201.00			10 140 024				201. 00
202.00	TOTAL (sum lines 118-201)	0	18, 168, 936	18, 168, 936	145, 617	1, 423, 704	1202. UU

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150005 P

Period: Worksheet B From 01/01/2015 Part II To 12/31/2015 Date/Time Prepared:

5/26/2016 11:23 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A **PLANT** LINEN SERVICE 9.00 10.00 11.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7 00 2, 134, 159 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 259, 671 8.00 00900 HOUSEKEEPI NG 31, 548 172, 048 9.00 9.00 10.00 01000 DI ETARY 123, 769 0 6, 128 580, 913 10.00 0 116, 322 01100 CAFETERI A 21, 980 11.00 C C11.00 13.00 01300 NURSING ADMINISTRATION 63, 975 1, 423 4, 426 13.00 C 0 14 00 01400 CENTRAL SERVICES & SUPPLY 114, 467 84 3, 480 0 1,649 14.00 01500 PHARMACY 15 00 50.514 0 4.782 15.00 303 810 01600 MEDICAL RECORDS & LIBRARY 16.00 40, 104 1, 516 0 5, 382 16.00 17.00 01700 SOCIAL SERVICE 135 1,906 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 80, 912 30.00 03000 ADULTS & PEDIATRICS 516, 305 62, 436 445, 253 26.378 31.00 03100 INTENSIVE CARE UNIT 65,098 12, 228 5, 432 54,030 5, 085 31.00 81, 630 43.00 04300 NURSERY 12, 324 3,842 571 1,837 43 00 ANCILLARY SERVICE COST CENTERS 50 00 204, 952 50 00 05000 OPERATING ROOM 17, 162 12, 703 5, 111 05001 ENDOSCOPY 39, 779 7,726 0 2, 603 50.01 50.01 312 51.00 05100 RECOVERY ROOM 120, 540 17, 767 2, 306 0 0 3, 208 51.00 05200 DELIVERY ROOM & LABOR ROOM 41, 796 52.00 14, 441 270 4.597 52.00 53.00 05300 ANESTHESI OLOGY 291 3, 215 53.00 24, 825 9, 353 54.00 05400 RADI OLOGY-DI AGNOSTI C 145, 210 7,749 54.00 0 0 0 0 0 0 05401 RADI ATI ON-ONCOLOGY 2, 921 54.01 2, 265 54.01 4.134 03450 NUCLEAR MEDICINE - DIAGNOSTIC 56,00 3.894 C 322 298 56,00 59.00 05900 CARDIAC CATHETERIZATION 65, 593 1, 296 59.00 C C 06000 LABORATORY 4, 975 7, 270 60.00 60, 200 106 60.00 2, 183 06400 INTRAVENOUS THERAPY 10.011 979 374 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 46, 945 654 4,643 65.00 66.00 06600 PHYSI CAL THERAPY 55, 132 16, 869 4, 934 3, 480 66.00 06700 OCCUPATI ONAL THERAPY 67.00 789 0 0 0 0 0 691 67.00 0 68 00 06800 SPEECH PATHOLOGY 17 547 312 779 68 00 06900 ELECTROCARDI OLOGY 69.00 30, 927 3,826 4, 352 2,007 69.00 06901 CARDI AC REHAB 21,840 108 69.01 69.01 831 869 70.00 07000 ELECTROENCEPHALOGRAPHY 19.815 322 70.00 314 1.735 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 C C 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS o 73.00 0 0 0 0 73.00 73 01 07301 ULTRA SOUND C o 964 73 01 5 039 353 07400 RENAL DIALYSIS 74.00 56 488 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 14, 546 7, 198 0 0 90.00 09100 EMERGENCY 167,079 9,067 91 00 32, 280 13, 721 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 2, 096, 383 250, 639 150, 734 580, 913 116, 322 118. 00 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 8, 437 7, 111 12, 703 0 192. 00 192. 01 19201 HEALTH TRACKS 0 0 192. 01 0 1,598 4, 394 0 194.00 07950 PRIMARY CARE CLINIC 218 0 194.00 0 C 194. 01 07951 PARTNERS IN CARE 29.339 C 1.174 0 194 01 194. 02 07952 OCCUPATIONAL MEDICINE 2, 659 0 0 194. 02 246 194. 03 07953 FOUNDATI ON 0 C 73 0 0 194. 03 194.04 07954 SCHOOL & TOWN CLINICS 0 194, 04 0 77 93 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 2, 134, 159 259, 671 172, 048 580, 913 116, 322 202. 00

Provi der CCN: 150005

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015

				To	12/31/2015	Date/Time Pre 5/26/2016 11:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	25 4111
	<b>'</b>	ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
	JOENEDAL OFFICE OF CONT. OFFITTEDO	13.00	14. 00	15. 00	16. 00	17. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00 5. 00
7. 00	00500 ADMINISTRATIVE & GENERAL 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	325, 319					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	542, 971				14. 00
15. 00	01500 PHARMACY	o	0	270, 991			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	o	0	0	247, 355		16. 00
17.00	01700 SOCIAL SERVICE	o	0	0	0	77, 802	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	108, 246	0	0	22, 033	54, 341	30. 00
31.00	03100 INTENSIVE CARE UNIT	20, 871	0	0	6, 698	5, 517	31. 00
43.00	04300 NURSERY	7, 541	0	0	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	20, 975	542, 971	0	0	0	
50. 01	05001 ENDOSCOPY	10, 682	0	0	0	0	50. 01
51. 00	05100 RECOVERY ROOM	13, 168	0	0	12, 266	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	18, 865	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	13, 194	0	0	(0.472	0	53.00
54. 00 54. 01	05400  RADI OLOGY-DI AGNOSTI C   05401  RADI ATI ON-ONCOLOGY	38, 387	0	0	60, 473	0	54.00
56. 00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54. 01 56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 321	0	0	0	0	59.00
60.00	06000 LABORATORY	5, 321	0	0	52, 046	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	J2, U40 N	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	19, 054	0	0	4, 113	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	17,034	0	0	19, 751	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY		0	0	2, 522	o o	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	0	o	-,	Ō	68. 00
69.00	06900 ELECTROCARDI OLOGY	8, 237	0	0	12, 868	0	69. 00
69. 01	06901 CARDI AC REHAB	3, 565	0	0	0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	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	270, 991	0	0	73. 00
73. 01	07301 ULTRA SOUND	0	0	0	0	0	73. 01
74. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
00.00	OUTPATIENT SERVICE COST CENTERS	1 0	ما		0	0	00.00
90.00	09000 CLINIC	0	0	0	U E4 E0E	17 5/5	90.00
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATI ON BEDS (NON-DISTINCT PART)	37, 213	0	0	54, 585	17, 565	91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118. 00		325, 319	542, 971	270, 991	247, 355	77 423	118. 00
110.00	NONREI MBURSABLE COST CENTERS	323, 317	342, 771	270, 771	247, 333	11,425	1110.00
192 00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	379	192. 00
	19201 HEALTH TRACKS	o	Ö	- 1	0		192. 01
	07950 PRIMARY CARE CLINIC	o	0	0	0		194. 00
	07951 PARTNERS IN CARE	0	o	o	0		194. 01
	07952 OCCUPATIONAL MEDICINE	0	o	0	0	0	194. 02
194. 03	07953 FOUNDATI ON	0	o	0	0	0	194. 03
	07954 SCHOOL & TOWN CLINICS	0	0	0	0	0	194. 04
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	325, 319	542, 971	270, 991	247, 355	77, 802	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150005

					o 12/31/2015	Date/Time Prepared:
	Cost Center Description	Subtotal	Intern &	Total		5/26/2016 11: 23 am
	р		sidents Cost			
			& Post			
		Δ	Stepdown Adjustments			
		24. 00	25.00	26. 00		
	RAL SERVICE COST CENTERS	<del></del>				1.00
	NEW CAP REL COSTS-BLDG & FIXT DEMONSTRATE BENEFITS DEPARTMENT					1.00
•	O ADMINISTRATIVE & GENERAL					5. 00
	OPERATION OF PLANT					7. 00
	D LAUNDRY & LINEN SERVICE					8. 00
•	D HOUSEKEEPI NG D DI ETARY					9.00
	O CAFETERI A					11.00
•	NURSING ADMINISTRATION					13. 00
	CENTRAL SERVICES & SUPPLY					14. 00
	O PHARMACY					15.00
	OMEDICAL RECORDS & LIBRARY OSOCIAL SERVICE					16. 00 17. 00
	FIENT ROUTINE SERVICE COST CENTERS					.,, 95
	D ADULTS & PEDIATRICS	3, 282, 914	0	3, 282, 914	!	30.00
	O INTENSIVE CARE UNIT	431, 518	0	431, 518		31.00
	D NURSERY LLARY SERVICE COST CENTERS	160, 071	0	160, 071		43. 00
	O OPERATING ROOM	1, 335, 538	O	1, 335, 538	3	50.00
	1 ENDOSCOPY	216, 188	Ö	216, 188		50. 01
	RECOVERY ROOM	915, 264	0	915, 264		51.00
	D DELIVERY ROOM & LABOR ROOM	250, 606	0	250, 606		52.00
	D  ANESTHESI OLOGY D  RADI OLOGY-DI AGNOSTI C	31, 064 1, 097, 148	0	31, 064 1, 097, 148		53. 00 54. 00
	1 RADI ATI ON-ONCOLOGY	548, 622	Ö	548, 622		54. 01
56. 00 0345	NUCLEAR MEDICINE - DIAGNOSTIC	21, 447	0	21, 447		56. 00
	O CARDI AC CATHETERI ZATI ON	308, 105	0	308, 105		59. 00
	D LABORATORY D I NTRAVENOUS THERAPY	528, 106 60, 324	0	528, 10 <i>6</i> 60, 324		60. 00 64. 00
•	RESPI RATORY THERAPY	281, 461	0	281, 461		65. 00
•	PHYSI CAL THERAPY	625, 593	0	625, 593		66. 00
	OCCUPATIONAL THERAPY	26, 555	0	26, 555		67. 00
	SPEECH PATHOLOGY	85, 691	0	85, 691		68.00
	D ELECTROCARDI OLOGY 1 CARDI AC REHAB	180, 633 162, 532	O	180, 633 162, 532		69. 00 69. 01
	ELECTROENCEPHALOGRAPHY	95, 071	o	95, 071		70.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C		71.00
	O I MPL. DEV. CHARGED TO PATIENT	31, 035	0	31, 035		72.00
	D DRUGS CHARGED TO PATIENTS 1 ULTRA SOUND	356, 934 29, 695	0	356, 934 29, 695		73. 00 73. 01
	RENAL DIALYSIS	1, 587	Ö	1, 587		74. 00
OUTP	ATIENT SERVICE COST CENTERS			·		
90.00 0900		606, 966	0	606, 966		90.00
91. 00   0910 92. 00   0920	D EMERGENCY D OBSERVATION BEDS (NON-DISTINCT PART)	971, 937	0	971, 937		91. 00 92. 00
	AL PURPOSE COST CENTERS		<u> </u>			92.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	12, 642, 605	0	12, 642, 605	5	118. 00
NONR	EIMBURSABLE COST CENTERS					
	PHYSICIANS' PRIVATE OFFICES 1 HEALTH TRACKS	4, 650, 173	0	4, 650, 173		192. 00 192. 01
	O PRIMARY CARE CLINIC	373, 106 153, 967	0	373, 10 <i>6</i> 153, 967		194. 00
	1 PARTNERS IN CARE	217, 515	o	217, 515		194. 01
194. 02 0795	OCCUPATIONAL MEDICINE	78, 463	О	78, 463	3	194. 02
	3 FOUNDATION	31, 634	o	31, 634		194. 03
194. 04 0 / 95	4 SCHOOL & TOWN CLINICS Cross Foot Adjustments	21, 473	O O	21, 473 (		194. 04 200. 00
201.00	Negative Cost Centers	0	0	(		201. 00
202. 00	TOTAL (sum lines 118-201)	18, 168, 936	O	18, 168, 936	6	202. 00

		ial Systems	HENDRI CKS REGI		00N 450005		eu of Form CMS-	
COSTA	ALLOCATI	ON - STATISTICAL BASIS		Provi der		Peri od: From 01/01/2015	Worksheet B-1	
						To 12/31/2015	Date/Time Pre 5/26/2016 11:	pared:
	(	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG &	EMPLOYEE	Reconciliatio	nADMI NI STRATI VE		23 aiii
		odst deliter beserretten	FIXT (SQUARE	BENEFITS DEPARTMENT	Recencification	& GENERAL (ACCUM. COST)	PLANT (SQUARE	
			FEET)	(GROSS		(ACCOM. COST)	FEET)	
			1.00	SALARI ES)		F 00	7.00	
	GENERAL	L SERVICE COST CENTERS	1. 00	4. 00	5A	5. 00	7.00	
1.00		NEW CAP REL COSTS-BLDG & FIXT	685, 998					1.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	5, 498	92, 589, 274	ı.			4. 00
5.00	1 1	ADMINISTRATIVE & GENERAL	53, 272	8, 119, 892	1		l .	5. 00
7.00		OPERATION OF PLANT	77, 332	2, 298, 589	1	0 10, 686, 811	288, 856	
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	9, 512 4, 270	303, 524 1, 817, 359	1	0 942, 474 0 3, 184, 770	l	
10. 00		DI ETARY	16, 752	402, 165		0 869, 056		1
11. 00		CAFETERI A	2, 975	1, 124, 574	1	0 1, 787, 687		
13. 00		NURSING ADMINISTRATION	8, 659	1, 852, 442	1	0 3, 015, 586		1
14.00		CENTRAL SERVICES & SUPPLY	15, 493	628, 336		0 1, 552, 276		1
15. 00 16. 00	1 1	PHARMACY MEDICAL RECORDS & LIBRARY	6, 837 6, 642	1, 836, 839 1, 253, 431	1	0 3, 971, 483 0 2, 914, 479		1
17. 00		SOCIAL SERVICE	2, 043	1, 617, 202	1	0 2, 478, 815		1
		ENT ROUTINE SERVICE COST CENTERS	_,,	.,,	1	=// =	-	1
30. 00	1 1	ADULTS & PEDIATRICS	69, 881	9, 392, 263	1	0 13, 156, 372		1
31.00		NTENSIVE CARE UNIT	8, 811	1, 675, 921	1	0 2, 667, 368		1
43. 00		NURSERY ARY SERVICE COST CENTERS	1, 668	699, 578	3	0 914, 395	1, 668	43. 00
50. 00		DPERATING ROOM	16, 644	1, 476, 262		0 11, 484, 021	27, 740	50.00
50. 01		ENDOSCOPY	5, 384	838, 996	1	0 1, 449, 065		1
51.00		RECOVERY ROOM	27, 411	1, 182, 898	1	0 2, 355, 553		
52. 00	1 1	DELIVERY ROOM & LABOR ROOM	5, 657	1, 833, 218		0 2, 325, 493		
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0 28, 548	4, 552, 907 3, 686, 274		0 934, 365 0 6, 389, 096	l	
54. 00		RADI ATI ON-ONCOLOGY	16, 405	985, 632	1	0 13, 396, 333		1
56. 00		NUCLEAR MEDICINE - DIAGNOSTIC	527	128, 832		0 359, 579	l	1
59. 00	05900	CARDIAC CATHETERIZATION	8, 878	481, 604	13, 71	0 0	8, 878	59. 00
60.00	1 1	_ABORATORY	12, 927	2, 449, 043	1	0 7, 431, 268		1
64. 00		NTRAVENOUS THERAPY	1, 355	839, 985	1	0 1, 241, 289		1
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	6, 977 17, 962	1, 460, 186 3, 798, 237	1	0 2, 460, 500 0 5, 672, 106		1
67. 00	1 1	OCCUPATIONAL THERAPY	714	321, 397	1	0 406, 834	1	1
68. 00		SPEECH PATHOLOGY	2, 375	291, 807	1	0 478, 795	l	1
69. 00		ELECTROCARDI OLOGY	4, 186	470, 133	1	0 883, 281	4, 186	1
69. 01	1 1	CARDI AC REHAB	4, 900	383, 471	1	0 640, 630		
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 682	97, 426		0 220, 267 0 0	2, 682 0	1
		IMPL. DEV. CHARGED TO PATIENT	0	0	1	0 4, 026, 321		1
	1 1	DRUGS CHARGED TO PATIENTS	Ö	0		0 11, 149, 827	i e	1
		JLTRA SOUND	682	454, 713		0 591, 691		73. 01
74. 00		RENAL DIALYSIS	0	0	)	0 135, 376	0	74. 00
90. 00	09000 (	LENT SERVICE COST CENTERS	20, 164	1, 596, 103	<b>o</b> l	0 6, 312, 839	0	90.00
91.00		EMERGENCY	22, 614	2, 844, 174	1	0 4, 801, 714		1
		OBSERVATION BEDS (NON-DISTINCT PART)	,,	_, _, ,		1, 22.7	,,	92.00
		L PURPOSE COST CENTERS						]
118.00		SUBTOTALS (SUM OF LINES 1-117)	496, 637	63, 195, 413	-31, 324, 03	1 133, 287, 815	283, 743	118. 00
102.00		MBURSABLE COST CENTERS PHYSICIANS' PRIVATE OFFICES	160, 366	24, 676, 137	,	0 43, 507, 934	1 1/12	192. 00
		HEALTH TRACKS	12, 425	2, 839, 755	1	0 43, 307, 934		192. 00
		PRIMARY CARE CLINIC	5, 561	425, 375		0 751, 807	l	194. 00
		PARTNERS IN CARE	6, 725	593, 018	В	0 1, 032, 083		194. 01
		OCCUPATIONAL MEDICINE	2, 608	185, 998	1	0 803, 176		194. 02
		FOUNDATION	1, 102	171, 784	1	0 272, 974	l .	194. 03
200.00		SCHOOL & TOWN CLINICS Cross Foot Adjustments	574	501, 794		0 688, 965	0	194. 04 200. 00
201.00		Negative Cost Centers						201. 00
202.00		Cost to be allocated (per Wkst. B,	18, 168, 936	4, 688, 759		31, 337, 741	12, 500, 032	
0		Part I)						
203.00		Jnit cost multiplier (Wkst. B, Part I)	26. 485407	0. 050640		0. 169669	l .	
204.00	1 1	Cost to be allocated (per Wkst. B, Part II)		145, 617		1, 423, 704	2, 134, 159	204.00
205.00		Jnit cost multiplier (Wkst. B, Part		0. 001573	В	0. 007708	7. 388315	205. 00
	1 1	1)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150005 | Period: | Worksheet B-1 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

					To	12/31/2015	Date/Time Pre 5/26/2016 11:	
		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERI A (MANHOURS)	NURSI NG ADMI NI STRATI ON (DI RECT	23 alli
			ŕ				NRSING HRS)	
	CENED	AL SERVICE COST CENTERS	8. 00	9. 00	10.00	11. 00	13. 00	
1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00	00100 00400 00500 00700 00800 00900 01100 01300 01400 01500	NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY	921, 192 0 0 0 0 298 1, 076	16, 564 590 0 137 335 78	21, 826 0 0 0 0	1, 196, 754 45, 539 16, 964 49, 196	815, 521 0 0	1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	0	146 13		55, 375 19, 614	0 0	16. 00 17. 00
		IENT ROUTINE SERVICE COST CENTERS		-				
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	287, 034 43, 380	6, 011 523		271, 354 52, 319	271, 354 52, 319	30. 00 31. 00
43. 00	1	NURSERY	13, 630	523		18, 903	18, 903	43. 00
	ANCI L	LARY SERVICE COST CENTERS				·		
50. 00 50. 01 51. 00 52. 00	05001 05100	OPERATING ROOM ENDOSCOPY RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	60, 883 27, 410 63, 029 51, 229	1, 223 30 222 26	0	52, 580 26, 779 33, 009 47, 292	52, 580 26, 779 33, 009 47, 292	50. 00 50. 01 51. 00 52. 00
53. 00 54. 00 54. 01	05300 05400 05401	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RADI ATI ON-ONCOLOGY	88, 068 8, 034	28 746 398	0 0 0	33, 075 96, 231 30, 057	33, 075 96, 231 0	54. 00 54. 01
56. 00 59. 00 60. 00 64. 00	05900 06000 06400	NUCLEAR MEDICINE - DIAGNOSTIC CARDIAC CATHETERIZATION LABORATORY INTRAVENOUS THERAPY	0 377 3, 474	31 0 479 36	0	3, 071 13, 338 74, 800 22, 457	0 13, 338 0 0	56. 00 59. 00 60. 00 64. 00
65. 00 66. 00 67. 00 68. 00	06600 06700	RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	59, 844 0	63 475 76 30	0 0	47, 765 35, 801 7, 111 8, 019	47, 765 0 0 0	65. 00 66. 00 67. 00 68. 00
69. 00 69. 01 70. 00	06900 06901 07000	ELECTROCARDI OLOGY CARDI AC REHAB ELECTROENCEPHALOGRAPHY	13, 574 384 1, 115	419 80 167	0 0 0	20, 650 8, 938 3, 314	20, 650 8, 938 0	69. 00 69. 01 70. 00
71. 00 72. 00 73. 00 73. 01	07200 07300	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS ULTRA SOUND	0 0	0 0 0 34	0	0 0 0 9, 915	0 0 0	71. 00 72. 00 73. 00 73. 01
74. 00	07400	RENAL DIALYSIS	198	47		0	0	74. 00
90. 00 91. 00 92. 00	09000 09100 09200	TIENT SERVICE COST CENTERS  CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	51, 602 114, 515			0 93, 288		
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	889, 154	14, 512	21, 826	1, 196, 754	815, 521	118. 00
	NONRE	IMBURSABLE COST CENTERS						
192. 01 194. 00	19201 07950	PHYSICIANS' PRIVATE OFFICES HEALTH TRACKS PRIMARY CARE CLINIC	25, 225 5, 668 0	1, 223 423 21	0	0 0 0	0	192. 00 192. 01 194. 00
	1	PARTNERS IN CARE OCCUPATIONAL MEDICINE	0	113 256		0		194. 01 194. 02
194. 03 194. 04 200. 00	07953 07954	FOUNDATION SCHOOL & TOWN CLINICS Cross Foot Adjustments	873 0 272	7 7 9		0	0	194. 03 194. 04 200. 00
201. 00 202. 00		Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	1, 102, 383	3, 909, 908	1, 880, 708	2, 219, 743	4, 018, 754	201. 00 202. 00
203. 00 204. 00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	1. 196692 259, 671	172, 048	580, 913	1. 854803 116, 322	4. 927836 325, 319	204. 00
205.00	)	Unit cost multiplier (Wkst. B, Part II)	0. 281886	10. 386863	26. 615642	0. 097198	0. 398909	205. 00

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2552-1
COST ALLOCATION - STATISTICAL BASIS		Provi der (		Period: From 01/01/2015 To 12/31/2015	Worksheet B-1 Date/Time Prepared: 5/26/2016 11:23 am
Cost Center Description	CENTRAL SERVI CES & SUPPLY (100% ALLOCATI ON) 14.00	PHARMACY (100% ALLOCATION)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00	SOCI AL SERVI CE  (TI ME SPENT)  17.00	
GENERAL SERVICE COST CENTERS	14.00	15.00	10.00	17.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 17.00 01700 SOCIAL SERVICE	100 0 0	100 0 0	239, 329, 98	9 0 14, 369	1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00
INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>	<u> </u>	5 14, 507	17.00
30. 00   03000   ADULTS & PEDIATRICS   31. 00   03100   I NTENSI VE CARE UNI T   43. 00   04300   NURSERY	0 0 0	0 0 0	21, 308, 10 6, 477, 51		30. 00 31. 00 43. 00
ANCILLARY SERVICE COST CENTERS  50 00 OFFRATING ROOM	100	0			50.00
SOLO   OSO   OPERATING ROOM	100 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	11, 862, 75, 6 58, 593, 87, 6 50, 334, 366, 6 3, 978, 21, 19, 101, 366, 2, 438, 97, 6 12, 445, 00, 6	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 50. 01 51. 00 52. 00 53. 00 54. 00 55. 00 60. 00 64. 00 65. 00 66. 00 66. 00 67. 00 68. 00 69. 01 70. 00 71. 00 73. 00 73. 01 74. 00
SPECIAL PURPOSE COST CENTERS  118.00 SUBTOTALS (SUM OF LINES 1-117)	100	100	239, 329, 98	9 14, 299	118. 00
NONRE   MBURSABLE   COST   CENTERS     192.00   19200   PHYSI CI ANS'   PRI VATE   OFFI CES     194.00   07950   PRI MARY   CARE   CLI NI C     194.01   07951   PARTNERS   IN   CARE     194.02   07952   OCCUPATI ONAL   MEDI CI NE     194.03   07953   FOUNDATI ON     194.04   07954   SCHOOL & TOWN   CLI NI CS     200.00   Cross   Foot   Adj ustments     Negati ve   Cost   Centers     202.00   Cost   to be   allocated   (per   Wkst.   B,	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	(	70 0 0 0 0 0 0 0 0 0 0 0 0	192. 00 192. 01 194. 00 194. 01 194. 02 194. 02 194. 02 200. 00 201. 00 202. 00
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	) 25, 969. 950000 542, 971	50, 521. 360000 270, 991	0. 015798 247, 35		203. 00 204. 00
Part II)					

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15000	05   Peri od:   Worksheet C   From 01/01/2015   Part I   To 12/31/2015   Date/Time Prepared:

					To 12/31/2015	Date/Time Pre 5/26/2016 11:		
			Ti tl	e XVIII	Hospi tal	PPS		
	·				Costs			
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs		
		(from Wkst. B,	Adj .		Di sal I owance			
		Part I, col.						
		26)						
		1.00	2. 00	3. 00	4. 00	5. 00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDI ATRI CS	25, 846, 284		25, 846, 28				
31. 00	03100 I NTENSI VE CARE UNI T	4, 517, 120		4, 517, 12				
43.00	04300 NURSERY	1, 563, 504		1, 563, 50	04 0	1, 563, 504	43. 00	
	ANCILLARY SERVICE COST CENTERS							
50. 00	05000 OPERATI NG ROOM	17, 948, 103	l e	17, 948, 10				
50. 01	05001 ENDOSCOPY	2, 149, 430		2, 149, 43		2, 149, 430		
51. 00	05100 RECOVERY ROOM	4, 000, 362		4, 000, 36		4, 000, 362		
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 353, 066		3, 353, 0		3, 353, 066		
53.00	05300 ANESTHESI OLOGY	1, 323, 843		1, 323, 84		1, 323, 843		
54.00	05400 RADI OLOGY-DI AGNOSTI C	10, 183, 596	l e	10, 183, 59		10, 183, 596	1	
54. 01	05401 RADI ATI ON-ONCOLOGY	15, 828, 586		15, 828, 58		15, 828, 586		
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	456, 408		456, 40		456, 408		
59. 00	05900 CARDI AC CATHETERI ZATI ON	460, 945	l .	460, 94		460, 945		
60.00	06000 LABORATORY	10, 092, 162		10, 092, 10		10, 092, 162		
64.00	06400 I NTRAVENOUS THERAPY	1, 564, 842		1, 564, 84		1, 564, 842		
65.00	06500 RESPI RATORY THERAPY	3, 554, 628				3, 554, 628		
66. 00	06600 PHYSI CAL THERAPY	7, 509, 305		.,,		7, 509, 305		
67. 00	06700 OCCUPATI ONAL THERAPY	545, 522		,		545, 522		
68. 00	06800 SPEECH PATHOLOGY	684, 763	l .	684, 76		684, 763		
69. 00	06900 ELECTROCARDI OLOGY	1, 666, 108		1, 666, 10		1, 666, 108		
69. 01	06901 CARDI AC REHAB	957, 211		957, 2°		957, 211		
70. 00	07000 ELECTROENCEPHALOGRAPHY	420, 602		420, 60	0	420, 602		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l		0	0		
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	4, 709, 463	l e	4, 709, 46		4, 709, 463		
73.00	07300 DRUGS CHARGED TO PATIENTS	18, 093, 743	l e	18, 093, 74		18, 093, 743		
73. 01	07301 ULTRA SOUND	748, 012		748, 0°		748, 012		
74.00	07400 RENAL DIALYSIS	169, 676		169, 6	6 0	169, 676	74. 00	
	OUTPATIENT SERVICE COST CENTERS	_						
90.00	09000 CLI NI C	7, 609, 266		7, 609, 20				
91. 00	09100 EMERGENCY	9, 174, 076		9, 174, 0				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 598, 074		4, 598, 0		4, 598, 074		
200.00		159, 728, 700		, . = . ,		, ,		
201.00	l l	4, 598, 074		4, 598, 0		4, 598, 074		
202.00	Total (see instructions)	155, 130, 626	0	155, 130, 62	26 0	155, 130, 626	202. 00	

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15000	05   Peri od:   Worksheet C   From 01/01/2015   Part I   To 12/31/2015   Date/Time Prepared:

				1	To 12/31/2015	Date/Time Pre 5/26/2016 11:	pared:
			Ti tl	e XVIII	Hospi tal	PPS	25 4111
			Charges	<u> </u>	noopi tai	1.0	
	Cost Center Description	Inpati ent	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 & PEDI ATRI CS	21, 304, 352		21, 304, 352	2		30. 00
31.00	03100 INTENSIVE CARE UNIT	6, 445, 266		6, 445, 266	6		31. 00
43.00	04300 NURSERY	6, 089, 087		6, 089, 087	7		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	18, 398, 551	23, 063, 245	41, 461, 796	0. 432883	0.000000	50. 00
50. 01	05001 ENDOSCOPY	451, 415	11, 411, 339	11, 862, 754	0. 181191	0.000000	50. 01
51.00	05100 RECOVERY ROOM	3, 070, 675	6, 795, 487	9, 866, 162	0. 405463	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9, 887, 161	177, 279	10, 064, 440	0. 333160	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	6, 854, 753	7, 858, 167	14, 712, 920	0. 089978	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 243, 565	51, 135, 863	58, 379, 428	0. 174438	0.000000	54.00
54. 01	05401 RADI ATI ON-ONCOLOGY	412, 591	53, 350, 578	53, 763, 169	0. 294413	0.000000	54. 01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	402, 839	4, 046, 767	4, 449, 606	0. 102573	0.000000	56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 486, 826	9, 482, 388	12, 969, 214		0.000000	
60.00	06000 LABORATORY	9, 636, 636	43, 154, 951	52, 791, 587	0. 191170	0.000000	60.00
64. 00	06400 I NTRAVENOUS THERAPY	478, 797	6, 715, 211	7, 194, 008		0.000000	64. 00
65.00	06500 RESPI RATORY THERAPY	2, 706, 866	1, 161, 284			0.000000	
66. 00	06600 PHYSI CAL THERAPY	2, 621, 938	16, 457, 742	19, 079, 680		0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	1, 110, 433	1, 251, 304	2, 361, 737	0. 230983	0.000000	
68. 00	06800 SPEECH PATHOLOGY	269, 016	1, 345, 966			0.000000	
69. 00	06900 ELECTROCARDI OLOGY	1, 876, 210	10, 498, 232			0.000000	
69. 01	06901 CARDI AC REHAB	33, 591	1, 303, 627			0.000000	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	87, 685	436, 873	524, 558		0.000000	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0.000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	4, 417, 394	3, 635, 248			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 149, 046	17, 602, 356	27, 751, 402	0. 651994	0.000000	
73. 01	07301 ULTRA SOUND	1, 690, 995	7, 363, 902	9, 054, 897		0. 000000	73. 01
74.00	07400 RENAL DIALYSIS	256, 595	16, 670	273, 265	0. 620921	0.000000	74. 00
	OUTPAȚIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	21, 822	34, 887, 399			0.000000	90. 00
91. 00	09100 EMERGENCY	10, 008, 991	42, 679, 259			0. 000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 943, 535			0. 000000	
200.00		129, 413, 096	359, 774, 672	489, 187, 768	3		200. 00
201.00							201. 00
202.00	Total (see instructions)	129, 413, 096	359, 774, 672	489, 187, 768	3		202. 00

Health Financial Systems	HENDRICKS REGIONAL HE	EALTH		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Pro	rovider CCN:	150005	From 01/01/2015	Worksheet C Part I Date/Time Prepared: 5/26/2016 11:23 am

					5/26/2016 11:23 am	n_
			Title XVIII	Hospi tal	PPS	
Cost Center Description	on	PPS Inpatient				
		Ratio				
		11. 00				
INPATIENT ROUTINE SERVICE C	OST CENTERS					
30.00 03000 ADULTS & PEDIATRICS					30.0	00
31.00 03100 INTENSIVE CARE UNIT					31. (	00
43. 00 04300 NURSERY					43. (	00
ANCILLARY SERVICE COST CENT	ERS					
50. 00 05000 OPERATING ROOM		0. 432883			50.0	
50. 01   05001   ENDOSCOPY		0. 181191			50.0	
51.00   05100   RECOVERY ROOM		0. 405463			51. (	00
52.00   05200   DELIVERY ROOM & LABOR	ROOM	0. 333160			52.0	
53. 00 05300 ANESTHESI OLOGY		0. 089978			53. (	00
54. 00   05400 RADI OLOGY-DI AGNOSTI C		0. 174438			54. (	00
54. 01   05401 RADI ATI ON-ONCOLOGY		0. 294413			54. (	01
56.00 03450 NUCLEAR MEDICINE - DIA	AGNOSTI C	0. 102573			56. 0	00
59. 00 05900 CARDI AC CATHETERI ZATI (	ON	0. 035541			59. (	00
60. 00   06000   LABORATORY		0. 191170			60.0	00
64.00 06400 INTRAVENOUS THERAPY		0. 217520			64. (	00
65. 00 06500 RESPIRATORY THERAPY		0. 918948			65. (	00
66. 00 06600 PHYSI CAL THERAPY		0. 393576			66. (	00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 230983			67. (	00
68.00 06800 SPEECH PATHOLOGY		0. 424007			68. (	00
69. 00 06900 ELECTROCARDI OLOGY		0. 134641			69. (	00
69. 01   06901   CARDI AC   REHAB		0. 715823			69. (	01
70. 00 07000 ELECTROENCEPHALOGRAPH	Y	0. 801822			70. (	00
71.00 07100 MEDICAL SUPPLIES CHARG	GED TO PATLENTS	0. 000000			71. (	00
72.00 07200 IMPL. DEV. CHARGED TO	PATI ENT	0. 584835			72. (	00
73.00 07300 DRUGS CHARGED TO PATIE	ENTS	0. 651994			73. (	00
73. 01   07301   ULTRA SOUND		0. 082609			73. (	01
74.00 07400 RENAL DIALYSIS		0. 620921			74. (	00
OUTPATIENT SERVICE COST CEN	TERS					
90. 00 09000 CLI NI C		0. 217973			90. (	00
91. 00 09100 EMERGENCY		0. 174120			91. (	00
92.00 09200 OBSERVATION BEDS (NON-	-DISTINCT PART)	1. 165978			92. (	00
200.00 Subtotal (see instruc-	tions)				200. (	00
201.00 Less Observation Beds					201. (	00
202.00 Total (see instruction	ns)				202. 0	00

Health Financial Systems	HENDRICKS REGIONAL HEALTH		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der C	CN: 150005		Worksheet C
			From 01/01/2015 To 12/31/2015	Part     Date/Time Prepared:

					To 12/31/2015	Date/Time Pre 5/26/2016 11:	
			Ti t	le XIX	Hospi tal	Cost	
	<u> </u>				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
I NF	PATIENT ROUTINE SERVICE COST CENTERS						
30.00 030	DOO ADULTS & PEDIATRICS	25, 846, 284		25, 846, 284	1 0	25, 846, 284	30. 00
31. 00   031	100 INTENSIVE CARE UNIT	4, 517, 120		4, 517, 120	0	4, 517, 120	31.00
43.00 043	300 NURSERY	1, 563, 504		1, 563, 504	1 0	1, 563, 504	43.00
ANC	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	17, 948, 103		17, 948, 103	0	17, 948, 103	50.00
50. 01 050	DO1 ENDOSCOPY	2, 149, 430		2, 149, 430	0	2, 149, 430	50. 01
51.00 051	100 RECOVERY ROOM	4, 000, 362		4, 000, 362	0	4, 000, 362	51.00
52. 00 052	200 DELIVERY ROOM & LABOR ROOM	3, 353, 066		3, 353, 066	0	3, 353, 066	52. 00
53. 00 053	300 ANESTHESI OLOGY	1, 323, 843		1, 323, 843	0	1, 323, 843	53. 00
54. 00   054	400 RADI OLOGY-DI AGNOSTI C	10, 183, 596		10, 183, 596	o	10, 183, 596	54. 00
54. 01   054	401 RADI ATI ON-ONCOLOGY	15, 828, 586		15, 828, 586		15, 828, 586	54. 01
56. 00 034	450 NUCLEAR MEDICINE - DIAGNOSTIC	456, 408		456, 408	sl ol	456, 408	56. 00
59. 00 059	900 CARDI AC CATHETERI ZATI ON	460, 945		460, 945	5 o	460, 945	59. 00
60.00 060	DOO LABORATORY	10, 092, 162		10, 092, 162	2 0	10, 092, 162	60.00
64. 00 064	400 INTRAVENOUS THERAPY	1, 564, 842		1, 564, 842	2 0	1, 564, 842	64. 00
65. 00 065	500 RESPI RATORY THERAPY	3, 554, 628	0	3, 554, 628	3 o	3, 554, 628	65. 00
66. 00 066	600 PHYSI CAL THERAPY	7, 509, 305	0	7, 509, 305	sl ol	7, 509, 305	66. 00
67. 00 067	700 OCCUPATI ONAL THERAPY	545, 522		545, 522		545, 522	
68. 00 068	BOO SPEECH PATHOLOGY	684, 763	0	684, 763	s o	684, 763	68. 00
69. 00 069	900 ELECTROCARDI OLOGY	1, 666, 108		1, 666, 108	3 ol	1, 666, 108	69. 00
	901 CARDI AC REHAB	957, 211		957, 211		957, 211	
4	DOO ELECTROENCEPHALOGRAPHY	420, 602		420, 602		420, 602	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l	(		0	
	200 IMPL. DEV. CHARGED TO PATIENT	4, 709, 463		4, 709, 463	o	4, 709, 463	72. 00
	300 DRUGS CHARGED TO PATIENTS	18, 093, 743	l e	18, 093, 743		18, 093, 743	
73. 01   073	301 ULTRA SOUND	748, 012		748, 012	ol ol	748, 012	73. 01
	400 RENAL DIALYSIS	169, 676		169, 676		169, 676	
	FPATIENT SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	l		'.		
	DOO CLINIC	7, 609, 266		7, 609, 266	0	7, 609, 266	90.00
	100 EMERGENCY	9, 174, 076		9, 174, 076		9, 174, 076	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 598, 074		4, 598, 074		4, 598, 074	
200.00	Subtotal (see instructions)	159, 728, 700	l e			159, 728, 700	
201.00	Less Observation Beds	4, 598, 074	l e	4, 598, 074		4, 598, 074	
202.00	Total (see instructions)	155, 130, 626	l e			155, 130, 626	

Health Financial Systems	HENDRICKS REGIONAL HEALTH		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der C	CN: 150005		Worksheet C
			From 01/01/2015 To 12/31/2015	Part     Date/Time Prepared:

				o 12/31/2015	Date/Time Prep 5/26/2016 11:	pared: 23 am
		Ti t	le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		·	+ col. 7)	Ratio	I npati ent	
					Rati o	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	21, 304, 352		21, 304, 352	2		30. 00
31.00 03100 INTENSIVE CARE UNIT	6, 445, 266		6, 445, 266			31. 00
43. 00 04300 NURSERY	6, 089, 087		6, 089, 087	7		43. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	18, 398, 551	23, 063, 245	41, 461, 796		0.000000	50.00
50. 01  05001  ENDOSCOPY	451, 415	11, 411, 339			0.000000	50. 01
51.00   05100   RECOVERY ROOM	3, 070, 675	6, 795, 487	9, 866, 162		0.000000	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	9, 887, 161	177, 279			0.000000	52. 00
53. 00   05300   ANESTHESI OLOGY	6, 854, 753	7, 858, 167			0.000000	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	7, 243, 565	51, 135, 863	58, 379, 428	0. 174438	0.000000	54.00
54. 01   05401   RADI ATI ON-ONCOLOGY	412, 591	53, 350, 578	53, 763, 169	0. 294413	0.000000	54. 01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	402, 839	4, 046, 767	4, 449, 606	0. 102573	0.000000	56. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	3, 486, 826	9, 482, 388	12, 969, 214	0. 035541	0.000000	59. 00
60. 00  06000 LABORATORY	9, 636, 636	43, 154, 951	52, 791, 587	0. 191170	0.000000	60.00
64.00   06400   I NTRAVENOUS THERAPY	478, 797	6, 715, 211	7, 194, 008	0. 217520	0.000000	64. 00
65. 00 06500 RESPI RATORY THERAPY	2, 706, 866	1, 161, 284	3, 868, 150	0. 918948	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 621, 938	16, 457, 742	19, 079, 680	0. 393576	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 110, 433	1, 251, 304	2, 361, 737	0. 230983	0.000000	67. 00
68. 00   06800   SPEECH PATHOLOGY	269, 016	1, 345, 966			0.000000	68. 00
69. 00   06900   ELECTROCARDI OLOGY	1, 876, 210	10, 498, 232	12, 374, 442	0. 134641	0.000000	69. 00
69. 01   06901   CARDI AC   REHAB	33, 591	1, 303, 627	1, 337, 218	0. 715823	0.000000	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	87, 685	436, 873	524, 558	0. 801822	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0.000000	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	4, 417, 394	3, 635, 248	8, 052, 642	0. 584835	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	10, 149, 046	17, 602, 356	27, 751, 402	0. 651994	0.000000	73. 00
73. 01   07301   ULTRA SOUND	1, 690, 995	7, 363, 902	9, 054, 897	0. 082609	0.000000	73. 01
74. 00   07400   RENAL DI ALYSI S	256, 595	16, 670	273, 265	0. 620921	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	21, 822	34, 887, 399	34, 909, 22	0. 217973	0.000000	90.00
91. 00 09100 EMERGENCY	10, 008, 991	42, 679, 259	52, 688, 250	0. 174120	0.000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 943, 535	3, 943, 535	1. 165978	0.000000	92.00
200.00 Subtotal (see instructions)	129, 413, 096	359, 774, 672	489, 187, 768	3	ļ	200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	129, 413, 096	359, 774, 672	489, 187, 768	3		202. 00
			•		•	•

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150005	From 01/01/2015	Worksheet C Part I Date/Time Prepared: 5/26/2016 11:23 am

			10 12/31/2015	5/26/2016 11:23 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00  03000 ADULTS & PEDIATRICS				30.00
31.00  03100   INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 000000			50.00
50. 01   05001   ENDOSCOPY	0. 000000			50. 01
51.00   05100   RECOVERY ROOM	0. 000000			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. O1   05401   RADI ATI ON-ONCOLOGY	0. 000000			54. 01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000			56.00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00   06000   LABORATORY	0. 000000			60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000			64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATIONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
69. 01   06901   CARDI AC   REHAB	0. 000000			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
73. 01   07301   ULTRA SOUND	0. 000000			73. 01
74. 00   07400   RENAL DIALYSIS	0. 000000			74. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od: From 01/01/2015	Worksheet D Part I	
				To 12/31/2015		pared:
					5/26/2016 11:	23 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	3, 282, 914	C	3, 282, 91	4 19, 792	165. 87	30. 00
31.00   INTENSIVE CARE UNIT	431, 518		431, 51	8 2, 030	212. 57	31.00
43. 00 NURSERY	160, 071		160, 07	1 3, 067	52. 19	43.00
200.00 Total (lines 30-199)	3, 874, 503		3, 874, 50	3 24, 889		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	6, 964	1, 155, 119				30. 00
31.00 INTENSIVE CARE UNIT	1, 084	230, 426				31.00
43. 00 NURSERY	0	C	)			43.00
200.00 Total (lines 30-199)	8, 048	1, 385, 545	5			200. 00

Heal th	Financial Systems	HENDRI CKS REG	IONAL HEALTH		In Li∈	eu of Form CMS-:	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der		Period: From 01/01/2015 To 12/31/2015		
			Ti t	le XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
			(from Wkst. C	, to Charges	Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	1, 335, 538		•		1	1
50. 01	05001 ENDOSCOPY	216, 188	1	1		0	00.0.
51. 00	05100 RECOVERY ROOM	915, 264		•			1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	250, 606	1	1	· ·	l .	
53. 00	05300 ANESTHESI OLOGY	31, 064	1				
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 097, 148	1				
54. 01	05401 RADI ATI ON-ONCOLOGY	548, 622			· ·		
56. 00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	21, 447					
59. 00	05900 CARDI AC CATHETERI ZATI ON	308, 105	1	•			1
60.00	06000 LABORATORY	528, 106	1	•			1
64. 00	06400 I NTRAVENOUS THERAPY	60, 324	1	1	· ·		1
65. 00	06500 RESPI RATORY THERAPY	281, 461	1				1
66. 00	06600 PHYSI CAL THERAPY	625, 593	1				1
67. 00	06700 OCCUPATI ONAL THERAPY	26, 555		•			1
68. 00	06800 SPEECH PATHOLOGY	85, 691		•			
69. 00	06900 ELECTROCARDI OLOGY	180, 633		•			1
	06901 CARDI AC REHAB	162, 532		•	· ·		69. 01
70 00	07000 ELECTROENCERUM OCRADUM	05 071	F 24 FF	0 1010	71 00/	40 004	70 00

95, 071

31, 035

29, 695

606, 966

971, 937

584, 034

9, 352, 136

1, 587

356, 934

0

524, 558

8, 052, 642

27, 751, 402

9, 054, 897 273, 265

34, 909, 221

52, 688, 250

455, 349, 063

3, 943, 535

0. 181240

0.000000

0.003854

0.012862

0.003279

0.005808

0.017387

0.018447

0. 148099

12, 884

12, 728

63, 763

1, 585

0

0

0 90.00

101, 873 91. 00

846, 522 200. 00

70.00

71.00

72.00

73.00

73.01

74.00

0 92.00

71, 086

3, 302, 570

4, 957, 451

5, 522, 444

39, 067, 797

483, 235

0

0

70. 00 07000 ELECTROENCEPHALOGRAPHY

07301 ULTRA SOUND

90. 00 09000 CLINIC

91.00 09100 EMERGENCY

07400 RENAL DIALYSIS

73.01

74.00

200.00

73. 00 07300 DRUGS CHARGED TO PATIENTS

71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT

OUTPATIENT SERVICE COST CENTERS

Total (lines 50-199)

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Health Financial Systems	HENDRI CKS REG	ONAL HEALTH		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 01/01/2015		
				To 12/31/2015		
		T: +1	o VVIII	Hooni tol	5/26/2016 11:	23 alli
	N : 61 1		e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adj ustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	)	0	0	31.00
43. 00   04300   NURSERY	0	0	1	o	0	43.00
200.00 Total (lines 30-199)	0	0	1	o	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
· ·	Days	5 ÷ col. 6)	Program Days			
		ĺ		Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	19, 792	0.00	6, 96	4 0		30.00
31.00 03100 INTENSIVE CARE UNIT	2, 030	0.00	1, 08	4 0		31.00
43. 00   04300 NURSERY	3, 067			ol o		43.00
200.00 Total (lines 30-199)	24, 889		8, 04	8 0		200. 00

Health Financial Systems		HENDRI CKS	REGI ONAL	HEALTH		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY	SERVI CE OTHER	PASS	Provi der	CCN: 150005	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared:

			'	0 12/31/2013	5/26/2016 11:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician N	lursing School	Allied Health	All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0	0	0	0	0	50.00
50. 01   05001   ENDOSCOPY	0	0	0	0	0	50. 01
51.00   05100   RECOVERY ROOM	0	0	0	0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
54. 01   05401   RADI ATI ON-ONCOLOGY	0	0	C	0	0	54. 01
56. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	C	0	0	56. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59. 00
60. 00   06000   LABORATORY	0	0	0	0	0	60. 00
64. 00   06400   I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00   06500   RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00  06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00   06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00  06900   ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
69. 01  06901  CARDI AC REHAB	0	0	0	0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
73.01 07301 ULTRA SOUND	0	0	C	0	0	73. 01
74.00 07400 RENAL DIALYSIS	0	0	C	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	0	0	C	0	0	, , , , , ,
91. 00   09100   EMERGENCY	0	0	0	0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	
200.00   Total (lines 50-199)	0	0	[ c	0	0	200. 00

	Financial Systems	HENDRI CKS REGI			In Lie	u of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS	S Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Pre 5/26/2016 11:	
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges	Ratio of Cost	0utpatient	Inpati ent	
			(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8.00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	1					
	O5000  OPERATI NG ROOM	0	41, 461, 796	•		6, 202, 886	
	05001 ENDOSCOPY	0	11, 862, 754			0	50. 01
	05100 RECOVERY ROOM	0	9, 866, 162	0.00000	0. 000000	1, 108, 573	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	10, 064, 440	0.00000		14, 546	
53.00	05300 ANESTHESI OLOGY	0	14, 712, 920	0.00000		1, 449, 519	53.00
54.00	05400   RADI OLOGY-DI AGNOSTI C	0	58, 379, 428	0.00000	0. 000000	3, 951, 914	54.00
54. 01	05401 RADI ATI ON-ONCOLOGY	0	53, 763, 169	0.00000	0. 000000	227, 578	54. 01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	4, 449, 606	0.00000	0. 000000	231, 379	56. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	12, 969, 214	0.00000	0. 000000	1, 729, 322	59. 00
60.00	06000 LABORATORY	0	52, 791, 587	0.00000	0. 000000	4, 963, 404	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	7, 194, 008	0.00000	0. 000000	195, 490	64. 00
65.00	06500 RESPI RATORY THERAPY	0	3, 868, 150	0.00000	0. 000000	1, 325, 536	65. 00
66.00	06600 PHYSI CAL THERAPY	0	19, 079, 680	0.00000	0. 000000	1, 469, 870	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	2, 361, 737	0. 00000	0. 000000	605, 182	67. 00
68.00	06800 SPEECH PATHOLOGY	0	1, 614, 982	0. 00000	0. 000000	165, 399	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	12, 374, 442	0.00000	0. 000000	1, 077, 313	69. 00
69. 01	06901 CARDI AC REHAB	0	1, 337, 218	0. 00000	0. 000000	13, 100	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	524, 558	0. 00000	0. 000000	71, 086	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0. 00000	0. 000000	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	8, 052, 642	0.00000	0. 000000	3, 302, 570	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	27, 751, 402	•		4, 957, 451	ł
70 04	OZOGA LILI TRA COLIND	1	0 054 007		0 000000	100 005	1 70 04

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9, 054, 897 273, 265

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5, 522, 444 91. 00 0 92. 00

39, 067, 797 200. 00

73. 01

74.00 0

73. 01 | 07301 | ULTRA SOUND | 74. 00 | 07400 | RENAL DI ALYSI S

91. 00 09100 EMERGENCY

200.00

90. 00 OUTPATIENT SERVICE COST CENTERS
90. 00 OOOO CLINIC

Total (lines 50-199)

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Health Financial Systems	HENDRI C	CKS REGIONAL	HEALTH	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTH	HER PASS	Provider CCN: 150005	From 01/01/2015	Worksheet D Part IV Date/Time Prepared:

				10 12/01/2010	5/26/2016 11: 23 am
		Ti tl	e XVIII	Hospi tal	PPS
Cost Center Description	I npati ent	Outpati ent	Outpati ent		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Through		
	Costs (col. 8		Costs (col.	9	
	x col. 10)		x col. 12)		
	11.00	12. 00	13. 00		
ANCILLARY SERVICE COST CENTERS					
50. 00   05000 OPERATING ROOM	0	18, 515, 244		0	50.00
50. 01  05001   ENDOSCOPY	0	0		0	50. 01
51.00   05100   RECOVERY ROOM	0	371, 349		0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0		0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	201, 126	l .	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	11, 839, 235		0	54. 00
54. 01   05401   RADI ATI ON-ONCOLOGY	0	17, 457, 079		0	54. 01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	1, 284, 598		0	56.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	2, 648, 750		0	59. 00
60. 00   06000   LABORATORY	0	4, 091, 337		0	60.00
64. 00   06400   I NTRAVENOUS THERAPY	0	2, 776, 237		0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	392, 477		0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	127, 358		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	18, 532		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 601, 197		0	69.00
69. 01   06901   CARDI AC   REHAB	0	562, 480		0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	532, 072		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 213, 928		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5, 098, 129		0	73.00
73. 01   07301   ULTRA SOUND	0	1, 334, 509		0	73. 01
74. 00   07400   RENAL DI ALYSI S	0	7, 170		0	74.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0	38, 681		0	90.00
91. 00 09100 EMERGENCY	o	8, 768, 566		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	1, 245, 848		0	92. 00
200.00 Total (lines 50-199)	o	80, 125, 902		0	200. 00
					•

Health Financial Systems	HENDRI CKS REGI ONAL HEALTH	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH S	ERVICES AND VACCINE COST Provider CCN: 150005	
		From 01/01/2015   Part V

					To 12/31/2015	Date/Time Pre 5/26/2016 11:	
			Ti tl	e XVIII	Hospi tal	PPS	20 4111
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	·	Ratio From	Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9	1	Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
	ABY OFBY OF COOT OFFITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
	_ARY SERVICE COST CENTERS	0.400000	40 545 044			0.044.004	F0 00
	OPERATING ROOM	0. 432883		•	0	8, 014, 934	
	ENDOSCOPY	0. 181191	<b>I</b>		0	0	50. 01
	RECOVERY ROOM	0. 405463			0	150, 568	
	DELIVERY ROOM & LABOR ROOM	0. 333160	<b>I</b>	)	0	0	52.00
	ANESTHESI OLOGY	0. 089978			0	18, 097	53. 00
	RADI OLOGY-DI AGNOSTI C	0. 174438			964	2, 065, 212	
	RADI ATI ON-ONCOLOGY	0. 294413		•	19, 585	5, 139, 591	
	NUCLEAR MEDICINE - DIAGNOSTIC	0. 102573		1	0	131, 765	
	CARDI AC CATHETERI ZATI ON	0. 035541			-	94, 139	
	LABORATORY	0. 191170				782, 141	60.00
	INTRAVENOUS THERAPY	0. 217520		1	-	603, 887	
	RESPI RATORY THERAPY	0. 918948			0	360, 666	
	PHYSI CAL THERAPY	0. 393576		1	0	50, 125	
	OCCUPATI ONAL THERAPY	0. 230983	•		0	0	
	SPEECH PATHOLOGY	0. 424007			0	7, 858	
	ELECTROCARDI OLOGY	0. 134641		1	0	215, 587	
	CARDI AC REHAB	0. 715823		•	0	402, 636	
	ELECTROENCEPHALOGRAPHY	0. 801822		2	0	426, 627	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	•	1	0	0	
	IMPL. DEV. CHARGED TO PATIENT	0. 584835		•	0	709, 948	
	DRUGS CHARGED TO PATIENTS	0. 651994			9, 443	3, 323, 950	
	ULTRA SOUND	0. 082609			0	110, 242	
	RENAL DIALYSIS	0. 620921	7, 170	) (	0	4, 452	74. 00
	TIENT SERVICE COST CENTERS						
	CLI NI C	0. 217973			0	8, 431	90. 00
	EMERGENCY	0. 174120			0	1, 526, 783	
	OBSERVATION BEDS (NON-DISTINCT PART)	1. 165978	1	•	-	1, 452, 631	
	Subtotal (see instructions)		80, 125, 902	630	· ·	25, 600, 270	
	Less PBP Clinic Lab. Services-Program				0		201. 00
	Only Charges		00 105 000		20.000	25 /00 272	202 00
202. 00	Net Charges (line 200 +/- line 201)		80, 125, 902	. 630	29, 992	25, 600, 270	J202. 00

Health Financial Systems			HENDRI CK	S REGIONAL	HEALTH			In Lieu	ı of Form Cl	MS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH	SERVICES A	ND VACCINE	COST	Provi der	CCN: 1		01/01/2015 12/31/2015		Prepared:

						То	12/31/2015	Date/Time Pr 5/26/2016 11	
				Ti tl e	e XVIII		Hospi tal	PPS	
		Cos	sts						
	Cost Center Description	Cost	Cos						
		Rei mbursed	Rei mbu						
		Servi ces	Servi ce						
		Subject To	Subj ec						
		Ded. & Coins.	Ded. & C						
		(see inst.)	(see ir						
	NOLLI ADV. CEDVI CE. COCT. CENTEDO	6. 00	7.0	0					
	NCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM								50.00
	D5000 OPERATING ROOM	0		0					
	D5100 RECOVERY ROOM	0		0					50. 01 51. 00
	D5200 DELIVERY ROOM & LABOR ROOM	0		0					52.00
	05300 ANESTHESI OLOGY	0		0					53.00
	05400 RADI OLOGY-DI AGNOSTI C	0		168					54. 00
	05401 RADI ATI ON-ONCOLOGY			5, 766					54. 00
	03450 NUCLEAR MEDICINE - DIAGNOSTIC			3, 700					56.00
	05900 CARDI AC CATHETERI ZATI ON			0					59.00
	06000 LABORATORY	120		0					60.00
1	06400 I NTRAVENOUS THERAPY	120		0					64. 00
	06500 RESPIRATORY THERAPY	0		0					65.00
	06600 PHYSI CAL THERAPY	0		0					66. 00
	06700 OCCUPATI ONAL THERAPY	0		0					67. 00
	06800 SPEECH PATHOLOGY	0		0					68. 00
1	06900 ELECTROCARDI OLOGY	0		o					69. 00
	06901 CARDI AC REHAB	0		o					69. 01
	07000 ELECTROENCEPHALOGRAPHY	0		o					70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	ol .	o					71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	j	o					72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	j	6, 157					73. 00
73. 01	07301 ULTRA SOUND	0	ol	o					73. 01
74.00	07400 RENAL DIALYSIS	0		0					74. 00
	OUTPATIENT SERVICE COST CENTERS								
	09000 CLI NI C	0		0					90. 00
	09100 EMERGENCY	0	)	0					91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	)	0					92. 00
200.00	Subtotal (see instructions)	120	)	12, 091					200. 00
201.00	Less PBP Clinic Lab. Services-Program	0							201. 00
	Only Charges								
202. 00	Net Charges (line 200 +/- line 201)	120	)	12, 091					202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150005	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/26/2016 11:23 am
	Title XVIII	Hospi tal	PPS
Cook Cook of Donor in the co			

		Title XVIII	Hospi tal	5/26/2016 11:: PPS	23 am_			
	Cost Center Description	THE AVITT	поэрт саг					
	PART I - ALL PROVIDER COMPONENTS			1. 00				
	INPATIENT DAYS							
1.00	Inpatient days (including private room days and swing-bed days,			19, 792 19, 792				
2.00								
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.							
4.00	Semi-private room days (excluding swing-bed and observation bed		16, 271	4. 00				
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost							
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December '	31 of the cost	0	6. 00			
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber t	or the cost		0.00			
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00			
8. 00	reporting period Total swing-bed NF type inpatient days (including private room o	davs) after December 3	1 of the cost	0	8. 00			
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber 5	or the cost		0.00			
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	6, 964	9. 00			
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	/ (including private r	nom dave)	0	10.00			
10.00	through December 31 of the cost reporting period (see instruction		Join days)	0	10.00			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00			
12. 00	December 31 of the cost reporting period (if calendar year, ento Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00			
12.00	through December 31 of the cost reporting period	only (Therading private	e room days)	0	12.00			
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00			
14. 00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program			0	14. 00			
15. 00	Total nursery days (title V or XIX only)	0	15. 00					
16. 00	Nursery days (title V or XIX only)	0	16. 00					
17.00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost							
17. 00	reporting period	0.00	17. 00					
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00			
10.00	reporting period	0.00	10.00					
19. 00	Medicald rate for swing-bed NF services applicable to services reporting period	0.00	19. 00					
20. 00	Medicaid rate for swing-bed NF services applicable to services	0. 00	20. 00					
21. 00	reporting period Total general inpatient routine service cost (see instructions)	25, 846, 284	21. 00					
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	23, 040, 204	22. 00			
	5 x line 17)			_				
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	l of the cost reporting	g period (line 6	0	23. 00			
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportion	ng period (line	0	24. 00			
05.00	7 x line 19)	6.11			05.00			
25. 00	Swing-bed cost applicable to NF type services after December 31 $\times$ line 20)	or the cost reporting	period (line 8	0	25. 00			
26. 00	Total swing-bed cost (see instructions)			0	26. 00			
27. 00	General inpatient routine service cost net of swing-bed cost (I	ne 21 minus line 26)		25, 846, 284	27. 00			
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00			
29. 00	Private room charges (excluding swing-bed charges)		9/	0				
30. 00	Semi -private room charges (excluding swing-bed charges)			0				
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	rne 28)		0. 000000 0. 00	1			
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00				
34. 00	Average per diem private room charge differential (line 32 minus		tions)	0. 00	1			
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	ł			
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an	fferential (line	0 25, 846, 284	36. 00 37. 00				
57.00	27 minus line 36)			20, 040, 204	] 07.00			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY							
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			1 205 00	38. 00			
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see in Program general inpatient routine service cost (line 9 x line 3)			1, 305. 90 9, 094, 288				
40. 00	Medically necessary private room cost applicable to the Program	•		0	40. 00			
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		9, 094, 288	41.00			

<u>Heal</u> th	Financial Systems	HENDRI CKS REGI	ONAL_HEALTH		In Lie	eu of Form CMS-2	<u>2552-</u> 10		
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Peri od: From 01/01/2015	Worksheet D-1			
					To 12/31/2015		pared:		
			T; +1	e XVIII	Hospi tal	5/26/2016 11: PPS	23 am_		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost			
	Soot Someon Boson Person	Inpatient Cost				(col. 3 x col.			
		1.00	2.00	col . 2)	4.00	4)			
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 0	5. 00	42. 00		
.2. 00	Intensive Care Type Inpatient Hospital Units			,	<u>-</u>		12.00		
43.00	INTENSIVE CARE UNIT	4, 517, 120	2, 030	2, 225. 1	1, 084	2, 412, 095	l		
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00		
46. 00	1						46. 00		
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00		
	Cost Center Description					1.00			
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)			1. 00 13, 485, 940	48. 00		
	Total Program inpatient costs (sum of lines			ons)		24, 992, 323	1		
	PASS THROUGH COST ADJUSTMENTS								
50. 00	Pass through costs applicable to Program inp.	atient routine	services (from	n Wkst. D, sum	of Parts I and	1, 385, 545	50. 00		
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	846, 522	51.00		
===	and IV)								
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu-		lated non ne	elcian anacth	atist and	2, 232, 067 22, 760, 256	1		
55.00	medical education costs (line 49 minus line		rateu, non-pny	/SICI all allestin	etist, and	22, 760, 256	33.00		
	TARGET AMOUNT AND LIMIT COMPUTATION	,							
	Program di scharges					0			
56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1		
57. 00	,	line 53)	ő	•					
58. 00	Bonus payment (see instructions)					0.00			
59. 00	OO Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket								
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	market basket		0.00	60.00		
61. 00	If line 53/54 is less than the lower of line					0	61. 00		
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target				
62. 00	Relief payment (see instructions)	riisti detrolis)				0	62. 00		
63. 00	63.00 Allowable Inpatient cost plus incentive payment (see instructions)								
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 0)								
04.00	instructions)(title XVIII only)	ts through bece	illiber 31 of the	e cost reportin	ng perrou (see		64. 00		
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	cost reporting	period (See	0	65. 00		
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	6/ nlus line /	(5) (+i+l	l only) For	0	66. 00		
00.00	CAH (see instructions)	ne costs (Trie	or prus rine c	os) (ti ti e xvii	1 Only). 101		00.00		
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 d	of the cost re	porting period	0	67. 00		
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost reno	rting period	0	68. 00		
00.00	(line 13 x line 20)	0 00313 41101 2	eccinoci oi oi	the cost ropo	iting period		00.00		
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00		
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil		•			Ι	70.00		
71. 00	Adjusted general inpatient routine service c	-					71.00		
72.00	Program routine service cost (line 9 x line	71)		ŕ			72. 00		
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv						73. 00 74. 00		
74. 00 75. 00	Capital-related cost allocated to inpatient	•			art II, column		75. 00		
	26, line 45)								
76. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00		
77. 00 78. 00	Inpatient routine service cost (line 74 minu	,					78.00		
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p					79. 00 80. 00		
	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)								
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81. 00 82. 00		
83. 00	Reasonable inpatient routine service costs (		* .				83. 00		
84.00	Program inpatient ancillary services (see in		`				84. 00		
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00		
00.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		ir ought oo)				00.00		
87. 00	Total observation bed days (see instructions	)				3, 521	87. 00		
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	line 2)			1, 305. 90 4, 598, 074			
07.00	observation bed cost (Time of A Time ob) (Se					1 7, 370, 074	1 07.00		

Health Financial Systems	HENDRI CKS REG	IONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	1
				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	3, 282, 914	25, 846, 284	0. 12701	7 4, 598, 074	584, 034	90.00
91.00 Nursing School cost	0	25, 846, 284	0.00000	4, 598, 074	0	91.00
92.00 Allied health cost	0	25, 846, 284	0.00000	4, 598, 074	0	92. 00
93.00 All other Medical Education	0	25, 846, 284	0.00000	4, 598, 074	0	93. 00

Health Financial Systems	HENDRICKS REGIONAL	. HEALTH	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150005	Peri od: From 01/01/2015	Worksheet D-1	
				Date/Time Pre 5/26/2016 11:	pared: 23 am
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1 00	

		Title XIX	Hospi tal	Cost	23 alli_			
	Cost Center Description							
	DADT I ALL DOOM DED COMPONENTO			1. 00				
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS							
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		19, 792	1. 00			
2.00	D Inpatient days (including private room days, excluding swing-bed and newborn days)							
3.00								
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days)		16, 271	4. 00			
5. 00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	10, 271	5. 00			
	reporting period							
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December 3	31 of the cost	0	6. 00			
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room of	days) through December	31 of the cost	0	7. 00			
7.00	reporting period	days) till odgir becelliber	31 Of the cost	O	7.00			
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 31	of the cost	0	8. 00			
	reporting period (if calendar year, enter 0 on this line)							
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	489	9. 00			
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	v (includina private ro	oom davs)	0	10. 00			
	through December 31 of the cost reporting period (see instruction	ons)						
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00			
12. 00	December 31 of the cost reporting period (if calendar year, ento Swing-bed NF type inpatient days applicable to titles V or XIX of		room days)	0	12. 00			
12.00	through December 31 of the cost reporting period	only (including private	e room days)	U	12.00			
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00			
	after December 31 of the cost reporting period (if calendar year				44.00			
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed of	lays)	0 2 067	14. 00 15. 00			
16. 00	Nursery days (title V or XIX only)			3,007				
10.00	SWING BED ADJUSTMENT				10.00			
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of	the cost	0. 00	17. 00			
10.00	reporting period	often December 21 of t	he eest	0.00	18. 00			
18. 00	O Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period							
19. 00	Medicaid rate for swing-bed NF services applicable to services	0.00	19. 00					
	reporting period							
20. 00	00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period							
21. 00	Total general inpatient routine service cost (see instructions)			25, 846, 284	21. 00			
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	0	22. 00			
22.00	5 x line 17)	1 -6 +1++!		0	22.00			
23. 00	Swing-bed cost applicable to SNF type services after December 3   x line 18)	or the cost reporting	period (line 6	0	23. 00			
24. 00	Swing-bed cost applicable to NF type services through December 3	31 of the cost reportir	ng period (line	0	24. 00			
	7 x line 19)	•						
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00			
26. 00	x line 20)  Total swing-bed cost (see instructions)			0	26. 00			
27. 00	General inpatient routine service cost net of swing-bed cost (I)	ne 21 minus line 26)		25, 846, 284				
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	·						
	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)		28. 00			
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00			
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ 1	i ne 28)		0. 000000				
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00				
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00				
34.00	Average per diem private room charge differential (line 32 minus		i ons)	0.00				
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	31)		0. 00 0	35. 00 36. 00			
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost dif	ferential (line	25, 846, 284				
	27 minus line 36)							
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	THE HEAD						
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST Adjusted general inpatient routine service cost per diem (see in			1, 305. 90	38. 00			
39.00	Program general inpatient routine service cost per diem (see in	*		638, 585				
40. 00	Medically necessary private room cost applicable to the Program	•		030, 303				
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		638, 585	41. 00			

44.00   CROMARY CARE UNIT	<u>Heal</u> th	Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	eu of Form CMS-2	<u> 2552-</u> 10
Cost Center Description	COMPUT	TATION OF INPATIENT OPERATING COST		Provi der			Worksheet D-1	
Cost Center Description								
Total   Program layer   Program Bays   Program Bays   Program Cost				Ti +	I A XI X	Hospi tal		23 am
1.00		Cost Center Description	Total			<del>_</del>		
1.00		'	Inpatient Cost	Inpatient Days	Diem (col. 1		(col. 3 x col.	
MRSERY (LILEY V. X.IX. unly)   1,563,500   3,007   509,78   0   0   42,00			1 00	2.00		4.00		
A col   INTERSIVE CARE UNIT   A col	42. 00	NURSERY (title V & XIX only)				_		42. 00
44.00   COROMARY CARE UNIT								
45.00   BURN INTENSIVE CARE UNIT			4, 517, 120	2, 030	2, 225. 1	0	0	
40.00								
48.00   Program Inpatient anciliary service cost (Wist. D-3, col. 3, line 200)   1.00   1.0								46. 00
1.00	47. 00							47. 00
49.00   Total Program Inpattent ancillary service cost (Wist. D., 3 od. 3, line 200)   487,993   489, 1993   489   490   Total Program Inpattent costs (sum of lines. 41 through 48) (see Instructions)   1.126,1798   49 00   174,993   140,993   1		Cost Center Description					1.00	
40.00 Total Program inpatient costs (sum of Fines 41 through 48) (see instructions)  40.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D., sum of Parts I and Dill)  50.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II and Dill)  50.00 Total Program excludable cost (sum of Fines 50 and 51)  50.00 Total Program (sum of Fines 50 and 51)  50.00 Total Program (sum of Fines 50 and 51)  50.00 Total Program (sum of Fines 50 and 51)  50.00 Total Program (sum of Fines 50 a	48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	3. Line 200)				48. 00
50.00 Pass through costs applicable to Program inpatient routine services (from Wist. D. sum of Parts I and III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wist. D. sum of Parts III		,			ns)		l	
Pass through costs applicable to Program inpatient and Illary services (from Wkst. 0, sum of Parts II and IV)	50.00		atient routine	services (from	Wkst. D, sum	of Parts I and	0	50.00
52.00 Total Program excludable cost (sum of lines 50 and 51) 5.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 0 53.00 medical education costs (line 49 minus line 52) FARSET AMOUNT AND LIMIT COMPUTATION  94.00 Program discharges 0.0 54.00 10 Program discharges 0.0 0.55.00 10 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.0 0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.0 0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.0 0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.0 0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.0 0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.0 0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.0 0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.0 0 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.0 0 Difference between adjusted inpatient providers cost report, updated by the market basket 0.0 0 Difference between adjusted inpatient providers are line 55. 59 or 60 onter the lessor of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.0 0 Difference swing-bed SNF inpatient routine costs (line 54 x 60), or 1% of the target amount (line 50, otherwise enter zero (see instructions) 0.0 0 Difference swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For OAH (see instructions) 0.0 0 Difference swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For OAH (see instructions) 0.1 11 0 V or XIX swing-bed NF inpatient routine	51. 00		atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	0	51.00
Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (tine 49 minus line 52)		and IV)						
medical education costs (line 49" minus line 52)				lated non new	cician anacth	atist and	1	
Program discharges	33.00			erateu, non-pny	Si Ci ali allestii	etist, and	0	33.00
55.00   Target amount (Per discharge   0.00   55.00   55.00   56.00   Target amount (Per discharge   0.60   56.00   57.00			,					
1   25.00   1   2   2   2   3   3   3   3   3   3   3								
0.00   Ifference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0.57.00   58.							l	
Description   Description		,	ing cost and ta	rget amount (I	ine 56 minus I	ine 53)	l	
market basket 60.00 Lesser of Ilines 53/54 is 1ess than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 63.00 Relicef payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) et instructions) (tilt eXVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) et instructions) (tilt eXVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tilt eXVIII only). For CAH (see instructions) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tilt eXVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 * line 68) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURS ING FACILITY, OTHE	58. 00							
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 66.00 fol.00 If line 53/54 is less than the lower of lines 55, 59 or 40 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.61.00 Relief payment (see instructions) 0.63.00 Relief payment (see instructions) Relief payment (se	59. 00		porting period	ending 1996, u	pdated and cor	mpounded by the	0.00	59. 00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (title XVIII only)  67.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only). For CAH (see instructions)  67.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Total V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 20)  70.00 Skilled nursing facility/offer nursing facility/offer nursing facility/offer nursing facility/offer nursing facility/offer nursing facility/offer nursing facility/offer nursing facility/offer nursing facility/offer)  70.00 Adjusted general inpatient routine service costs (fine 70 + line 2)  71.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  72.00 Program capital-related costs (line 75 + line 2)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Program capital-related costs (line 75 + line 2)  75.00 Program capital-related costs (	60. 00	I and the second	cost report, up	dated by the m	arket basket		0.00	60.00
amount (Line 56), otherwise enter zero (see instructions) 62.00 A liowable Inpatient cost plus incentive payment (see instructions) 63.00 A liowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF Inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF Inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 68.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Skilled nursing facility/other nursing facility/CIFID routine service cost (line 37) 69.00 Skilled nursing facility/other nursing facility/CIFID routine service cost (line 37) 69.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 69.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 69.00 Pagram routine service cost (line 7 + line 2) 69.00 Program routine service cost (line 7 + line 2) 69.00 Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 69.00 Program capital-related costs (line 9 x line 70) 69.00 Program capital-related costs (line 9 x line 70) 69.00 Program capital-related costs (line 9 x line 70) 69.00 Program inpatient routine service costs (from provider records) 69.00 Total Program inpatient routine service costs (from provider records) 69.00 Total Program inpatient operating costs (sum of lines	61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	er of 50% of		0	61. 00
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient costs plus incentive payment (see instructions) 63.00 Allowable Inpatient costs plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (See instructions) (title XVIII only) 67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (See instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID ONLY 60.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 60.00 Total vide quereral inpatient routine service costs (line 72 + line 73) 60.00 Total Program general inpatient routine service costs (line 72 + line 73) 60.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 60.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 61.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 62.00 Inpatient routine service cost (line 74 minus line 77) 63.00 Total Program routine service cost (line 74 minus line 77) 64.00 Total Program routine service cost (line 74 minus line 79) 65.00 Reasonable inpatient routine service costs (see instructions) 66.00 Total Program inpatient operating costs (se				s (lines 54 x	60), or 1% of	the target		
Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). 67.00 Total Work Swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) 68.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Inc. 12 x line 19) 68.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Inc. 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (Line 67 + Line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (Line 37) 70.00 Total did cally necessary private room cost applicable to Program (Line 14 x Line 35) Total Program general inpatient routine service costs (Line 72 + Line 73) 75.00 Total Program general inpatient routine service costs (From Worksheet B, Part II, column 26, Line 45) 10.00 Total Program capital-related costs (Line 9 x Line 76) 10.00	62. 00		i iisti ucti oiis)				0	62. 00
Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only)		Allowable Inpatient cost plus incentive paym	ent (see instru	ıctions)			0	63. 00
instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID DNLY  70.00 Skilled nursing facility/Other nursing facility/ICF/IID routine service cost (line 37)  70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  71.00 Program routine service cost (line 9 x line 71)  72.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  73.00 Total Program general inpatient routine service costs (line 72 + line 73)  74.00 Total Program apeneral inpatient routine service costs (line 72 + line 73)  75.00 Can line 45)  76.00 Per diem capital-related costs (line 9 x line 76)  77.00 Inpatient routine service cost (line 74 minus line 77)  77.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)  80.00 Total Program routine service cost (see instructions)  81.00 Reasonable inpatient routine service costs (see instructions)  82.00 Reasonable inpatient routine service costs (see instructions)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Total Program inpatient operating costs (see instructions)  84.00 Total Program inpatient routine service cost (see instructions)  84.00 Total Program inpatient operating costs (see instructions)  85.00 A	44.00		to through Door	mbas 21 of the	anat ranarti	na ported (Coo	0	44.00
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Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)	65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
CAH (see instructions)  7. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  8. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 7 + line 68)  9. 00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37)  7. 00 Skilled nursing facility/other nursing facility/lCF/IID routine service cost (line 37)  7. 00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  7. 00 Program routine service cost (line 9 x line 71)  7. 00 Total Program general inpatient routine service costs (line 72 + line 73)  7. 00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  7. 00 Per diem capital -related costs (line 7 + line 2)  7. 00 Program capital -related costs (line 9 x line 70)  7. 00 Program capital -related costs (line 9 x line 70)  7. 00 Program capital routine service cost for excess costs (from provider records)  7. 00 Inpatient routine service cost for excess costs (from provider records)  8. 00 Inpatient routine service cost limitation (line 9 x line 81)  8. 00 Program inpatient ancillary services (see instructions)  8. 00 Program inpatient ancillary services (see instructions)  8. 00 Program inpatient ancillary services (see instructions)  9. 00 Total Program inpatient operating costs (sum of lines 83 through 85)  9. 00 Total Program inpatient operating costs (sum of lines 83 through 85)  9. 00 Total observation bed days (see instructions)  10 Total observation bed days (see instruct	44 00		no costs (lino	44 plus lino 4	E) (+; +  o V/	only) For	_	44 00
Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Adjusted general inpatient routine service cost (line 70 + line 2)  70.00 Program routine service cost (line 9 x line 71)  70.00 Program routine service cost (line 9 x line 71)  70.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  70.00 Per diem capital-related costs (line 75 + line 2)  70.00 Program capital-related costs (line 75 + line 2)  70.00 Aggregate charges to beneficiaries for excess costs (from provider records)  70.00 Aggregate charges to beneficiaries for excess costs (from provider records)  70.00 Aggregate charges to beneficiaries for excess costs (from provider records)  70.00 Inpatient routine service cost per diem limitation  70.00 Inpatient routine service cost (see instructions)  70.00 Program inpatient ancillary services (see instructions)  70.00 Program inpatient ancillary services (see instructions)  70.00 Program inpatient ancillary services (see instructions)  70.00 Program inpatient noutine service cost (sum of lines 83 through 85)  70.00 PRATI IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  70.00 Total Program inpatient routine cost per diem (line 27 + line 2)  70.00 Total Program inpatient routine cost per diem (line 27 + line 2)  70.00 Total Program inpatient routine service cost see instructions)  70.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  70.00 Program inpatient noutine service cost (sum of lines 83 through 85)  70.00 Program inpatient noutine service cost (sum of lines 83 through 85)  70.00 Program inpatient noutine service cost (sum of lines 83 through 85)	00.00		ne costs (Title	64 prus rine 6	o)(title xvii	OH y). FOI	0	86.00
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69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital -related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total Deservation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	00.00	1 . · · · · · · · · · · · · · · · · · ·	e costs arter t	ecember 31 01	the cost repor	triig perrou	0	00.00
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Total Program general inpatient routine service costs (line 72 + line 73)  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76. 00  Per diem capital-related costs (line 75 ÷ line 2)  Program capital-related costs (line 9 x line 76)  Inpatient routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  Inpatient routine service cost per diem limitation  Inpatient routine service cost limitation (line 9 x line 81)  Reasonable inpatient routine service costs (see instructions)  Reasonable inpatient ancillary services (see instructions)  Utilization review - physician compensation (see instructions)  Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87. 00  Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  74. 00  75. 00  76. 00  77. 00  78. 00  79. 00  80. 00  80. 00  80. 00  81. 00  82. 00  83. 00  84. 00  85. 00  76. 00  77. 00  77. 00  78. 00  79. 00  88. 00  79. 00  88. 00  79. 00  88. 00  79. 00  88. 00	72. 00	Program routine service cost (line 9 x line	71)		,			72. 00
75.00  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00  Per diem capital-related costs (line 75 ÷ line 2)  77.00  Program capital-related costs (line 9 x line 76)  Inpatient routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00  Inpatient routine service cost per diem limitation  Inpatient routine service cost per diem limitation  Inpatient routine service cost limitation (line 9 x line 81)  Reasonable inpatient routine service costs (see instructions)  84.00  Program inpatient ancillary services (see instructions)  85.00  Utilization review - physician compensation (see instructions)  75.00  76.00  77.00  78.00  79.00  80.00  81.00  Reasonable inpatient outine service costs (ince 75 ince 70)  82.00  83.00  84.00  85.00  Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00  88.00  Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  1, 305.90  88.00	73.00							73.00
26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service costs per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  76.00  77.00  77.00  77.00  78.00  79.00  80.00  81.00  81.00  82.00  83.00  84.00  85.00  87.00  87.00			•			art II. column		
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79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Panul Inpatient 79)  80.00 Second Panul Inpatient routine service costs (from provider records)  81.00 Second Panul Inpatient Panul Inpat		,	,					
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82.00   Inpatient routine service cost limitation (line 9 x line 81)   82.00   83.00   Reasonable inpatient routine service costs (see instructions)   83.00   84.00   Program inpatient ancillary services (see instructions)   84.00   Utilization review - physician compensation (see instructions)   85.00   Total Program inpatient operating costs (sum of lines 83 through 85)   86.00   PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST   87.00   Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)   1,305.90   88.00				cost limitation	(line 78 min	us line 79)		80.00
83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Reasonable inpatient routine service costs (see instructions)  81.00 84.00 85.00 85.00 85.00 86.	81.00	1		)				1
84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  84.00 85.00 86.00 86.00 86.00 86.00	82.00	1		* .				83. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	84. 00	1		*				84. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  1,305.90 88.00	85.00							85. 00
87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  3,521 87.00 1,305.90 88.00	86.00			rougn 85)				J 86. 00
	87. 00						3, 521	87. 00
89.00   Ubservation bed cost (line 87 x line 88) (see instructions) 4,598,074   89.00	88. 00		•	,			l '	
	89.00	UDServation bed COST (line 8/ x line 88) (se	e instructions)				4, 598, 074	I 84. 00

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015		
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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	3, 282, 914	25, 846, 284	0. 12701	7 4, 598, 074	584, 034	90.00
91.00 Nursing School cost	0	25, 846, 284	0.00000	4, 598, 074	0	91.00
92.00 Allied health cost	0	25, 846, 284	0.00000	4, 598, 074	0	92. 00
93.00 All other Medical Education	0	25, 846, 284	0. 00000	0 4, 598, 074	0	93. 00

Health Financial Systems	HENDRI CKS REGIONAL	HEALTH			In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			CCN: 150005	Per	ri od:	Worksheet D-3	
				Fro To	om 01/01/2015 12/31/2015	Date/Time Pre 5/26/2016 11:	pared: 23 am
		Ti tl	le XVIII		Hospi tal	PPS	
Cost Center Description			Ratio of Co		I npati ent	Inpati ent	
			To Charges	;	Program	Program Costs	
					Charges	(col. 1 x col. 2)	
			1.00		2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00		2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS					7, 408, 812		30.00
31.00 03100 INTENSIVE CARE UNIT					3, 262, 537		31.00
43. 00 04300 NURSERY							43. 00
ANCILLARY SERVICE COST CENTERS							
50. 00   05000   OPERATI NG ROOM			0. 4328		6, 202, 886		
50. 01   05001   ENDOSCOPY			0. 1811		0	0	
51. 00   05100   RECOVERY ROOM			0. 4054		1, 108, 573	449, 485	1
52.00   05200   DELIVERY ROOM & LABOR ROOM			0. 3331		14, 546	4, 846 130, 425	
53. 00   05300  ANESTHESTOLOGY 54. 00   05400  RADI OLOGY-DI AGNOSTI C			0. 0899		1, 449, 519 3, 951, 914	130, 425	
54. 01   05400   RADI ATI ON-ONCOLOGY			0. 1742		227, 578		1
56. 00   03450   NUCLEAR   MEDICINE - DI AGNOSTI C			0. 1025		231, 379	23, 733	
59. 00 05900 CARDI AC CATHETERI ZATI ON			0. 0355	-	1, 729, 322	61, 462	1
60. 00   06000   LABORATORY			0. 1911		4, 963, 404	948, 854	
64.00 06400 INTRAVENOUS THERAPY			0. 2175		195, 490		1
65. 00 06500 RESPIRATORY THERAPY			0. 9189	48	1, 325, 536	1, 218, 099	65. 00
66. 00 06600 PHYSI CAL THERAPY			0. 3935		1, 469, 870	578, 506	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY			0. 2309		605, 182	139, 787	
68. 00 06800 SPEECH PATHOLOGY			0. 4240		165, 399		
69. 00 06900 ELECTROCARDI OLOGY			0. 1346		1, 077, 313	· ·	
69. 01   06901   CARDI AC   REHAB			0. 7158		13, 100	9, 377	
70. 00 07000 ELECTROENCEPHALOGRAPHY			0. 8018		71, 086	56, 998	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT			0. 0000 0. 5848		2 202 570	0 1, 931, 459	
73. 00 07300 DRUGS CHARGED TO PATIENTS			0. 5848		3, 302, 570 4, 957, 451	3, 232, 228	
73. 01   07300   DROGS CHARGED TO PATTENTS			0. 0826		483, 235	3, 232, 220	1
74. 00 07400 RENAL DI ALYSI S			0. 6209		403, 233	0	1
OUTPATIENT SERVICE COST CENTERS			0.020	_	<u> </u>		7 1. 00
90. 00 09000 CLI NI C			0. 2179	73	0	0	90.00
91. 00 09100 EMERGENCY			0. 1741	20	5, 522, 444	961, 568	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			1. 1659	78	0	0	
200.00 Total (sum of lines 50-94 and 96-98)					39, 067, 797	13, 485, 940	
201.00 Less PBP Clinic Laboratory Services-Pr	ogram only charges (I	ine 61)			0		201. 00
202.00 Net Charges (line 200 minus line 201)			1		39, 067, 797		202. 00

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150005	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Pre 5/26/2016 11:	pared:
		Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			461, 559		30.0
31. 00	03100   NTENSI VE CARE UNIT			43, 337		31.0
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS			247, 103		43.0
50. 00	05000 OPERATING ROOM		0. 4328	83 146, 181	63, 279	50. 0
50. 00	05001 ENDOSCOPY		0. 4328			1
51. 00	05100 RECOVERY ROOM		0. 4054	· ·	10, 762	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 3331			
3. 00	05300 ANESTHESI OLOGY		0. 0899			
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1744		14, 245	
54. 01	05401 RADI ATI ON-ONCOLOGY		0. 2944		0	1
6. 00	03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 1025		388	1
9. 00	05900 CARDI AC CATHETERI ZATI ON		0. 0355	41 0	0	59.0
0.00	06000 LABORATORY		0. 1911	70 111, 175	21, 253	60.0
4. 00	06400 I NTRAVENOUS THERAPY		0. 2175	20 15, 890	3, 456	64.0
5.00	06500 RESPI RATORY THERAPY		0. 9189		26, 646	65.0
6. 00	06600 PHYSI CAL THERAPY		0. 3935		6, 453	
7. 00	06700 OCCUPATI ONAL THERAPY		0. 2309	· ·	1, 498	
8. 00	06800 SPEECH PATHOLOGY		0. 4240		1, 049	
9. 00	06900 ELECTROCARDI OLOGY		0. 1346	41 50, 554	6, 807	
9. 01	06901 CARDI AC REHAB		0. 7158		217	
0. 00	07000 ELECTROENCEPHALOGRAPHY		0. 8018	· ·	1, 025	
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	
2. 00	07200 I MPL. DEV. CHARGED TO PATIENT		0. 5848		0	72.0
3.00	07300 DRUGS CHARGED TO PATIENTS		0. 6519		91, 701	
73. 01	07301 ULTRA SOUND		0. 0826			1
4.00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS		0. 6209	21 2, 202	1, 367	74.0
20 00	09000 CLINIC		0. 2179	73 0	0	90. (
91.00	09100 EMERGENCY		0. 2179		17, 914	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 1659	· ·	0	1
72.00 200 00	,		1. 1037	1 443 689	487 503	

487, 593 200. 00 201. 00 202. 00

1, 443, 689

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

200. 00 201. 00 202. 00

			Т	o 12/31/2015	Date/Time Pre 5/26/2016 11:	
		Ti tl	e XVIII	Hospi tal	PPS	25 aiii
				1.00	0.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	1. 00	2. 00	
1.00	DRG Amounts Other than Outlier Payments			0		1.00
1. 01	DRG amounts other than outlier payments for discharges occurrin	g prior		11, 385, 494		1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	a on or		4, 354, 545		1. 02
1.02	after October 1 (see instructions)	g on or		4, 334, 343		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for			0		1. 03
1 04	discharges occurring prior to October 1 (see instructions)					1 04
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0		1. 04
2.00	Outlier payments for discharges. (see instructions)			266, 067		2. 00
2. 01	Outlier reconciliation amount			0		2. 01
2. 02 3. 00	Outlier payment for discharges for Model 4 BPCI (see instructio Managed Care Simulated Payments	ns)		0		2. 02 3. 00
4. 00	Bed days available divided by number of days in the cost report	i na		117. 35		4. 00
	peri od (see i nstructi ons)					
F 00	Indirect Medical Education Adjustment		1	0.00		
5. 00	FTE count for allopathic and osteopathic programs for the most cost reporting period ending on or before 12/31/1996. (see instr			0.00		5. 00
6.00	FTE count for allopathic and osteopathic programs which meet th			0.00		6. 00
	criteria for an add-on to the cap for new programs in accordance	e with 42				
7. 00	CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified un	der 12		0.00		7. 00
7.00	CFR §412. 105(f) (1) (i v) (B) (1)	uei 42		0.00		7.00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified u			0. 00		7. 01
	CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July then see instructions.	1, 2011				
8. 00	Adjustment (increase or decrease) to the FTE count for allopath	ic and		0.00		8. 00
0.00	osteopathic programs for affiliated programs in accordance with			0.00		0.00
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67	FR 50069				
8. 01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot	s under		0.00		8. 01
0.01	section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		0.01
	instructions.					
8. 02	The amount of increase if the hospital was awarded FTE cap slot			0.00		8. 02
9. 00	closed teaching hospital under section 5506 of ACA. (see instru Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9. 00
	and 8,02) (see instructions)	(=1 =1 = 1				
10. 00	FTE count for allopathic and osteopathic programs in the curren	t year		0.00		10.00
11. 00	from your records  FTE count for residents in dental and podiatric programs.			0.00		11.00
12. 00				0.00		12.00
13. 00	Total allowable FTE count for the prior year.			0.00		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year or after September 30, 1997, otherwise enter zero.	ended on		0.00		14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00		15. 00
16.00	Adjustment for residents in initial years of the program			0.00		16. 00
17. 00	Adjustment for residents displaced by program or hospital closu	re		0.00		17. 00
18.00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0. 00 0. 000000		18. 00 19. 00
	Prior year resident to bed ratio (see instructions)			0. 000000		20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000		21. 00
	IME payment adjustment (see instructions)			0		22. 00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section	n 422 of t	he MMA	0		22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE residen		THE WINA	0.00		23. 00
	slots under 42 Sec. 412.105 (f)(1)(iv)(C).	•				
24. 00	IME FTE Resident Count Over Cap (see instructions)	war of		0.00		24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lo line 23 or line 24 (see instructions)	wer or		0.00		25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000		26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000		27. 00
28. 00	IME add-on adjustment amount (see instructions)  IME add-on adjustment amount - Managed Care (see instructions)			0		28. 00 28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			o		29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29. 01
20.00	Di sproporti onate Share Adjustment			4 = 5		1 20 00
30. 00	Percentage of SSI recipient patient days to Medicare Part A pat (see instructions)	ent days		1. 52		30.00
31. 00	Percentage of Medicaid patient days (see instructions)		1	15. 44		31.00
32.00	Sum of lines 30 and 31			16. 96		32. 00
33.00	Allowable disproportionate share percentage (see instructions)			3.77		33.00
54. UU	Disproportionate share adjustment (see instructions)		I	148, 350		34.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2015 | Part A | Date/Time Prepared: | 5/26/2016 11: 23 am Provi der CCN: 150005

35. 00 To 35. 01 Fac 35. 02 Ho en 35. 03 Pro am 36. 00 To 35. Add 40. 00 To exception	compensated Care Adjustment otal uncompensated care amount (see instructions) actor 3 (see instructions) aspital uncompensated care payment (If line 34 is zero,	Title XVIII	Hospi tal Pri or to October 1 1.00	On/After October 1 2.00	
35. 00 To 35. 01 Fac 35. 02 Ho en 35. 03 Pro ama 36. 00 To 35. Addressed Advantage Advant	otal uncompensated care amount (see instructions) actor 3 (see instructions) ospital uncompensated care payment (If line 34 is zero,	0	October 1	October 1	
35. 00 To 35. 01 Fac 35. 02 Ho en 35. 03 Pro ama 36. 00 To 35. Added 40. 00 To	otal uncompensated care amount (see instructions) actor 3 (see instructions) ospital uncompensated care payment (If line 34 is zero,	0			
35. 00 To 35. 01 Fac 35. 02 Ho en 35. 03 Pro ama 36. 00 To 35. Added 40. 00 To	otal uncompensated care amount (see instructions) actor 3 (see instructions) ospital uncompensated care payment (If line 34 is zero,	J	1. 00	2.00	
35. 00 To 35. 01 Fac 35. 02 Ho en 35. 03 Pro ama 36. 00 To 35. Added 40. 00 To	otal uncompensated care amount (see instructions) actor 3 (see instructions) ospital uncompensated care payment (If line 34 is zero,				
35. 01 Fac 35. 02 Hos en' 35. 03 Pro amo 36. 00 To 35. Add 40. 00 To exc	actor 3 (see instructions) ospital uncompensated care payment (If line 34 is zero,		Ol	0	35. 00
35. 02 Hosen and a second and a	ospital uncompensated care payment (If line 34 is zero,		0. 000000000	0. 000000000	35. 01
35. 03 Pro amo 36. 00 To 35. Add 40. 00 To exc			731, 549	608, 096	35. 02
35. 03 Pro amo 36. 00 To 35. Add 40. 00 To exc	nter zero on this line) (see instructions)		,		
36. 00 To- 35. Add 40. 00 To- exc	ro rata share of the hospital uncompensated care payment		547, 158	152, 855	35. 03
40. 00 To exc	nount (see instructions)				l
40. 00 To	otal uncompensated care (sum of columns 1 and 2 on line		700, 013		36. 00
40. 00 To	5. 03)				I
exc	lditional payment for high percentage of ESRD beneficiary di	ischarges (lines 40 through			l
	otal Medicare discharges on Worksheet S-3, Part I		0		40. 00
68:	ccl udi ng di scharges for MS-DRGs 652, 682, 683, 684 and				l
44 00 T-	35 (see instructions)		0		41 00
	otal ESRD Medicare discharges excluding MS-DRGs 652,		U		41.00
	32, 683, 684 an 685. (see instructions) otal ESRD Medicare covered and paid discharges excluding		0		41. 01
	S-DRGs 652, 682, 683, 684 an 685. (see instructions)		J		41.01
	vide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
	ualify for adjustment)				1
	otal Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
683	32, 683, 684 an 685. (see instructions)				l
44. 00 Ra	atio of average length of stay to one week (line 43		0.000000		44. 00
	vided by line 41 divided by 7 days)				1
	verage weekly cost for dialysis treatments (see		0. 00		45. 00
	nstructions)				
	otal additional payment (line 45 times line 44 times line		O		46. 00
	1.01)		14 054 440		47.00
	ubtotal (see instructions)		16, 854, 469		47. 00 48. 00
	ospital specific payments (to be completed by SCH and DH, small rural hospitals only.(see instructions)		٥		48.00
	otal payment for inpatient operating costs (see		16, 854, 469		49. 00
	nstructions)		10, 054, 407		17.00
	ayment for inpatient program capital (from Wkst. L, Pt. I		1, 361, 544		50.00
	nd Pt. II, as applicable)		.,,		1
	cception payment for inpatient program capital (Wkst. L,		0		51.00
Pt.	t. III, see instructions)				l
52. 00 Di i	rect graduate medical education payment (from Wkst. E-4,		0		52. 00
	ne 49 see instructions).				
	ursing and Allied Health Managed Care payment		0		53.00
	pecial add-on payments for new technologies		0		54.00
	et organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		O		55. 00
1	ne 69)				F/ 00
	ost of physicians' services in a teaching hospital (see Intructions)		٥		56. 00
	butine service other pass through costs (from Wkst. D,		0		57.00
	t. III, column 9, lines 30 through 35).				37.00
	ncillary service other pass through costs from Wkst. D,		0		58. 00
	t. IV, col. 11 line 200)				1
	otal (sum of amounts on lines 49 through 58)		18, 216, 013		59. 00
	rimary payer payments		29, 596		60.00
	otal amount payable for program beneficiaries (line 59		18, 186, 417		61.00
	nus line 60)				
	eductibles billed to program beneficiaries		1, 936, 648		62.00
	pinsurance billed to program beneficiaries		8, 820		63.00
	lowable bad debts (see instructions)		185, 721		64.00
, ,	djusted reimbursable bad debts (see instructions)		120, 719		65.00
	lowable bad debts for dual eligible beneficiaries (see		16, 712		66. 00
	nstructions)		16 261 770		67.00
	ubtotal (line 61 plus line 65 minus lines 62 and 63) redits received from manufacturers for replaced devices		16, 361, 668		67. 00 68. 00
	or applicable to MS-DRGs (see instructions)		٩		00. UU
	utlier payments reconciliation (sum of lines 93, 95 and		n		69. 00
	b). (For SCH see instructions)		٩		1 55
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
	JRAL DEMONSTRATION PROJECT		o		70. 50
70. 89 Pi	oneer ACO demonstration payment adjustment amount (see		0		70. 89
1	nstructions)				ı
	SP bonus payment HVBP adjustment amount (see		0		70. 90
	nstructions)				l
	SP bonus payment HRR adjustment amount (see instructions)		0		70. 91
1	undled Model 1 discount amount (see instructions)		0		70. 92
	/BP payment adjustment amount (see instructions)		41, 319		70. 93
	RR adjustment amount (see instructions)		-13, 295		70. 94
70. 95   Red	ecovery of accelerated depreciation		ا		70. 95

Heal th	Financial Systems HENDRICKS REG	ΕΙ ΟΝΔΙ	ΗΕΔΙ ΤΗ	In Li	eu of Form CMS-	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150005	Peri od: From 01/01/201! To 12/31/201!	Worksheet E Part A	pared:
			Title XVIII	Hospi tal	PPS	
				Prior to	On/After	
				October 1	October 1	
			0	1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)			0	D	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)			0	D	70. 97
70. 98	Low Volume Payment-3				ol	70. 98
70. 99	HAC adjustment amount (see instructions)					70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			16, 389, 69	2	71. 00
71. 01	Sequestration adjustment (see instructions)			327, 79	4	71. 01
72.00	Interim payments			15, 924, 47	9	72. 00
73.00	Tentative settlement (for contractor use only)				ol	73. 00
74. 00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			137, 41	9	74. 00
75. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			348, 76	9	75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			<u>'</u>		
90. 00	, ,					90. 00
91.00	Capital outlier from Wkst. L, Pt. I, line 2					91. 00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)					92. 00
93. 00	Capital outlier reconciliation adjustment amount (see					93. 00
	instructions)					
94. 00	The rate used to calculate the time value of money (see instructions)			0.0		94. 00
95. 00	Time value of money for operating expenses (see instructions)					95. 00
96. 00	Time value of money for capital related expenses (see linstructions)					96. 00
	THISTI WOTI OHS)			Prior to 10/1	On/After 10/1	
				1 00	2.00	

2.00

0.0000000000 101.00

0 100. 00

0 102. 00

0. 0000 103. 00 0 104. 00

1.00

0.0000000000

0.0000

0

HSP Bonus Payment Amount

100.00 HSP bonus amount (see instructions)

HVBP Adjustment for HSP Bonus Payment

101.00 HVBP adjustment factor (see instructions)
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)
HRR Adjustment for HSP Bonus Payment

103.00 HRR adjustment factor (see instructions)
104.00 HRR adjustment amount for HSP bonus payment (see instructions)

Provi der CCN: 150005

				Ti +I	e XVIII	Hospi tal	5/26/2016 11: PPS	23 am
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01	through 4)	
1. 00	DRG amounts other than outlier	0 1. 00	1.00	2. 00	3. 00	4. 00	5. 00 0	1. 00
1.00	payments	1.00	Ĭ	Ŭ	0			1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	11, 385, 494	0	11, 385, 494	0	11, 385, 494	1. 01
4 00	occurring prior to October 1	4.00	4 054 545		0	4 054 545	4 054 545	4 00
1. 02	DRG amounts other than outlier payments for discharges	1. 02	4, 354, 545	0	0	4, 354, 545	4, 354, 545	1. 02
	occurring on or after October							
1. 03	DRG for Federal specific	1. 03	0	0	0	0	0	1. 03
1.03	operating payment for Model 4	1.05		J	0	0		1.03
	BPCI occurring prior to							
1. 04	October 1 DRG for Federal specific	1. 04	0	0	0	0	0	1. 04
1.01	operating payment for Model 4	1.01	J	Ü	0	9		1.01
	BPCI occurring on or after							
2. 00	October 1 Outlier payments for	2. 00	266, 067	0	171, 643	94, 424	266, 067	2. 00
2.00	discharges (see instructions)	2.00	200,007	J	171,043	77, 727	200,007	2.00
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
3.00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0	0	0	0	3.00
0.00	reconciliation	2.01	Ĭ	Ŭ	9	J		0.00
4.00	Managed care simulated	3. 00	0	0	0	0	0	4. 00
	payments Indirect Medical Education Adju	ustment						
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
	A, line 21 (see instructions)		_	_	_	_	_	
6. 00	IME payment adjustment (see instructions)	22. 00	0	O	0	O	0	6. 00
6. 01	IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see							
	instructions) Indirect Medical Education Adju	stment for the	Add-on for Se	ction 422 of t	he MMA			l
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
0.00	(see instructions)	20.00	0	0	0			0.00
8. 00	IME adjustment (see instructions)	28. 00	U	U	U	U	0	8. 00
8. 01	IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
	for managed care (see							
9. 00	instructions) Total IME payment (sum of	29. 00	0	0	0	0	0	9.00
	lines 6 and 8)							
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	0	0	0	9. 01
	8. 01)							
40.00	Disproportionate Share Adjustme				0.0077			
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0377	0. 0377	0. 0377	0. 0377		10. 00
	instructions)							
11. 00	Disproportionate share adjustment (see instructions)	34.00	148, 350	0	107, 308	41, 042	148, 350	11. 00
11. 01	Uncompensated care payments	36.00	700, 013	0	547, 158	152, 855	700, 013	11. 01
	Additional payment for high per	rcentage of ESF			,			
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	16, 854, 469	0	12, 211, 603	4, 642, 866	16, 854, 469	13.00
14.00	Hospital specific payments	48. 00	0	0	0	0	0	14. 00
	(completed by SCH and MDH, small rural hospitals only.)							
	(see instructions)							
15. 00	Total payment for inpatient	49. 00	16, 854, 469	0	12, 211, 603	4, 642, 866	16, 854, 469	15. 00
	operating costs (see instructions)							
16. 00	Payment for inpatient program	50.00	1, 361, 544	0	981, 109	380, 435	1, 361, 544	16. 00
	capi tal							
17. 00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17. 00
17. 01	Net organ aquisition cost	55.00	o	o	0	o	0	17. 01
17. 02	Credits received from	68. 00	O	o	0	O	0	
	manufacturers for replaced							
18. 00	devices for applicable MS-DRGs Capital outlier reconciliation		0	0	0	0	0	18. 00
	adjustment amount (see							
	instructions)						<u> </u>	

						o 12/31/2015	Date/Time Pre 5/26/2016 11:	
				Ti tl	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01		
		0	1.00	2. 00	3. 00	4. 00	5. 00	
19. 00	SUBTOTAL			0	13, 192, 712	5, 023, 301	18, 216, 013	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	1, 259, 889	0	910, 693	349, 197	1, 259, 890	
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	C	0	0	20. 01
	than outlier							
	Capital DRG outlier payments	2. 00	57, 685	0	57, 685	19, 051	76, 736	1
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	C	0	0	21. 01
	outlier payments							
22. 00		5. 00	0. 0000	0. 0000	0.0000	0.0000		22. 00
	percentage (see instructions)		_	_	_	_	_	
23. 00	Indirect medical education	6. 00	0	0	0	0	0	23. 00
	adjustment (see instructions)	40.00	0.0040					
24.00	Allowable disproportionate	10. 00	0. 0349	0. 0349	0. 0349	0. 0349		24. 00
	share percentage (see							
05.00	instructions)	44.00	40.070		04 700	40 407	40.070	05.00
25. 00	Di sproporti onate share	11. 00	43, 970	0	31, 783	12, 187	43, 970	25. 00
27.00	adjustment (see instructions) Total prospective capital	12. 00	1 2/1 5/4	0	001 100	200 425	1 2/1 5/4	24 00
26. 00		12.00	1, 361, 544	U	981, 109	380, 435	1, 361, 544	26.00
	payments (see instructions)	W/S E, Part A	(Amounto to F					
		line	Part A)					
		0	1. 00	2.00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor	U	1.00	2.00	0.000000		3.00	27. 00
28. 00	Low volume adjustment ractor	70. 96			0.000000	0.00000	0	
20.00	(transfer amount to Wkst. E,	70. 70					0	20.00
	Pt. A, line)							
29. 00	1	70. 97				0	0	29. 00
27.00	(transfer amount to Wkst. E,	70.77						27.00
	Pt. A, line)							
100.00	Transfer low volume		Υ					100.00
	adjustments to Wkst. E, Pt. A.		,					
	1	l .	1	ı	1	T.	1	1

 
 Heal th Financial
 Systems
 HENDRICKS REGI

 HOSPITAL
 ACQUIRED
 CONDITION (HAC)
 REDUCTION CALCULATION EXHIBIT 5
 | Peri od: | Worksheet E | From 01/01/2015 | Part A Exhi bit 5 | Date/Ti me Prepared: 5/26/2016 11: 23 am Provi der CCN: 150005

						5/26/2016 11:	23 am_
			Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. E, Pt.	Amt. from	Period to		Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
			A)				
		0	1. 00	2. 00	3. 00	4. 00	
1.00	DRG amounts other than outlier payments	1. 00					1.00
1. 01	DRG amounts other than outlier payments for	1. 01	11, 385, 494	11, 385, 494		11, 385, 494	1. 01
	discharges occurring prior to October 1						
1. 02	DRG amounts other than outlier payments for	1. 02	4, 354, 545		4, 354, 545	4, 354, 545	1. 02
	discharges occurring on or after October 1						
1.03	DRG for Federal specific operating payment	1. 03	0	0		0	1. 03
	for Model 4 BPCI occurring prior to October						
4 04	7	4.04					4 04
1.04	DRG for Federal specific operating payment	1. 04	0		0	0	1. 04
	for Model 4 BPCI occurring on or after						
0.00	October 1	0.00	0// 0/7	474 (40	04.404	0// 0/7	0.00
2.00	Outlier payments for discharges (see	2. 00	266, 067	171, 643	94, 424	266, 067	2. 00
2 01	instructions)	2.02			0	0	2 01
2. 01	Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
3. 00	BPCI	2. 01	0		0	0	3. 00
4. 00	Operating outlier reconciliation	3.00		0	0	0	4. 00
4.00	Managed care simulated payments Indirect Medical Education Adjustment	3.00	1 0	U	U	U	4.00
5. 00	Amount from Worksheet E, Part A, Line 21	21, 00	0.000000	0.000000	0. 000000		5. 00
5.00	(see instructions)	21.00	0.00000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0		0	o o	6. 01
0.01	instructions)	22.01		J	O	O	0. 01
	Indirect Medical Education Adjustment for the	Add-on for Se	ection 422 of t	he MMA			
7.00	IME payment adjustment factor (see	27. 00	0. 000000		0. 000000		7. 00
	instructions)						
8.00	IME adjustment (see instructions)	28. 00	0	0	0	0	8.00
8. 01	IME payment adjustment add on for managed	28. 01	0	0	0	0	8. 01
	care (see instructions)						
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01	0	0	0	0	9. 01
	lines 6.01 and 8.01)						
	Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage	33.00	0. 0377	0. 0377	0. 0377		10.00
	(see instructions)						
11. 00	Di sproporti onate share adjustment (see	34.00	148, 350	107, 308	41, 042	148, 350	11. 00
44.04	instructions)	0/ 00	700 040	547.450	450.055	700 040	44 04
11. 01	Uncompensated care payments	36.00	700, 013	547, 158	152, 855	700, 013	11. 01
12. 00	Additional payment for high percentage of ESF Total ESRD additional payment (see	46. 00	0 o	0	0	0	12. 00
12.00	instructions)	46.00	0	U	U	U	12.00
13. 00	Subtotal (see instructions)	47. 00	16, 854, 469	12, 211, 603	4, 642, 866	16, 854, 469	13. 00
14. 00	Hospital specific payments (completed by SCH	48. 00	10, 034, 407	12, 211, 003	4, 042, 000	10, 034, 407	14. 00
14.00	and MDH, small rural hospitals only.) (see	46.00		U	U	U	14.00
	instructions)						
15. 00	Total payment for inpatient operating costs	49. 00	16, 854, 469	12, 211, 603	4, 642, 866	16, 854, 469	15. 00
13.00	(see instructions)	47.00	10, 034, 409	12, 211, 003	4, 042, 000	10, 054, 407	13.00
16. 00	Payment for inpatient program capital	50.00	1, 361, 544	1, 000, 160	361, 384	1, 361, 544	16. 00
17. 00	Special add-on payments for new technologies	54.00	1, 301, 344	., 555, 166 n	0.7, 004	1, 301, 344	17. 00
17. 00	Net organ aguisition cost	55. 00	0	ا	0	Ö	17. 01
17. 01	Credits received from manufacturers for	68. 00	0	· ·	0	0	17. 01
17.02	replaced devices for applicable MS-DRGs	33.00			O		17.02
18. 00	Capital outlier reconciliation adjustment	93. 00	0	n	n	0	18. 00
	amount (see instructions)				Ĭ		
19. 00	SUBTOTAL			13, 211, 763	5, 004, 250	18, 216, 013	19.00
	•	•	•				

Health Financial Systems	HENDRICKS REGIONAL HEALTH				In Lieu of Form CMS-2552-10			
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5		Provi der		Period: From 01/01/2015 Fo 12/31/2015	Worksheet E Part A Exhibi Date/Time Pre 5/26/2016 11:	pared:	
			Ti tl	e XVIII	Hospi tal	PPS		
	Wkst. L, line	,	t. from st. L)					
	0		1. 00	2.00	3. 00	4. 00		
20.00 Capital DRG other than outlier	1.00		1, 259, 889	910, 69	2 349, 197	1, 259, 889	20.00	
20 01 Madel 4 DDCI Carital DDC athera there and its	1 01	i	_				20 01	

			Ti tl	e XVIII	Hospi tal	PPS	20 4
		Wkst. L, line	(Amt. from				
			Wkst. L)				
	T	0	1. 00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	1, 259, 889	910, 692	349, 197	1, 259, 889	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	
21. 00	Capital DRG outlier payments	2. 00	57, 685	57, 685	0	57, 685	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0. 0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0349	0. 0349	0. 0349		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	43, 970	31, 783	12, 187	43, 970	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	1, 361, 544	1, 000, 160	361, 384	1, 361, 544	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	0	0		0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	41, 319	19, 157	22, 162	41, 319	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-13, 295	-10, 247	-3, 048	-13, 295	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	0	0	31. 01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99		0	0	0	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	HENDRICKS REGIONAL HEALT	_TH	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi		From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/26/2016 11: 23 am
		T' 11 \0.0111		DDC

			10 12,01,2010	5/26/2016 11:	23 am
		Title XVIII	Hospi tal	PPS	
				1.00	
	DART R. MEDICAL AND OTHER HEALTH CERVICORS			1. 00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			10 011	1 00
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructi	one)		12, 211 25, 600, 270	1. 00 2. 00
3.00	PPS payments		15, 767, 207	3.00	
4. 00	Outlier payment (see instructions)		334, 140	4.00	
5. 00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0.000	5.00
6. 00	Line 2 times line 5	1 013)		0.000	6.00
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8. 00	Transitional corridor payment (see instructions)			0.00	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	v. col. 13. line 200		0	9. 00
10. 00	Organ acqui si ti ons	,,		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			12, 211	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES			,	
	Reasonabl e charges				
12.00	Ancillary service charges			30, 622	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	ie 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			30, 622	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	payment for services o	n a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18. 00	Total customary charges (see instructions)			30, 622	1
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	18, 411	19. 00
00.00	instructions)		40) (		00.00
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	TIT TIME IT exceeds IT	ne 18) (See	0	20. 00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		12, 211	21. 00
22. 00	Interns and residents (see instructions)	Thistructions)		12, 211	22.00
23. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	10113)		16, 101, 347	24.00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			10, 101, 347	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH. see instructions)		3, 395, 671	•
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl		and 231 (see	12, 717, 887	
	instructions)		] (	1_,,	
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	ie 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			12, 717, 887	30.00
31.00	Primary payer payments			5, 346	31. 00
32. 00	Subtotal (line 30 minus line 31)			12, 712, 541	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00	Allowable bad debts (see instructions)			468, 959	
35. 00	Adjusted reimbursable bad debts (see instructions)			304, 823	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ıcti ons)		160, 476	
37. 00	Subtotal (see instructions)			13, 017, 364	
	MSP-LCC reconciliation amount from PS&R			-137	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	ed devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			13, 017, 501	40.00
40. 01	Sequestration adjustment (see instructions)			260, 350	40. 01
41. 00	Interim payments			12, 636, 465	•
42.00	Tentative settlement (for contractors use only)			120 (0)	42.00
43.00	Balance due provider/program (see instructions)	o with CMS Dub 1E 2	abanton 1	120, 686	•
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS PUB. 15-2,	cnapter I,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91.00	,			0	90.00
91.00	The rate used to calculate the Time Value of Money			0.00	•
	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			1	94. 00
, 4. 00	1.05a. (Sum of 111105 /1 drid /0)			, 0	, , , , , , ,

Peri od: Worksheet E-1
From 01/01/2015 Part I
To 12/31/2015 Date/Ti me Prepared: 5/26/2016 11: 23 am Provi der CCN: 150005

					5/26/2016 11: 2	23 am
			e XVIII	Hospi tal	PPS	
		Inpatien	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		15, 847, 708		12, 447, 658	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,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2015	32, 771	12/31/2015	137, 607	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER	07/31/2015	44, 000		51, 200	3. 02
3. 03		0770172010	11,000		01,200	3. 03
3. 04			Ö		l o	3. 04
3. 05			Ö		l ol	3. 05
	Provider to Program		_		_	
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		76, 771		188, 807	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		15, 924, 479		12, 636, 465	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,					3. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		137, 419		120, 686	6. 01
6. 02	SETTLEMENT TO PROGRAM		137, 417		120, 000	6. 02
7. 00	Total Medicare program liability (see instructions)		16, 061, 898		12, 757, 151	7. 00
	, , , , , , , , , , , , , , , , , , , ,		, , . , . , .	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
						8. 00

Health Financial Systems	HENDRICKS REGIONAL	HEALTH		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CC	N: 150005	Peri od: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2016 11:23 am

			10 12/31/2015	5/26/2016 11:	
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		1, 126, 178		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1, 126, 178	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1, 126, 178	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		751, 999		8. 00
9.00	Ancillary service charges		1, 443, 689	0	
10. 00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0	_	11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		2, 195, 688	0	12. 00
40.00	CUSTOMARY CHARGES	<del>.</del>			40.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14. 00	basis	normant for compless on	0	0	14. 00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42		٩	Ü	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	CIR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		2, 195, 688	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	1, 069, 510	0	
17.00	line 4) (see instructions)	TT TTTE TO EXCECUS	1,007,010	· ·	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	o	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		o	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16	)	1, 126, 178	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provid	ers.		
22. 00	Other than outlier payments		0	0	
	Outlier payments		0	0	
24. 00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		1 12/ 170	0	
29.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		1, 126, 178	0	29. 00
30. 00	Excess of reasonable cost (from line 18)		O	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1, 126, 178	0	31.00
32. 00	Deductibles		1, 120, 176	0	
33. 00	Coinsurance			0	33.00
	Allowable bad debts (see instructions)			0	34. 00
35. 00	Utilization review			O	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	1, 126, 178	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
	Subtotal (line 36 ± line 37)		1, 126, 178	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0	_	39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		1, 126, 178	0	ı
41. 00	Interim payments		962, 819	0	l
42.00	Balance due provider/program (line 40 minus line 41)		163, 359	0	•
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				

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

Provi der CCN: 150005 | Peri od: From 01/01/2015 | To 12/21/2015

Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 5/26/2016 11: 23 am

					5/26/2016 11:	23 am _
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1.00	2.00	3. 00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2, 530, 068	0	0	0	1. 00
2.00	Temporary investments	318, 764	0	0	0	2. 00
3.00	Notes receivable	0	0	o	0	3. 00
4.00	Accounts receivable	27, 497, 667	0	o	0	4. 00
5.00	Other recei vable	l o	0	ol	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	0	0	ol	0	6. 00
7. 00	Inventory	2, 091, 937	٥	ol	0	7. 00
8. 00	Prepaid expenses	2,071,707	٥	Ö	0	8. 00
9. 00	Other current assets	33, 026, 792	0	0	0	9. 00
10. 00	Due from other funds	5, 229, 192		0	0	10.00
				-		
11. 00	Total current assets (sum of lines 1-10)	70, 694, 420	0	0	0	11. 00
40.00	FI XED ASSETS	4/ 57/ 000		اء		40.00
12. 00	Land	16, 574, 202		0	0	12. 00
13. 00	Land improvements	0	0	0	0	13. 00
14. 00	Accumul ated depreciation	0	0	0	0	14. 00
15. 00	Bui I di ngs	0	0	0	0	15. 00
16.00	Accumul ated depreciation	0	0	0	0	16. 00
17.00	Leasehold improvements	658, 195	0	0	0	17. 00
18. 00	Accumulated depreciation	0	0	0	0	18. 00
19.00	Fi xed equipment	334, 931, 747	0	ol	0	19. 00
20.00	Accumulated depreciation	-154, 653, 678		o	0	20. 00
21. 00	Automobiles and trucks	0	٥	ol	0	21. 00
22. 00	Accumulated depreciation	٥	o o	Ö	0	22. 00
23. 00	Major movable equipment			o	0	23. 00
	Accumulated depreciation	0		ol ol	0	
24. 00	!	0	0	U o		24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	U	0	25. 00
26. 00	Accumul ated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumul ated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	197, 510, 466	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	176, 298, 339	0	0	0	31. 00
32.00	Deposits on Leases	0	0	ol	0	32. 00
33. 00	Due from owners/officers	0	0	o	0	33. 00
34. 00	Other assets	16, 849, 872	0	ol	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	193, 148, 211		Ö	0	35. 00
	1			0	0	36.00
36. 00	Total assets (sum of lines 11, 30, and 35)	461, 353, 097	U	υ	0	30.00
27.00	CURRENT LIABILITIES	7 (20 107		ما		27.00
37. 00	Accounts payable	7, 638, 187		0	0	37. 00
38. 00	Salaries, wages, and fees payable	9, 008, 222	0	0	0	38. 00
39. 00	Payroll taxes payable	0	0	O	0	39. 00
40.00	Notes and Loans payable (short term)	0	0	0	0	40. 00
41.00	Deferred income	0	0	0	0	41. 00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	949, 937		0	0	43.00
44.00	Other current liabilities	17, 317, 226	0	o	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	34, 913, 572		o	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	Ö		ol	0	
48. 00	Unsecured Loans	٥	ő	ő	0	
49. 00	Other long term liabilities	102, 964, 391		o	0	49. 00
	Total long term liabilities (sum of lines 46 thru 49	102, 964, 391		o	0	50.00
50.00	,			-		
51. 00	Total liabilites (sum of lines 45 and 50)	137, 877, 963	0	0	0	51. 00
	CAPI TAL ACCOUNTS		ı			
52. 00	General fund balance	323, 475, 134				52. 00
53. 00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			o		56. 00
57.00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	replacement, and expansion				Ü	
59. 00	Total fund balances (sum of lines 52 thru 58)	323, 475, 134	0	o	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	461, 353, 097		ol	0	
	59)		]	Ĭ	Ü	
		•		'		

STATEMENT OF CHANGES IN FUND BALANCES

Provi der CCN: 150005

Peri od: Worksheet G-1 From 01/01/2015

12/31/2015 Date/Time Prepared: 5/26/2016 11:23 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 313, 752, 176 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 9, 722, 958 2.00 3.00 Total (sum of line 1 and line 2) 323, 475, 134 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 5.00 0 0 0 0 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 323, 475, 134 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 323, 475, 134 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 0 11.00 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 0 19.00 Fund balance at end of period per balance 19.00 sheet (line 11 minus line 18)

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150005

			0 12/31/2015	5/26/2016 11:	pared: 23 am
	Cost Center Description	Inpati ent	Outpati ent	Total	25 4111
		1.00	2.00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>	<u> </u>		
	General Inpatient Routine Services				
1.00	Hospi tal	27, 393, 43		27, 393, 439	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	27, 393, 439		27, 393, 439	
	Intensive Care Type Inpatient Hospital Services		<u>'</u>		
11. 00	INTENSIVE CARE UNIT	6, 445, 26	5	6, 445, 266	11. 00
12.00	CORONARY CARE UNIT				12. 00
13.00	BURN INTENSIVE CARE UNIT				13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	6, 445, 26		6, 445, 266	
	11-15)	3,, ===		27 7 = 2 2	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	33, 838, 70	5	33, 838, 705	17. 00
18. 00	Ancillary services	85, 543, 578		361, 350, 838	
19. 00	Outpati ent servi ces	10, 030, 81		91, 541, 006	19. 00
20. 00	RURAL HEALTH CLINIC	1 ' '	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		o	0	21. 00
22. 00	HOME HEALTH AGENCY			_	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGI CAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26. 00
27. 00	PHYSICIAN OFFICES AND PROFESSIONAL F	9, 023, 67	59, 842, 372	68, 866, 044	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	138, 436, 76		555, 596, 593	
	G-3, line 1)		, , , , , ,		
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		234, 203, 828		29. 00
30.00	ADD (SPECIFY)				30. 00
31.00					31.00
32.00					32.00
33.00					33.00
34.00					34.00
35.00					35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)				37.00
38.00					38. 00
39.00					39. 00
40.00					40.00
41.00					41.00
42.00	Total deductions (sum of lines 37-41)		o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	er	234, 203, 828		43.00
	to Wkst. G-3, line 4)				
				· ·	

Heal th	Financial Systems HENDRICKS REGIONAL	. HEALTH	In Lie	u of Form CMS-2	2552-10
STATE	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 150005   Period:				
			From 01/01/2015 To 12/31/2015	Date/Time Pre 5/26/2016 11:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			555, 596, 593	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			320, 232, 280	2. 00
3.00	Net patient revenues (line 1 minus line 2)			235, 364, 313	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	)		234, 203, 828	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			1, 160, 485	5. 00
	OTHER I NCOME			1 000 500	, 00
6.00	Contributions, donations, bequests, etc			1, 990, 590	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	ervi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00				0	10.00
11.00				0	11. 00
12.00				0	12.00
	Revenue from laundry and linen service			0	13.00
	Revenue from meals sold to employees and guests			0	14. 00
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical supplies to other tha	n patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17. 00
	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	Rental of vending machines			0	21. 00
22. 00				0	22. 00
23. 00	The state of the s			0	23. 00
	MI SCELLANEOUS REVENUE			6, 571, 883	
	Total other income (sum of lines 6-24)			8, 562, 473	
	Total (line 5 plus line 25)			9, 722, 958	
	OTHER EXPENSES (SPECIFY)			0	27. 00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)		l	9, 722, 958	29. 00

Heal th	Financial Systems HENDRICKS REGIONA	AL HEALTH	In Lie	eu of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 150005	Peri od:	Worksheet L	
			From 01/01/2015 To 12/31/2015		nared:
			10 12/31/2013	5/26/2016 11:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			1, 259, 889	1. 00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			57, 685	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3. 00 4. 00	Total inpatient days divided by number of days in the cost repu	orting period (see inst	ructions)	51. 39 0. 00	1
4. 00 5. 00	Number of interns & residents (see instructions) Indirect medical education percentage (see instructions)			0.00	1
6. 00	Indirect medical education percentage (see instructions)	sum of lines 1 and 1 01	columns 1 and	0.00	1
0.00	1.01) (see instructions)	Sum of Triles I and I. of	, corumns r and	Ĭ	0.00
7.00	Percentage of SSI recipient patient days to Medicare Part A pa	tient days (Worksheet E	, part A line	1. 52	7. 00
	30) (see instructions)		•		
8. 00	Percentage of Medicaid patient days to total days (see instruc	tions)		15. 44	
9.00	Sum of lines 7 and 8			16. 96	
10.00	Allowable disproportionate share percentage (see instructions)	3. 49			
11. 00 12. 00	Disproportionate share adjustment (see instructions) Total prospective capital payments (see instructions)	43, 970 1, 361, 544	1		
12.00	Total prospective capital payments (see Thistructions)			1, 301, 344	12.00
				1. 00	
1 00	PART II - PAYMENT UNDER REASONABLE COST				1 00
1. 00 2. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (see Instructions)				
4. 00	Capital cost payment factor (see instructions)			o o	
5. 00	Total inpatient program capital cost (line 3 x line 4)			Ö	1
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
1.00	Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs for extraordinary circumstances	s (see instructions)		Ö	
3.00	Net program inpatient capital costs (line 1 minus line 2)	,		0	
4.00	Applicable exception percentage (see instructions)			0.00	4. 00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	
6.00	Percentage adjustment for extraordinary circumstances (see ins			0.00	
7. 00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 x	: line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)	11.5		0	1
9. 00 10. 00	Current year capital payments (from Part I, line 12, as application Current year comparison of capital minimum payment level to capital minimum payment level minimum		Loca Lino O)	0	
11. 00	Carryover of accumulated capital minimum payment level over ca				
11.00	Worksheet L, Part III, line 14)	pritar payment (from pri	or year		11.00
12.00	Net comparison of capital minimum payment level to capital pay			0	
13. 00	Current year exception payment (if line 12 is positive, enter			0	13. 00
14. 00	Carryover of accumulated capital minimum payment level over cap	pital payment for the f	ollowing period	0	14. 00
15. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see inst	ructions)		0	15. 00
16. 00		i de ti diis)		0	
	Current year exception offset amount (see instructions)			Ö	
	· · · · · · · · · · · · · · · · · · ·			'	•