payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050

EXPLES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0005 | Period: | Worksheet S | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared:

					7/21/2020 4:	
PART I - COST	REPORT STATUS					
Provi der	1. [ X ] Electronically prepared cost	report		Date: 7/21/20	20 Time:	4: 19 pi
use only	2. [ ] Manually prepared cost repor	t				
	3. [ 0 ] If this is an amended report 4. [ F ] Medicare Utilization. Enter			submitted this co	ost report	
Contractor use only	5. [ 1 ] Cost Report Status (1) As Submitted 7. Control (2) Settled without Audit 8. [ N ] (3) Settled with Audit (4) Reopened (5) Amended	ractor No.	ovider CCN 12. [	PR Date: ontractor's Vendo O ]If line 5, co number of tim	lumn 1 is 4:	

## PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HENDRICKS REGIONAL HEALTH (15-0005) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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.

[ X ]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) DENNIS RESSLER

Officer or Administrator of Provider(s)

SENIOR VP OF FINANCE/CFO

Title

(Dated when report is electronically signed.)

Date

			Title XVIII				
Cost Center Description		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-239, 541	88, 324	0	1, 397, 582	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
7.00	SKILLED NURSING FACILITY	0	o	0		0	7. 00
200.00	Total	0	-239, 541	88, 324	0	1, 397, 582	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 Provider CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 7/21/2020 4:19 pm 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)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 HENDRICKS REGIONAL 150005 26900 07/01/1966 Ν 0 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 8.00 Swing Beds - NF 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 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2019 12/31/2019 20.00 9 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate 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 §412.106(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 22.01 Υ Υ 22.01 cost reporting 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)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N Ν Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. 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 el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e 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 554 745 0 24.00 2.446 0 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. Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 7/21/2020 4:19 pm In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days eligible days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 25.00 If this provider is an IRF, enter the in-state 25, 00  $\cap$ 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. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the 26. 00 cost reporting period. Enter "1" for urban or "2" for rural. Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37 01 37 01 instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 | Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 'N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν Ν 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 N Ν 48.00 Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA Ν 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 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 month of this cost reporting period? Enter for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 Ν defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, 59.00 Pt. NAHE 413.85 Worksheet A Pass-Through Y/N Line # Oual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 7/21/2020 4:19 pm Y/N IME Direct GME IME Direct GME 3. 00 1. 00 2.00 4.00 5.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0 00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61 04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA \$5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 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. Enter in column 4, the direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 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 62.01 0.00 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 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00 Ν Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs in FTEs 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 0.00 0.00 0.000000 64.00

in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider

settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

In Lieu of Form CMS-2552-10 Health Financial Systems HENDRICKS REGIONAL HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Worksheet S-2 Provider CCN: 15-0005 Peri od: From 01/01/2019 To 12/31/2019 Part I Date/Time Prepared: 7/21/2020 4:19 pm Ratio (col. 3/ Program Name Program Code Unwei ghted Unwei ghted FTĔs FTEs in (col. 3 + col. Hospi tal 4)) Nonprovi der Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col. Nonprovi der Hospi tal 2)) Si te 1.00

		Section 5504 of the ACA Current Year FIE Residents in Nonprovider SettingsEffective for cost reporting periods								
		beginning on or after July 1, 20	010				- '			
	66.00	Enter in column 1 the number of	unweighted non-primar	ry care resident	0.00	0. 00	0. 000000	66.00		
		FTEs attributable to rotations o	occurring in all nonpr	ovider settings.						
		Enter in column 2 the number of	unweighted non-primar	y care resident						
		FTEs that trained in your hospit								
		(column 1 divided by (column 1 +	column 2)). (see ins	structi ons)						
Ī			Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/			
					FTEs	FTEsin	(col. 3 + col.			
					Nonprovi der	Hospi tal	4))			
					Si te					
			1. 00	2.00	3. 00	4. 00	5. 00			
	67.00	Enter in column 1, the program			0.00	0. 00	0. 000000	67.00		
		name associated with each of								
		your primary care programs in								

			0			
	1. 00	2.00	3. 00	4.00	5. 00	
67.00 Enter in column 1, the program			0.00	0. 00	0. 000000	67.00
name associated with each of						
your primary care programs in						
which you trained residents.						
Enter in column 2, the program						
code. Enter in column 3, the						
number of unweighted primary						
care FTE residents attributable						
to rotations occurring in all						
non-provider settings. Enter in						
column 4, the number of						
unweighted primary care						
resident FTEs that trained in						
your hospital. Enter in column						
5, the ratio of (column 3						
divided by (column 3 + column						
4)). (see instructions)						

		1. 00	2. 00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider?	N			70.00
	Enter "Y" for yes or "N" for no.				
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most	N	N	0	71. 00
	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see				
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching				
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
	Column 3: If column 2 is Y, indicate which program year began during this cost reporting period.				
	(see instructions)				
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	N			75. 00
	subprovider? Enter "Y" for yes and "N" for no.				
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most	N	N	0	76. 00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for				
	no. Column 2: Did this facility train residents in a new teaching program in accordance with 42				
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for ves or "N" for no. Column 3: If column 2 is Y.			1	

indicate which program year began during this cost reporting period. (see instructions)

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0005	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Pro 7/21/2020 4:	epared:		
				1.00	+		
Long Term Care Hospital PPS							
.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes .00 Is this a LTCH co-located within another hospital for part c "Y" for yes and "N" for no.  TEFRA Providers			g period? Enter	N N	80. 00 81. 00		
.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) .00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00		
.00 Is this hospital an extended neoplastic disease care hospita	ıl classified	under section		N	87. 00		
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	XI X			
E			1. 00	2. 00			
Title V and XIX Services  .00 Does this facility have title V and/or XIX inpatient hospita	ıl services? E	nter "Y" for	N	Υ	90.00		
yes or "N" for no in the applicable column.  .00 Is this hospital reimbursed for title V and/or XIX through t	he cost repor	t either in	N	Υ	91. 00		
full or in part? Enter "Y" for yes or "N" for no in the appl .00 Are title XIX NF patients occupying title XVIII SNF beds (du	icable column	l.		N	92.00		
instructions) Enter "Y" for yes or "N" for no in the applica	ble column.	, ,					
.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.			N	N	93.00		
.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N	N	94.0		
.00 Does title V or XIX reduce operating cost? Enter "Y" for yes	applicable column.						
.00 $ lf $ line 96 is "Y", enter the reduction percentage in the app			0.00	0.00	97. 0		
.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f	Y	Y	98. 0				
column 1 for title V, and in column 2 for title XIX.  On Does title V or XIX follow Medicare (title XVIII) for the reconstruction of the column 1 for title XVIII for the reconstruction of the column 1 for title XVIII for the column 1 for title XVIII for the column 1 for title XIX.		Y	98. 0				
title XIX.  .02 Does title V or XIX follow Medicare (title XVIII) for the calbed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of			Y	Y	98. 0		
for title V, and in column 2 for title XIX.  1.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for years.				N	98. 03		
for title V, and in column 2 for title XIX.  Od Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			N	N	98. 0		
in column 2 for title XIX.  .05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				Y	98. 0		
column 2 for title XIX.  .06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98. 00		
Rural Providers							
5.00 Does this hospital qualify as a CAH? 6.00 If this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of paymen	t N		105. 00		
for outpatient services? (see instructions) 7.00 Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column			N		107. 0		
Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IP Enter "Y" for yes or "N" for no in column 2. (see instructi	you train I&R PF and/or IRF	s in an					
8.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche				108. 0		
	Physi cal 1.00	0ccupationa 2.00	Speech 3.00	Respiratory 4.00	+		
9.00 on 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	109. 0		
		·	•				
0.00 Did this hospital participate in the Rural Community Hospita	ıl Demonstrati	on project (§	410A	1.00 N	110.00		
Demonstration) for the current cost reporting period? Enter "							

Health Financial Systems HENDRICKS REGIONAL HEALTI	1	In Lie	eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provide	r CCN: 15-0005	Peri od: From 01/01/2019	Worksheet S- Part I	-2
		To 12/31/2019	Date/Time Pr	
			7/21/2020 4:	19 pm
		1. 00	2.00	
111.00  f this facility qualifies as a CAH, did it participate in the Frontie   Health Integration Project (FCHIP) demonstration for this cost reporti   "Y" for yes or "N" for no in column 1. If the response to column 1 is   integration prong of the FCHIP demo in which this CAH is participating   Enter all that apply: "A" for Ambulance services; "B" for additional b   for tele-health services.	ng period? Enter Y, enter the in column 2.	N N		111. 00
	1.00	2.00	3.00	_
112.00 Did this hospital participate in the Pennsylvania Rural Health Model	1.00 N	2.00	3.00	112. 00
demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", ente in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information	r			
115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for n	o N			0115.00
in column 1. If column 1 is yes, enter the method used (A, B, or E onlin column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based of the definition in CMS Pub. 15-1, chapter 22, §2208.1.	y)			
116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116. 00
117.00  S this facility legally-required to carry malpractice insurance? Ente	r Y			117. 00
118.00 s the malpractice insurance a claims-made or occurrence policy? Enter if the policy is claim-made. Enter 2 if the policy is occurrence.	1	1		118. 00
IT the portey is craim-made. Litter 2 if the portey is occurrence.	Premi ums	Losses	Insurance	
	1. 00	2. 00	3.00	_
118.01 List amounts of malpractice premiums and paid losses:	888, 7	08 (	D	0 118. 01
		1. 00	2.00	$\dashv$
118.02 Are malpractice premiums and paid losses reported in a cost center oth Administrative and General? If yes, submit supporting schedule listin and amounts contained therein.		N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies fo Hold Harmless provision in ACA §3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no.	"Y" for yes or r the Outpatient		N	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no.	ices charged to	Y		121. 00
122.00 Does the cost report contain healthcare related taxes as defined in §1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", e			5. 00	122. 00
the Worksheet A line number where these taxes are included.  Transplant Center Information				
125.00 Does this facility operate a transplant center? Enter "Y" for yes and	"N" for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the ce	rtification date	,		126. 00
in column 1 and termination date, if applicable, in column 2.				
127.00 If this is a Medicare certified heart transplant center, enter the cer in column 1 and termination date, if applicable, in column 2.	tification date			127. 00
128.00 If this is a Medicare certified liver transplant center, enter the cer in column 1 and termination date, if applicable, in column 2.	tification date			128. 00
129.00 If this is a Medicare certified lung transplant center, enter the cert column 1 and termination date, if applicable, in column 2.	ification date i	n		129. 00
130.00 If this is a Medicare certified pancreas transplant center, enter the	certi fi cati on			130. 00
· · · · · · · · · · · · · · · · · · ·				131. 00
date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter th	e certification			
date in column 1 and termination date, if applicable, in column 2.  131.00 If this is a Medicare certified intestinal transplant center, enter the date in column 1 and termination date, if applicable, in column 2.  132.00 If this is a Medicare certified islet transplant center, enter the certified islet transplant center.				132. 00
date in column 1 and termination date, if applicable, in column 2.  131.00 If this is a Medicare certified intestinal transplant center, enter the date in column 1 and termination date, if applicable, in column 2.  132.00 If this is a Medicare certified islet transplant center, enter the certin column 1 and termination date, if applicable, in column 2.  133.00 Removed and reserved  134.00 If this is an organ procurement organization (0P0), enter the 0P0 numb	tification date			132. 00 133. 00 134. 00
date in column 1 and termination date, if applicable, in column 2.  131.00 If this is a Medicare certified intestinal transplant center, enter th date in column 1 and termination date, if applicable, in column 2.  132.00 If this is a Medicare certified islet transplant center, enter the cer in column 1 and termination date, if applicable, in column 2.  133.00 Removed and reserved	tification date er in column 1	N		133. 00

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0005 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: To 12/31/2019 7/21/2020 4:19 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143. 00 Ci ty: 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 γ 1. 00 2.00 145.00|If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01

	Financial Systems HENDRICKS REGINDURGE HENDRICKS REGINDURG REGINDURG HENDRICKS REGINDURG REGINDURG HENDRICKS REGINDURG RE	Provi der C	CN: 15-0005	Peri od:	u of Form CMS- Worksheet S-2	
,		l	1	From 01/01/2019 To 12/31/2019	Part II	
				_	7/21/2020 4:	
				Y/N	Date	
	0	1 C 11 NO		1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	itor all NO re	sponses. Enter	all dates in 1	ne	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
	Has the provider changed ownership immediately prior to the	beainnina of	the cost	N		1
_	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions)			
		,	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
	Has the provider terminated participation in the Medicare F		N			2
	yes, enter in column 2 the date of termination and in colum	n 3, "V" for				
	voluntary or "I" for involuntary.					
	Is the provider involved in business transactions, includir		N			3
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provice					
	officers, medical staff, management personnel, or members o					
	of directors through ownership, control, or family and other	er similar				
	relationships? (see instructions)		V//NI	Tuno	Data	
			1.00	7ype 2. 00	3. 00	+
Ti	Financial Data and Reports		1.00	2.00	3.00	+
	Column 1: Were the financial statements prepared by a Cert	ified Public	Υ	A	05/12/2020	<b>-</b> 4
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f		'	^	03/12/2020	7
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.	in tubic in				
	Are the cost report total expenses and total revenues diffe	erent from	l N			5
	those on the filed financial statements? If yes, submit rec					~
				Y/N	Legal Oper.	
				1. 00	2.00	
,	Approved Educational Activities			<u>'</u>		
) c	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	N		7 6
	the Legal operator of the program?					
0	Are costs claimed for Allied Health Programs? If "Y" see ir	nstructions.		N		7
0	Were nursing school and/or allied health programs approved	and/or renewed	l during the	N		8
	cost reporting period? If yes, see instructions.					
	Are costs claimed for Interns and Residents in an approved		al education	N		9
	program in the current cost report? If yes, see instruction					
	Was an approved Intern and Resident GME program initiated o	or renewed in t	the current	N		10
	cost reporting period? If yes, see instructions.					١.,
	Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11
	Teaching Program on Worksheet A? If yes, see instructions.				V /N	
					Y/N 1. 00	
П	Bad Debts				1.00	_
	Is the provider seeking reimbursement for bad debts? If yes	see instruct	ions		Υ	12
	If line 12 is yes, did the provider's bad debt collection p			st renorting	N.	13
	period? If yes, submit copy.	orrey change c	idi i iig tiii 3 co.	st reporting		'
	If line 12 is yes, were patient deductibles and/or co-payme	nts waived? If	ves see ins	tructions	N	14
	Bed Complement	into war vou. 11	yes, see 1115	tr do tr ons.		┨ ``
	Did total beds available change from the prior cost reporti	na period? If	ves. see insti	ructions.	Υ	15
	<u> </u>		t A		t B	
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data			<u>"</u>		
00	Was the cost report prepared using the PS&R Report only?	Υ	03/06/2020	Υ	03/06/2020	16
	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					
- 1	instructions)					
00	Was the cost report prepared using the PS&R Report for	N		N		17
	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)					
	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
			1	N		19
00	If line 16 or 17 is yes, were adjustments made to PS&R	N		IN		17
00		N		IN .		17

Heal th	Financial Systems HENDRICKS REG	IONAL HEALTH		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 15-0005	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Pre 7/21/2020 4:1	pared:
		Descri	pti on	Y/N	Y/N	) p
		C		1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
		Y/N 1.00	Date 2.00	Y/N 3. 00	Date	
21. 00	Was the cost report prepared only using the provider's	N N	2.00	N N	4. 00	21. 00
	records? If yes, see instructions.					
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)			_
22.00	Capital Related Cost	T	NI NI	22.00		
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost	N N	22. 00
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	porting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	yes, submit	N	27. 00		
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit er	reporting	N	28. 00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	eserve Fund)	N	29. 00		
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	, see	N	30. 00		
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new (	debt? If yes	, see	N	31.00
32. 00	Purchased Services  Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		d through co	ntractual	N	32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.		g to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement with	provi der-ba	sed physicians?	N	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ts with the	provi der-based	N	35. 00
				Y/N	Date	
	Hama Offi as Costs			1. 00	2. 00	
36. 00	Home Office Costs Were home office costs claimed on the cost report?			N		36 00
	If line 36 is yes, has a home office cost statement been pr	repared by the I	home office?			36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00
39. 00	If line 36 is yes, did the provider render services to other see instructions.			, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
		1.0	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,	MI CHAEL		ALESSANDRI NI		41. 00
42. 00		BLUE & CO., LLG	С			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317. 713. 7959		MALESSANDRI NI @E	BLUEANDCO. COM	43. 00

Heal th	Financial Systems HENDRICKS RE	EGI ONA	L HEALTH	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0005		riod: om 01/01/2019 12/31/2019	Worksheet S- Part II Date/Time Pr 7/21/2020 4:	epared:
			2.00				
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	DI RE	ECTOR				41. 00
	held by the cost report preparer in columns 1, 2, and 3,						
	respectively.						
42.00	Enter the employer/company name of the cost report						42. 00
	preparer.						
43.00	Enter the telephone number and email address of the cost						43.00
	report preparer in columns 1 and 2, respectively.						

| Period: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0005

				To	12/31/2019	Date/Time Prep 7/21/2020 4:19	
						I/P Days / 0/P	<i>y</i> p
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	121	44, 165	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3. 00	HMO I PF Subprovi der						3. 00
4.00	HMO IRF Subprovider					_	4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		121	44, 165	0. 00	0	7. 00
0.00	beds) (see instructions)	21 00	1.0	4 200	0.00	0	0.00
8.00	INTENSIVE CARE UNIT	31. 00	12	4, 380	0. 00	U	8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						11. 00 12. 00
12.00	NURSERY	43. 00				0	12.00
14. 00	Total (see instructions)	43.00	133	48, 545	0.00	0	14. 00
15. 00	CAH visits		133	40, 545	0.00	0	15. 00
16. 00	SUBPROVIDER - IPF					U	16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	44. 00	C	o		0	19. 00
20.00	NURSING FACILITY	44.00		)		O	20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		133	3			27. 00
28.00	Observation Bed Days					0	28. 00
29.00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		C	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01

Provider CCN: 15-0005

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3	
From 01/01/2019	Part	
To 12/31/2019	Date/Time Prepared:	7/21/2020 4:19 pm

						7/21/2020 4:1	9 pm
		I/P Days	o/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	6, 755	532	16, 877			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	2, 145	3, 010				2. 00
3.00	HMO IPF Subprovider	2, 143	3,010				3.00
4. 00	HMO IRF Subprovider		0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	o o	Ö	0	,		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	Ĭ	Ö	Ö			6. 00
7. 00	Total Adults and Peds. (exclude observation	6, 755	532	16, 877			7. 00
	beds) (see instructions)	3,.55					
8.00	INTENSIVE CARE UNIT	1, 137	О	2, 371			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		0	2, 887			13. 00
14. 00	Total (see instructions)	7, 892	532	22, 135		1, 752. 38	14. 00
15. 00	CAH visits	0	0	C			15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18. 00	SUBPROVI DER				0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	C	0.00	0.00	1
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE						20. 00 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)			41			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	o	C	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	1, 752. 38	27. 00
28. 00	Observation Bed Days		o	3, 500	)		28. 00
29. 00	Ambul ance Tri ps	o					29. 00
30.00	Employee discount days (see instruction)			C	)		30.00
31. 00	Employee discount days - IRF			C			31. 00
32.00	Labor & delivery days (see instructions)	0	203	575			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
	outpatient days (see instructions)						l
	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01

Provider CCN: 15-0005

				-	To 12/31/2019	Date/Time Prep 7/21/2020 4:19	
		Full Time Equivalents		Di sc	harges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13.00	14.00	15. 00	
1. 00 2. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)		C	) 2, 19 <sup>2</sup> 53!		6, 154	2. 00
3. 00 4. 00 5. 00 6. 00 7. 00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)				0		3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00 18. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER	0.00	C	) 2, 19 <sup>-</sup>	1 124	6, 154	14. 00 15. 00 16. 00 17. 00 18. 00
19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0.00					19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00 0. 00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and discharges			1			33. 00 33. 01

| Period: | Worksheet S-3 | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0005

Wash   A limit   New York   A limit   New York   New						To	12/31/2019		
PARK   11 - 986E DATA   1.00								Average Hourly	7 DIII
Mail			Number	Reported					
Main						V		COI. 3)	
MAMPIES   MAMP		DADT II WACE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
Instructions   1.0									
Mon-physic clan anestherit st Part	1.00		200. 00	151, 043, 524	. 0	151, 043, 524	3, 644, 941. 00	41. 44	1. 00
3. 00 Non-physician anesthotist Pert	2. 00	,		0		o	0.00	0.00	2. 00
8		Α		_					
Admin Istrative 4. 01 Physicians - Part A - Teaching 7. 00 Physicians - Part B for Nospitul - State British	3.00	Non-physician anesthetist Part  B		O		0	0.00	0.00	3.00
Hospic clams - Part A - Toaching	4.00	,		945, 705	o c	945, 705	5, 837. 00	162. 02	4. 00
5.00   Physic cian Part B for   10,311,820   0   10,311,820   68,628 00   150.26   5.00   15	4. 01			0		0	0.00	0.00	4. 01
Non-physician-Part B for hospital-based RIC and FURC services   1.00   0   0   0   0   0   0   0   0   0		Physician and Non		10, 311, 820	O	10, 311, 820			1
hospital - based RIKC and FORC   Services	6 00			0		0	0.00	0.00	6.00
7.00   Interens & residents (in an approved program) approved program)   0   0   0   0   0   0   0   0   0	0.00	hospital-based RHC and FQHC		, and the second			0.00	0.00	
approved program) 7. 01 Contracted interns and residents (in an approved program) 8. 00 Home office and/or related on the program of the prog	7 00		21 00	0		0	0.00	0.00	7 00
residents (in an approved programs)		approved program)		_					
Programs	7. 01			0	O	0	0.00	0.00	7. 01
Organization personnel		programs)							
9.00   SVÉ	8.00			O		0	0.00	0.00	8.00
Instructions   OTHER MAGES & RELATED COSTS		SNF	44. 00	0	0	0			ł
DTHER WAGES & RELATED COSTS	10. 00			53, 284, 869	359, 157	53, 644, 026	970, 717. 00	55. 26	10.00
Care   Contract Labor: Top Level   0   0   0   0   0   0   0   0   0		OTHER WAGES & RELATED COSTS	'		1				
12.00   Contract Labor: Top level management and other management and other management and administrative services   13.00   Contract Labor: Physician-Part   750,626   0 750,626   4,455.00   168.49   13.00   14.00   14.00   14.00   14.00   15.00   16.0	11. 00			704, 560	0	704, 560	12, 376. 00	56. 93	11. 00
management and administrative   services	12. 00	Contract Labor: Top Level		0	0	0	0.00	0. 00	12. 00
Services   Services   A - Administrative   A - Ad									
A - Administrative		servi ces			_				
14. 00   Home office and/or related or organization sall aries and wage-related costs   0   0   0   0   0   0   0   0   0	13. 00			750, 626	O	750, 626	4, 455. 00	168. 49	13.00
Wage-related costs	14. 00	Home office and/or related		0	0	0	0.00	0. 00	14. 00
14. 01   Home office salaries   0   0   0   0   0.00   0.00   14. 01     14. 02   Related organization salaries   0   0   0   0   0.00   0.00   14. 01     15. 00   Home office: Physician Part A   0   0   0   0   0.00   0.00   15. 00     16. 00   Home office and Contract   0   0   0   0   0   0.00   0.00   16. 00     16. 01   Home office contract   0   0   0   0   0   0.00   0.00   16. 01     16. 02   Home office contract   0   0   0   0   0   0.00   0.00   16. 01     16. 02   Home office contract   0   0   0   0   0   0.00   0.00   16. 01     17. 00   Wage-related costs (core)   (see instructions)   18. 00   0   0   0   0   0   0   0     18. 00   Wage-related costs (other)   (see instructions)   19. 00   Excluded areas   11, 201, 314   0   11, 201, 314   19. 00   20. 00     19. 00   Excluded areas   11, 201, 314   0   11, 201, 314   0   20. 00     20. 00   Non-physician anesthetist Part   0   0   0   0   0     20. 00   Physician Part A -   112, 441   0   112, 441   22. 00     20. 00   Physician Part A -   112, 441   0   112, 441   22. 00     20. 01   Physician Part A -   112, 441   0   112, 441   22. 00     20. 02   10   Physician Part A -   12, 441   0   12, 441   22. 00     20. 02   10   Physician Part A -   12, 441   0   12, 441   22. 00     20. 03   12, 20   23. 00   24. 00   25. 00     20. 04   25. 50   25. 50     20. 05   Related costs (RHC/FOHC)   0   0   0   0     20. 05   25. 50   Related organization   25. 50     20. 25. 50   Home office: Physician Part A   0   0   0   0     25. 50   Home office: Physician Part A   0   0   0     25. 50   Home office: Physician Part A   0   0   0     25. 50   Home office: Physician Part A   0   0   0     25. 50   Home office: Physician Part A   0   0     25. 50   Home office: Physician Part A   0   0   0     25. 50   Home office: Physician Part A   0   0   0     25. 50   Home office: Physician Part A   0   0   0     25. 50   Home office: Physician Part A   0   0   0     26. 50   Home office: Physician Part A   0   0   0     27. 50   Home office: Physician Part A   0									
15.00   Home office: Physician Part A   0   0   0   0   0.00   0.00   15.00		Home office salaries		0	0	0			
- Administrative Home office and Contract Physicians Part A - Teaching 16.01 Home office Physicians Part A 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0		0			
Physicians Part A - Teaching   Home office Physicians Part A   Teaching   Home office Physicians Part A   Teaching   Home office contract   Depty of the physicians Part A - Teaching   Home office contract   Depty of the physicians Part A - Teaching   Home office contract   Depty of the physicians Part A - Teaching   Home office contract   Depty of the physicians Part A - Teaching   Depty of the physicians Part A - Teaching   Depty of the physicians Part A		- Administrative		_					
16. 01 Home office Physicians Part A - Teaching 16. 02 Home office contract	16. 00			O		0	0.00	0.00	16.00
Home office contract   0   0   0   0   0   0   0   0   0	16. 01	Home office Physicians Part A		0	0	0	0.00	0. 00	16. 01
Physici ans Part A - Teaching	16. 02			0		0	0.00	0.00	16. 02
17. 00   Wage-rel ated costs (core) (see instructions)   17. 00   instructions)   18. 00   Wage-rel ated costs (other) (see instructions)   18. 00   Wage-rel ated costs (other) (see instructions)   18. 00   11. 201, 314   19. 00   11. 201, 314   19. 00		Physicians Part A - Teaching							
18.00   Wage-rel ated costs (other)   (see instructions)   18.00   (see instructions)   19.00   Excluded areas   11,201,314   0   11,201,314   19.00   20.00   Non-physician anesthetist Part   0   0   0   0   0   21.00   0   0   0   0   0   0   0   0   0	17. 00			25. 798. 223		25, 798, 223			17. 00
19.00     Excl uded areas     11, 201, 314     0     11, 201, 314     19.00       20.00     Non-physician anesthetist Part A     0     0     0     0     20.00       21.00     Non-physician anesthetist Part B     0     0     0     0     0     21.00       22.00     Physician Part A - Administrative     112, 441     0     112, 441     22.00       23.00     Physician Part A - Teaching     0     0     0     22.01       23.00     Physician Part B     1, 276, 708     0     1, 276, 708     23.00       24.00     Wage-related costs (RHC/FQHC)     0     0     0     24.00       25.00     Interns & residents (in an approved program)     0     0     0     25.00       25.50     Home office wage-related (core)     0     0     0     0     25.50       25.51     Related organization wage-related (core)     0     0     0     0     25.52       4. Administrative -     0     0     0     0     0     0		instructions)							
20.00   Non-physician anesthetist Part	18.00								18.00
A Non-physician anesthetist Part B				11, 201, 314	0	11, 201, 314			
B	20.00	A		O					20.00
Administrative  22.01 Physician Part A - Teaching  23.00 Physician Part B  24.00 Wage-related costs (RHC/FQHC)  25.00 Interns & residents (in an approved program)  25.50 Home office wage-related  (core)  25.51 Related organization  wage-related (core)  40.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 01 Physician Part A - Teaching 23. 00 Physician Part B 23. 00 Wage-related costs (RHC/FQHC) 25. 00 Interns & residents (in an approved program) 25. 50 Home office wage-related (core) 25. 51 Related organization wage-related (core) 25. 52 Home office: Physician Part A 26. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00	3		112, 441	o d	112, 441			22. 00
23. 00 Physician Part B	22 01			0		0			22 01
25. 00 Interns & residents (in an approved program)  25. 50 Home office wage-related (core)  25. 51 Related organization wage-related (core)  25. 52 Home office: Physician Part A - Administrative - 25. 52		, ,		1, 276, 708	1	_			23. 00
approved program)  25. 50   Home office wage-related   0   0   0   25. 50    25. 51   Related organization   0   0   0    25. 52   Home office: Physician Part A   0   0   0    25. 52   Administrative -   25. 52				0		0			
(core) Related organization wage-related (core) Home office: Physician Part A - Administrative -	23.00	approved program)		Ö					23.00
25. 51 Related organization 0 0 0 0 25. 51 wage-related (core) 0 0 0 0 25. 52 Home office: Physician Part A 0 0 0 0 25. 52 - Administrative -	25. 50			0	0	0			25. 50
25.52 Home office: Physician Part A 0 0 0 25.52 - Administrative -	25. 51	Related organization		0	C	О			25. 51
- Admi ni strati ve -	25. 52			n	0	n			25. 52
wage-related (core)		- Administrative -		J					
		wage-rerated (core)	I		I	l l		ı	I

Provider CCN: 15-0005

					Ť	o 12/31/2019		
				5 1 161 11		5 1 1 11	7/21/2020 4: 1	
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col . 2 ± col .	Salaries in	col. 5)	
		1.00	2.00	A-6)	3) 4.00	col . 4 5.00	/ 00	
25. 53	Hama affi as. Dhyai ai ana Dant A	1. 00	2.00	3.00	4.00	5.00	6. 00	25. 53
25. 53	Home office: Physicians Part A - Teaching - wage-related		U	U	0			25. 53
	(core)							
	OVERHEAD COSTS - DIRECT SALARII	<u> </u>						
26. 00	Employee Benefits Department	4.00	3, 981, 850	-1, 293, 981	2, 687, 869	61, 446. 00	43. 74	26. 00
27. 00	Administrative & General	5. 00	13, 027, 091	114, 477		i i		
28. 00	Administrative & General under	0.00	2, 744, 999		2, 744, 999			
	contract (see inst.)		_, ,	_	_, ,	.,		
29.00	Maintenance & Repairs	6. 00	0	0	0	0.00	0. 00	29. 00
30.00	Operation of Plant	7. 00	2, 860, 266	25, 167	2, 885, 433	107, 656. 00	26. 80	30. 00
31.00	Laundry & Linen Service	8. 00	417, 061	3, 670	420, 731	25, 121. 00	16. 75	31. 00
32.00	Housekeepi ng	9. 00	2, 847, 917	25, 059	2, 872, 976	159, 487. 00	18. 01	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	2, 109, 885	-1, 421, 773	688, 112	37, 377. 00	18. 41	34.00
35.00	Di etary under contract (see		0	0	0	0.00	0. 00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	1, 440, 338	1, 440, 338	69, 151. 00	20. 83	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38. 00	Nursing Administration	13. 00	4, 043, 153	35, 575	4, 078, 728	92, 771. 00	43. 97	38. 00
39. 00	Central Services and Supply	14. 00	1, 117, 284	9, 831	1, 127, 115	39, 135. 00	28. 80	39. 00
40.00	Pharmacy	15. 00	2, 534, 978	22, 305	2, 557, 283	58, 729. 00	43. 54	40.00
41.00	Medical Records & Medical	16. 00	654, 025	115, 594	769, 619	33, 801. 00	22. 77	41.00
	Records Library							
42.00	Social Service	17. 00	1, 944, 361	17, 108	1, 961, 469			42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0. 00	43.00

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part III | To 12/31/2019 | Date/Time Prepared: | Part III | Par

					''	0 12/31/2019	7/21/2020 4: 19	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	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		143, 476, 703	0	143, 476, 703	3, 611, 057. 00	39. 73	1.00
	instructions)							
2.00	Excluded area salaries (see		53, 284, 869	359, 157	53, 644, 026	970, 717. 00	55. 26	2.00
	instructions)							
3.00	Subtotal salaries (line 1		90, 191, 834	-359, 157	89, 832, 677	2, 640, 340. 00	34. 02	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 455, 186	0	1, 455, 186	16, 831. 00	86. 46	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		25, 910, 664	- 0	25, 910, 664	0.00	28. 84	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		117, 557, 684	-359, 157	117, 198, 527	2, 657, 171. 00	44. 11	6. 00
7.00	Total overhead cost (see		38, 282, 870	-906, 630	37, 376, 240	1, 150, 488. 00	32. 49	7.00
	instructions)							

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0005	Period: Worksheet S-3
		From 01/01/2019   Part IV

	To 12/31/2019	Date/lime Prep   7/21/2020 4:1	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	6, 582, 600	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1, 296, 958	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	18, 913, 825	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
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)	160, 061	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)	445, 126	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	1, 081, 780	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)		
	TAXES		
	FICA-Employers Portion Only	9, 530, 142	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unemployment Insurance	32, 970	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER THE PLANT OF		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
22.00	instructions))	0	22.00
22. 00	Day Care Cost and Allowances Tuition Reimbursement	0	22. 00 23. 00
23. 00		345, 223	
24. UÜ	Total Wage Related cost (Sum of lines 1 -23)	38, 388, 685	24. 00
25 00	Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)		25 00
Z5. UU	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0005	Peri od: Worksheet S-3 From 01/01/2019 Part V To 12/31/2019 Date/Time Prepared:

		10 12/31/2019	7/21/2020 4:1	
	Cost Center Description	Contract Labor		7 DIII
	5551 53.15. 53551 P. 15.1	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 - (0ther)	0	0	5. 00
6. 00	Swing Beds - SNF	0	0	6. 00
7. 00	Swing Beds - NF	0	0	7. 00
8. 00	Hospi tal -Based SNF	0	0	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 Dialysis	0	0	17. 00
18. 00	Other	0	0	18. 00

	Financial Systems HENDRICKS REGIONAL AL UNCOMPENSATED AND INDIGENT CARE DATA P	rovider CCN: 15-0005		wof Form CMS-2 Worksheet S-1	
103F1 17	AL UNCOMPENSATED AND INDIGENT CARE DATA	OVI del CCN. 13-0003	From 01/01/2019		U
			To 12/31/2019	Date/Time Pre 7/21/2020 4:1	pared: 9 pm
				1. 00	
	Uncompensated and indigent care cost computation			1.00	
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by line 202 col	umn 8)	0. 292545	1.0
	Medicaid (see instructions for each line)				
2. 00	Net revenue from Medicaid			846, 157	
	Did you receive DSH or supplemental payments from Medicaid?			Y	3.0
	If line 3 is yes, does line 2 include all DSH and/or supplementa If line 4 is no, then enter DSH and/or supplemental payments from		i cai d?	Y	4. 0 5. 0
5. 00	Medicaid charges	iii wedi cai u		60, 904, 784	
7. 00	Medicaid cost (line 1 times line 6)			17, 817, 390	
	Difference between net revenue and costs for Medicaid program (I	ine 7 minus sum of	lines 2 and 5; if	16, 971, 233	
	< zero then enter zero)				
	Children's Health Insurance Program (CHIP) (see instructions for	each line)			
	Net revenue from stand-alone CHIP			0	
	Stand-allone CHIP charges			0	
	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (I	ina 11 minus lina 0	: if < zero then	0	
12.00	enter zero)	THE IT IIITIUS TITIE 9	, II < Zero tileli		12.0
	Other state or local government indigent care program (see instr	uctions for each li	ne)		1
	Net revenue from state or local indigent care program (Not inclu			0	13.0
4. 00	Charges for patients covered under state or local indigent care	program (Not includ	ed in lines 6 or	0	14.0
	10)			_	
	State or local indigent care program cost (line 1 times line 14)			0	
16. 00	Difference between net revenue and costs for state or local indi 13; if < zero then enter zero)	gent care program (	line is minus line	0	16. 0
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/local in	di gent care prograr	ns (see	
	instructions for each line)				
	Private grants, donations, or endowment income restricted to fun Government grants, appropriations or transfers for support of ho			0 1 0	
	Total unreimbursed cost for Medicaid , CHIP and state and local		ams (sum of lines	16, 971, 233	
. ,, 00	8, 12 and 16)	. Har gont our o prog.	amo (5 <b>a</b> m 61 111166	10, 7, 1, 200	.,,,,
		Uni nsure	ed Insured	Total (col. 1	
		pati ent		+ col . 2)	
	Uncompensated Care (see instructions for each line)	1.00	2. 00	3. 00	
20. 00	Charity care charges and uninsured discounts for the entire faci	lity 11,686	, 253 3, 300, 985	14, 987, 238	20.00
.0. 00	(see instructions)	11,000	7 200	1 1, 707, 200	20.0
21. 00	Cost of patients approved for charity care and uninsured discoun	ts (see 3, 418	, 755 3, 300, 985	6, 719, 740	21.0
	instructions)				
22. 00	Payments received from patients for amounts previously written o	ff as	0 0	0	22. 0
23. 00	charity care Cost of charity care (line 21 minus line 22)	3, 418	, 755 3, 300, 985	6, 719, 740	23 0
23.00	cost of charity care (fine 21 minus fine 22)	] 3,410	, 733 3, 300, 703	0, 717, 740	23.00
				1. 00	
24. 00	Does the amount on line 20 column 2, include charges for patient		th of stay limit	N	24. 00
25. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the		ram's length of	0	25. 0
26. 00	stay limit Total bad debt expense for the entire hospital complex (see inst	ructions)		21, 119, 569	26. 0
26. 00 27. 00	Medicare reimbursable bad debts for the entire hospital complex			254, 279	
27. 01	Medicare allowable bad debts for the entire hospital complex (se			391, 199	
28. 00	Non-Medicare bad debt expense (see instructions)			20, 728, 370	
		nco (coo instructio	ne)	6, 200, 901	
	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	nse (see mistructio	113)	0, 200, 901	29.0
29. 00 30. 00	Cost of non-medicare and non-reimbursable medicare bad debt expe Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus lin	•	113)	12, 920, 641 29, 891, 874	30. 0

Health Financial Systems	HENDRICKS REGIO	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der Co		eri od:	Worksheet A	
				rom 01/01/2019 o 12/31/2019	Date/Time Pre	narod:
			'	o 12/31/2019	7/21/2020 4:1	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
·			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1 00			4 00	col . 4)	
CENEDAL CEDALCE COCT CENTEDS	1. 00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS  1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT		25, 801, 328	25, 801, 328	sl ol	25, 801, 328	1.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT	3, 981, 850	28, 224, 339			30, 776, 639	4.00
5. 00   00500   ADMINISTRATIVE & GENERAL	13, 027, 091	59, 005, 453			71, 951, 168	5.00
7. 00   00700   OPERATION OF PLANT	2, 860, 266	8, 688, 890			11, 567, 150	7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE	417, 061	377, 662			832, 077	8.00
9. 00   00900   HOUSEKEEPI NG	2, 847, 917	781, 020	1		3, 652, 672	9. 00
10. 00   01000 DI ETARY	2, 109, 885	1, 606, 654		1	1, 207, 531	
11. 00   01100   CAFETERI A	0	0	l	1	2, 527, 573	11. 00
13.00 01300 NURSING ADMINISTRATION	4, 043, 153	920, 409	4, 963, 562		4, 997, 461	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	1, 117, 284	849, 505	1, 966, 789	-27, 804	1, 938, 985	14. 00
15. 00   01500   PHARMACY	2, 534, 978	9, 578, 630			2, 436, 369	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	654, 025	891, 977			1, 742, 895	16. 00
17.00 01700 SOCIAL SERVICE	1, 944, 361	286, 814	2, 231, 175	31, 246	2, 262, 421	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00   03000   ADULTS & PEDI ATRI CS	17, 481, 865	2, 929, 838			15, 186, 030	30.00
31. 00   03100   NTENSI VE CARE UNIT	2, 143, 875	665, 347			2, 758, 869	31.00
43. 00   04300   NURSERY	0	-31, 501	1		1, 207, 329	43.00
44.00 O4400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	U <sub>1</sub>	0	1	) U	0	44. 00
50. 00 05000 OPERATING ROOM	2, 695, 795	10, 570, 671	13, 266, 466	-3, 795, 093	9, 471, 373	50.00
50. 01   05001   ENDOSCOPY	1, 056, 393	520, 463			1, 419, 871	50. 01
51. 00   05100 RECOVERY ROOM	1, 466, 015	296, 206			1, 765, 998	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	-339	-74, 297			3, 858, 442	52.00
53. 00   05300   ANESTHESI OLOGY	5, 865, 975	806, 356	6, 672, 331	-4, 964	6, 667, 367	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 256, 021	2, 702, 663	8, 958, 684	-299, 133	8, 659, 551	54.00
54. 01   05401   RADI ATI ON-ONCOLOGY	1, 341, 311	23, 388, 526	24, 729, 837	150, 006	24, 879, 843	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	) C	1 1	0	56. 00
56. 01   05601   NUCLEAR   MEDICINE	210, 618	177, 953			385, 007	56. 01
59. 00   05900   CARDI AC   CATHETERI ZATI ON	573, 379	1, 333, 070			885, 488	59. 00
60. 00   06000   LABORATORY	3, 231, 544	5, 648, 413			8, 931, 182	60.00
64. 00 06400 I NTRAVENOUS THERAPY	949, 710	252, 082	1		1, 390, 562	64.00
65. 00 06500 RESPI RATORY THERAPY	2, 584, 912	673, 241			3, 196, 053	
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	6, 077, 950	2, 396, 401	1		8, 443, 948	66. 00 67. 00
68. 00   06800   SPEECH PATHOLOGY	530, 496 294, 880	90, 770 31, 827	1		618, 218 329, 116	
69. 00   06900   ELECTROCARDI OLOGY	917, 357	268, 951	1		1, 159, 464	1
69. 01   06901   CARDI AC   REHAB	635, 678	79, 634			717, 466	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	138, 975	13, 983			154, 181	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	O	0		8, 477, 517	8, 477, 517	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	ol c	9, 892, 690	9, 892, 690	73. 00
73.01 07301 ULTRA SOUND	613, 166	79, 917	693, 083	-4, 648	688, 435	73. 01
74. 00 07400 RENAL DIALYSIS	122	301, 893	302, 015	-1, 544	300, 471	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	1, 707, 579	4, 726, 802			6, 016, 677	90.00
91. 00 09100 EMERGENCY	5, 447, 507	2, 383, 537	7, 831, 044	-76, 691	7, 754, 353	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	97, 758, 655	197, 245, 427	295, 004, 082	1, 905, 688	296, 909, 770	118 00
NONREI MBURSABLE COST CENTERS	77, 700, 000	177,210,127	270,001,002	1, 700, 000	270, 707, 110	1110.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	45, 405, 333	19, 358, 884	64, 764, 217	-1, 932, 439	62, 831, 778	192. 00
192.01 19201 HEALTH TRACKS	3, 211, 735	853, 788	4, 065, 523	5, 692	4, 071, 215	192. 01
194.00 07950 PRIMARY CARE CLINIC	967, 050	1, 358, 344	2, 325, 394	2, 130	2, 327, 524	
194. 01 07951 PARTNERS IN CARE	0	3, 186				194. 01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	288, 819	644, 064		1	932, 288	
194. 03 07953 FOUNDATION	165, 436	21, 097	1		187, 989	
194. 04 07954 SCHOOL & TOWN CLINICS	1, 527, 505	696, 780			2, 237, 080	
194. 05 07955  MANAGED   FACILITY 194. 06 07956  RENTAL   PROPERTIES	331, 705 0	308, 455 138, 143			643, 079 138, 143	
194.06 07956 RENTAL PROPERTIES 194.07 07957 SNF NON CERTIFIED	1, 387, 286	204, 301			1, 593, 941	
200.00 TOTAL (SUM OF LINES 118 through 199)	151, 043, 524	220, 832, 469			371, 875, 993	
	, ,	223, 002, 407	3.1,070,770	· · · · · · · · · · · · · · · · · · ·	5.1,575,775	1=55.50

Heal th FinancialSystemsHENDRICKSRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Peri od: Worksheet A From 01/01/2019 Date/Time Prepared: 7/21/2020 4:19 pm Provider CCN: 15-0005

				7/21/2020 4:1	
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8)	For Allocation	1	
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-173, 111	25, 628, 217	1	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-362, 576		1	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-22, 521, 716	49, 429, 452	1	5. 00
7. 00	00700 OPERATION OF PLANT	-319, 361	11, 247, 789	1	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	832, 077	1	8. 00
9.00	00900 HOUSEKEEPI NG	-129	3, 652, 543	1	9.00
10.00	01000 DI ETARY	-493, 708	713, 823		10.00
11.00	01100 CAFETERI A	-1, 114, 539	1, 413, 034		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-40, 594	4, 956, 867	l .	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-105, 696			14.00
15. 00	01500 PHARMACY	-29, 387	2, 406, 982		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-357	1, 742, 538		16.00
17. 00	01700 SOCIAL SERVICE	-2, 830	2, 259, 591		17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	-3, 855, 850	11, 330, 180		30.00
31. 00	03100 INTENSIVE CARE UNIT	-3, 655, 650	2, 758, 869	1	31.00
43. 00	04300 NURSERY	0	1, 207, 329	•	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	1, 207, 329	l .	44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS	ı	0	)	44.00
50. 00	05000 OPERATING ROOM	-17, 209	9, 454, 164	1	50.00
50. 00	05001 ENDOSCOPY	0	1, 419, 871		50. 00
51. 00	05100 RECOVERY ROOM	ő	1, 765, 998	l control of the cont	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	Ö	3, 858, 442	•	52.00
53. 00	05300 ANESTHESI OLOGY	-5, 575, 668	1, 091, 699		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-175, 950	8, 483, 601		54.00
54. 01	05401 RADI ATI ON-ONCOLOGY	-80, 772	24, 799, 071		54. 01
56. 00	05600 RADI OI SOTOPE	0	0		56. 00
56. 01	05601 NUCLEAR MEDICINE	0	385, 007	7	56. 01
59.00	05900 CARDI AC CATHETERI ZATI ON	0	885, 488	1	59. 00
60.00	06000 LABORATORY	-86, 134	8, 845, 048	1	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	1, 390, 562		64.00
65.00	06500 RESPI RATORY THERAPY	68, 268	3, 264, 321		65. 00
66.00	06600 PHYSI CAL THERAPY	-527, 230	7, 916, 718	3	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	-41, 613	576, 605	5	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	329, 116		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-50, 442	1, 109, 022	2	69. 00
69. 01	06901 CARDI AC REHAB	0	717, 466		69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	154, 181		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	8, 477, 517	1	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	9, 892, 690		73. 00
73. 01	07301 ULTRA SOUND	-29, 701	658, 734	•	73. 01
74. 00	07400 RENAL DI ALYSI S	0	300, 471		74. 00
	OUTPATIENT SERVICE COST CENTERS				
90. 00	09000 CLI NI C	20, 555	6, 037, 232	•	90.00
	09100 EMERGENCY	-802, 411	6, 951, 942	2	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
	SPECIAL PURPOSE COST CENTERS			J	
118.00	,	-36, 318, 161	260, 591, 609	<u>/ </u>	118. 00
100.00	NONREI MBURSABLE COST CENTERS		(2.021.770		100.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0		1	192. 00
	19201 HEALTH TRACKS	0	4, 071, 215		192. 01 194. 00
	07950 PRIMARY CARE CLINIC 07951 PARTNERS IN CARE	0	2, 327, 524		
		0	3, 186		194. 01
	207952 OCCUPATIONAL MEDICINE		932, 288 187, 989	1	194. 02
	3 07953 FOUNDATION   07954 SCHOOL & TOWN CLINICS	0	•	1	194. 03 194. 04
	07954 SCHOOL & TOWN CLINICS	0	2, 237, 080		194. 04
	0/955 MANAGED FACILITY	0	643, 079 138, 143		194. 05
	707950 RENTAL PROPERTIES	0		1	194. 06
200.00		-36, 318, 161			200. 00
200.00	I TOTAL (SOM OF LINES ITO LITTOUGH 199)	-30, 310, 101	1 333, 337, 632	-1	1200.00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 7/21/2020 4:19 pm Provider CCN: 15-0005

					7/21/2020 4:1	9 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	A - DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	9, 892, 690		1. 00
2.00	I NTRAVENOUS THERAPY	64.00	0	192, 231		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 7. 00	•	0. 00 0. 00	0	0		6. 00 7. 00
8. 00	•	0.00	o	0		8. 00
9. 00		0.00	o	0		9. 00
10. 00		0.00	o	0		10. 00
11. 00		0.00	ő	0		11. 00
12. 00		0.00	o	Ö		12. 00
13. 00		0.00	o	Ö		13. 00
14.00		0.00	O	0		14.00
15. 00		0.00	O	0		15. 00
16.00		0.00	O	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	•	0		23. 00
	U D MOD DI ANT SESTINGS		0	10, 084, 921		
4 00	B - MOB PLANT RECLASS	4 00		F (0F		4 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5, 685		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	58, 635		2.00
3. 00 4. 00	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	7. 00 8. 00	0	9, 360 58, 843		3. 00 4. 00
5. 00	SOCIAL SERVICE	17. 00	0	16, 488		5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	83, 749		6. 00
7. 00	RADI ATI ON-ONCOLOGY	54. 01	0	158, 147		7. 00
8. 00	LABORATORY	60.00	ő	5, 597		8. 00
9. 00	PHYSI CAL THERAPY	66.00	o	21, 566		9. 00
10. 00	OCCUPATI ONAL THERAPY	67. 00	o	21, 566		10. 00
11. 00	CLINIC	90.00	o	177, 382		11. 00
12. 00	PHARMACY	15. 00	O	2, 490		12. 00
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	5, 031		13. 00
				624, 539		
	C - CAFETERIA RECLASS					
1.00	CAFETERI A	11. 00	1, 427, 775	1, 087, 235		1. 00
	0		1, 427, 775	1, 087, 235		
4 00	D - IMPLANTABLE DEVICES	70.00		0 477 547		4 00
1. 00	IMPL. DEV. CHARGED TO	72. 00	0	8, 477, 517		1. 00
2. 00	PATI ENT	0.00	0	0		2. 00
2.00				8, 477, 517		2.00
	F - MEDICAL SUPPLY RECLASS		<u> </u>	57 1777 517		
1.00	OPERATING ROOM	50.00	0	4, 051, 203		1. 00
2.00	LABORATORY	60.00	O	17, 194		2. 00
3.00		0.00	О	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 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
15. 00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	o	0		17. 00
18. 00		0.00	o	o		18. 00
19. 00		0.00	Ö	Ö		19. 00
20. 00		0.00	Ö	Ō		20. 00
21. 00		0.00	O	Ō		21. 00
22. 00		0.00	O	0		22. 00
23.00		0.00	О	0		23. 00
24.00		0.00	0	0		24. 00
25. 00		0. 00	0	0		25. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0005 Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

					To 12/31/2019 Date/lime Pro 7/21/2020 4:1	
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
26. 00		0.00	0	0		26. 00
27. 00 28. 00		0. 00 0. 00	0	0		27. 00 28. 00
29. 00		0.00	0	0		29.00
30.00		0.00	o	0		30.00
31. 00		0.00	o	Ö		31. 00
32.00		0.00	0	0		32. 00
33.00		0.00	0	0		33. 00
34.00		0.00	0	0		34. 00
35. 00		0.00	0	0		35. 00
36.00		0.00	0	0		36.00
37. 00			<u> </u>	4, 068, 397		37. 00
	G - HIM RECLASS		O <sub>I</sub>	4,000,377		1
1.00	MEDICAL RECORDS & LIBRARY	16.00	108, 881	76, 268		1.00
	0 — — — — —		108, 881	76, 268		
	H - HEALTH INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	41, 615		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	2, 395		2.00
3. 00	RESPIRATORY THERAPY	6500	o	$\frac{612}{44.632}$		3. 00
	I - CHILDBIRTH CENTER RECLASS	<u> </u>	U	44, 622		
1.00	NURSERY	43.00	1, 056, 264	208, 529		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52. 00	3, 295, 835	626, 618		2. 00
	0 — — — — —		4, 352, 099	835, 147		
	J - MEDICAL DIRECTOR RECLASS					
1. 00	ADMI NI STRATI VE & GENERAL		108, 735	0		1. 00
	TOTALS		108, 735	0		
1. 00	K - PTO ACCRUAL ADMINISTRATIVE & GENERAL	5. 00	114, 623	0		1.00
2.00	OPERATION OF PLANT	7.00	25, 167	Ö		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	3, 670	Ö		3. 00
4.00	HOUSEKEEPI NG	9. 00	25, 059	0		4. 00
5.00	DI ETARY	10.00	6, 002	0		5. 00
6.00	CAFETERI A	11.00	12, 563	0		6. 00
7.00	NURSING ADMINISTRATION	13.00	35, 575	0		7. 00
8.00	CENTRAL SERVICES & SUPPLY	14.00	9, 831	0		8. 00
9. 00 10. 00	PHARMACY MEDICAL RECORDS & LIBRARY	15. 00 16. 00	22, 305 6, 713	0		9. 00 10. 00
11. 00	SOCIAL SERVICE	17. 00	17, 108	0		11. 00
12. 00	ADULTS & PEDIATRICS	30.00	115, 527	Ö		12. 00
13.00	INTENSIVE CARE UNIT	31.00	18, 864	0		13. 00
14.00	NURSERY	43.00	9, 294	0		14. 00
15. 00	OPERATING ROOM	50.00	23, 720	0		15. 00
16. 00	ENDOSCOPY	50. 01	9, 295	0		16. 00
17. 00	RECOVERY ROOM	51.00	12, 899 28, 997	0		17. 00 18. 00
18. 00 19. 00	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	52. 00 53. 00	51, 614	0		19. 00
20. 00	RADI OLOGY-DI AGNOSTI C	54. 00	55, 046	0		20.00
21. 00	RADI ATI ON-ONCOLOGY	54. 01	11, 802	Ö		21. 00
22. 00	NUCLEAR MEDICINE	56. 01	1, 853	0		22. 00
23. 00	CARDIAC CATHETERIZATION	59. 00	5, 045	0		23. 00
24. 00	LABORATORY	60.00	28, 434	0		24. 00
25. 00	I NTRAVENOUS THERAPY	64.00	8, 356	0		25. 00
26. 00	RESPIRATORY THERAPY	65. 00 66. 00	22, 744	0		26. 00 27. 00
27. 00 28. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	67.00	53, 479 4, 668	0		28.00
29. 00	SPEECH PATHOLOGY	68.00	2, 595	0		29. 00
30. 00	ELECTROCARDI OLOGY	69.00	8, 072	Ö		30. 00
31.00	CARDI AC REHAB	69. 01	5, 593	0		31.00
32.00	ELECTROENCEPHALOGRAPHY	70.00	1, 223	О		32. 00
33. 00	ULTRA SOUND	73. 01	5, 395	0		33. 00
34. 00	RENAL DI ALYSI S	74.00	1	0		34. 00
35.00	CLINIC EMEDIENCY	90.00	15, 025	0		35.00
36. 00 37. 00	EMERGENCY PHYSICIANS' PRIVATE OFFICES	91. 00 192. 00	47, 932 398, 560	0		36. 00 37. 00
38.00	HEALTH TRACKS	192.00	28, 260	0		38.00
39. 00	PRIMARY CARE CLINIC	194.00	8, 509	0		39. 00
40. 00	OCCUPATIONAL MEDICINE	194. 02	2, 541	Ö		40. 00
41.00	FOUNDATI ON	194. 03	1, 456	О		41. 00
42. 00	SCHOOL & TOWN CLINICS	194.04	13, 440	0		42. 00
43.00	MANAGED FACILITY	194. 05	2, 919	0		43.00
44. 00	SNF NON CERTIFIED	<u> </u>	12, 207	9		44. 00
	TOTALS		1, 293, 981	O		

Health Financial Systems

HENDRICKS REGIONAL HEALTH

In Lieu of Form CMS-2552-10

Provider CCN: 15-0005

Period: Worksheet A-6
From 01/01/2019
To 12/31/2019
Date/Time Prepared: 7/21/2020 4: 19 pm

						1/21/2020 4:	19 pm
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4.00	5. 00			
500.00	Grand Total: Increases		7, 291, 471	25, 298, 646			500.00

RECLASSI FI CATI ONS

Provider CCN: 15-0005

Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

7/21/2020 4:19 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - DRUG RECLASS 94, 780 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 1.00 0 0 2.00 ADMINISTRATIVE & GENERAL 5.00 207, 000 2.00 PHARMACY 15.00 0 9, 676, 203 0 3.00 3.00 0 4.00 ADULTS & PEDIATRICS 30.00 0 5, 561 4.00 INTENSIVE CARE UNIT 31.00 0 0 5.00 671 5.00 0 0 6.00 NURSERY 43.00 6.00 312 0 0 OPERATING ROOM 50.00 7.00 380 7.00 8.00 **ENDOSCOPY** 50.01 0 138 0 8.00 o 0 9.00 RECOVERY ROOM 51.00 1,530 9.00 10 00 DELIVERY ROOM & LABOR ROOM 52 00 0 0 10 00 0 11.00 ANESTHESI OLOGY 53.00 0 495 11.00 12.00 RADI OLOGY-DI AGNOSTI C 54.00 o 10, 222 0 12.00 13.00 RADI ATI ON-ONCOLOGY 54.01 0 999 0 13.00 0 0 CARDIAC CATHETERIZATION 59 00 14 00 69 14 00 15.00 INTRAVENOUS THERAPY 64.00 0 579 15.00 16.00 RESPIRATORY THERAPY 65.00 o 281 0 16.00 0 17.00 PHYSICAL THERAPY 66, 00 0 24, 294 17.00 0 0 67.00 25, 584 OCCUPATIONAL THERAPY 18.00 18.00 19.00 ELECTROCARDI OLOGY 69.00 0 30, 481 0 19.00 CARDI AC REHAB o 0 20.00 69.01 55 20.00 0 0 21.00 RENAL DIALYSIS 74.00 1.449 21.00 22.00 CLINIC 90.00 0 1, 378 0 22.00 EMERGENCY 23.00 91.00 2, 457 0 23.00 ō 10, 084, 921 B - MOB PLANT RECLASS 1.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 624, 539 0 1.00 2.00 0 0 0.00 0 2.00 0 3.00 0.00 0 3.00 0 4 00 0.00 0 0 4 00 5.00 0.00 0 0 0 5.00 6.00 0.00 o 0 0 6.00 0 0 7.00 0.00 0 7.00 8.00 0.00 0 0 8.00 9.00 0.00 0 0 9.00 0 10.00 0.00 0 0 10.00 11.00 0.00 0 0 0 11.00 12.00 0.00 0 0 0 12.00 13.00 0.00 0 13.00 624, 539 - CAFETERIA RECLASS DI ETARY 1.00 10.00 1, 427, 775 1,087,235 0 1.00 1, 427, 775 1, 087, 235 D - IMPLANTABLE DEVICES CLINIC 1.00 90.00 607, 881 786 1.00 2.00 OPERATING ROOM 7, 869, 636 50.00 0 2.00 ō 8, 477, 517 MEDICAL SUPPLY RECLASS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 1, 944 0 1.00 2.00 ADMINISTRATIVE & GENERAL 5.00 0 12,835 0 2.00 OPERATION OF PLANT 7.00 0 0 3 00 16 533 3 00 0 LAUNDRY & LINEN SERVICE 0 4.00 8.00 25, 159 4.00 5.00 HOUSEKEEPI NG 9.00 0 1, 324 0 5.00 0 6.00 NURSING ADMINISTRATION 13.00 0 6.00 1,676 CENTRAL SERVICES & SUPPLY 0 0 7 00 14 00 40,030 7 00 8.00 PHARMACY 15.00 0 25, 831 0 8.00 9.00 SOCIAL SERVICE 17.00 o 2, 350 0 9.00 0 ADULTS & PEDIATRICS 30.00 0 148, 393 10.00 10.00 INTENSIVE CARE UNIT 0 0 11 00 31.00 68.546 11 00 12.00 NURSERY 43.00 0 34, 945 0 12.00 **ENDOSCOPY** 50.01 o 166, 142 0 13.00 13.00 0 RECOVERY ROOM 0 14.00 51.00 7. 592 14.00 0 DELIVERY ROOM & LABOR ROOM 15.00 52.00 18, 369 15.00 0 16.00 ANESTHESI OLOGY 53.00 0 56, 083 16.00 o 0 17.00 RADI OLOGY-DI AGNOSTI C 54.00 427, 706 17.00 0 0 18, 944 18.00 RADI ATI ON-ONCOLOGY 54.01 18.00 19 00 NUCLEAR MEDICINE 56.01 0 5. 417 19 00 20.00 CARDIAC CATHETERIZATION 59.00 0 1, 025, 937 0 20.00 0 0 21.00 INTRAVENOUS THERAPY 64.00 11, 238 21.00 RESPIRATORY THERAPY 0 0 22.00 65.00 22.00 85, 175 0 23.00 PHYSICAL THERAPY 66.00 81, 154 23.00 OCCUPATI ONAL THERAPY 0 0 24.00 67.00 3, 698 24.00 ELECTROCARDI OLOGY 69.00 0 0 25, 00 4.435 25, 00 CARDI AC REHAB 26.00 69.01 3, 384 26.00 Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0005

Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 7/21/2020 4:19 pm

						7/21/2020 4	: 19 pm
		Decreases				I	
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
07.00	6. 00	7. 00	8. 00	9. 00	10. 00		07.00
27. 00	ULTRA SOUND	73. 01	0	10, 043		•	27. 00
28. 00	RENAL DI ALYSI S	74.00	0	96			28. 00
29. 00	CLINIC	90.00	0	852			29. 00
30.00	EMERGENCY	91.00	0	122, 166 1, 597, 633	-	1	30.00
31. 00 32. 00	PHYSICIANS' PRIVATE OFFICES HEALTH TRACKS	192. 00 192. 01	0			1	31. 00 32. 00
33. 00	PRIMARY CARE CLINIC	192.01	0	22, 568 6, 379		1	33.00
34. 00	OCCUPATIONAL MEDICINE	194. 00	0	3, 136		1	34.00
35. 00	SCHOOL & TOWN CLINICS	194. 02	0	645	_		35. 00
36. 00	SNF NON CERTIFIED	194. 07	0	9, 853		1	36.00
37. 00	SPEECH PATHOLOGY	68. 00	0	186		1	37. 00
37.00	n		— — — <del>ў</del>	4, 068, 397			37.00
	G - HIM RECLASS		<u> </u>	4,000,377			
1.00	ADMINISTRATIVE & GENERAL	5. 00	108, 881	76, 268	0		1.00
1.00	0		108, 881	76, 268			1.00
	H - HEALTH INSURANCE		100,001	70, 200			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44, 530	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	92		•	2. 00
3.00		0.00	0	0	0	•	3. 00
0.00			— — <del>"</del>	44, 622	`		0.00
	I - CHILDBIRTH CENTER RECLASS		9	11,022			
1.00	ADULTS & PEDIATRICS	30.00	4, 352, 099	835, 147	0		1.00
2.00	1.552.75 & 1.25771111.55	0.00	0	000,	0	•	2. 00
2.00			4, 352, 099	835, 147			2.00
	J - MEDICAL DIRECTOR RECLASS		1,002,077	3007 117			
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	108, 735	0	0		1.00
	TOTALS		108, 735	0			
	K - PTO ACCRUAL	'			·		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 293, 981	0	0		1.00
2.00		0.00	0	0	0		2. 00
3.00		0.00	o	0			3. 00
4.00		0.00	o	0	0		4. 00
5.00		0.00	o	0			5. 00
6.00		0.00	o	0	0		6. 00
7.00		0.00	o	0	0		7. 00
8.00		0.00	o	0	0		8. 00
9.00		0.00	o	0	0		9. 00
10.00		0.00	o	0	0		10.00
11.00		0.00	o	0	0		11. 00
12.00		0.00	O	0	0		12. 00
13.00		0.00	O	0	0		13.00
14.00		0.00	o	0	0		14. 00
15.00		0.00	0	0	0		15. 00
16.00		0.00	O	0	0		16. 00
17.00		0.00	o	0	0		17. 00
18.00		0.00	0	0	0		18. 00
19.00		0.00	0	0	0		19. 00
20.00		0.00	0	0	0		20. 00
21.00		0.00	o	0	0		21. 00
22.00		0.00	o	0	0		22. 00
23.00		0.00	0	0			23. 00
24.00		0.00	O	0			24. 00
25.00		0.00	0	0	0		25. 00
26.00		0.00	0	0	0		26. 00
27.00		0.00	o	0	0		27. 00
28.00		0.00	o	0			28. 00
29.00		0.00	o	0	0		29. 00
30.00		0.00	o	0			30.00
31.00		0.00	o	0	0		31. 00
32.00		0.00	o	0			32. 00
33.00		0.00	o	0	0		33. 00
34.00		0.00	0	0	0		34. 00
35.00		0.00	О	0	0		35. 00
36.00		0.00	О	0	0		36. 00
37.00		0.00	o	0	0		37. 00
38. 00		0.00	o	0	0		38. 00
39. 00		0.00	О	0			39. 00
40.00		0.00	o	0		•	40. 00
41.00		0.00	o	0			41.00
42. 00		0.00	ol	0			42. 00
43. 00		0.00	ō	0		1	43. 00
44. 00		0.00	ol	0		•	44. 00
	TOTALS — — — — —		1, 293, 981			]	
500.00	Grand Total: Decreases		7, 291, 471	25, 298, 646		]	500.00
		'	'				

					o 12/31/2019	Date/Time Pre	
				Acqui ci ti ana		7/21/2020 4:1	9 pm
		Begi nni ng	Purchases	Acqui si ti ons Donati on	Total	Disposals and	
		Bal ances	Pui Cliases	טטוומנו טוו	Total	Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		2.00	3.00	4.00	3.00	
1.00	Land	25, 010, 345	0	(	0	0	1. 00
2.00	Land Improvements	9, 993, 537	o	Ċ	0	0	2. 00
3.00	Buildings and Fixtures	286, 006, 646	3, 443, 523	C	3, 443, 523	0	3. 00
4.00	Building Improvements	0	0	C	0	0	4. 00
5.00	Fixed Equipment	165, 143, 649	14, 025, 308	C	14, 025, 308	28, 548, 500	5. 00
6.00	Movable Equipment	0	О	C	0	0	6. 00
7.00	HIT designated Assets	o	o	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	486, 154, 177	17, 468, 831	C	17, 468, 831	28, 548, 500	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	486, 154, 177	17, 468, 831	C	17, 468, 831	28, 548, 500	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		al				4 00
1.00	Land	25, 010, 345	0				1. 00
2.00	Land Improvements	9, 993, 537	0				2.00
3.00	Buildings and Fixtures	289, 450, 169	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equi pment	150, 620, 457	0				5. 00
6.00	Movable Equipment	0	0				6. 00
7.00	HIT designated Assets	475 074 500	0				7. 00
8. 00 9. 00	Subtotal (sum of lines 1-7) Reconciling Items	475, 074, 508	0				8. 00 9. 00
9. 00 10. 00	Total (line 8 minus line 9)	475, 074, 508	0				9. 00 10. 00
10.00	Tiotal (Time o milius Time 7)	475,074,500	υĮ			ļ	10.00

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2			2552-10				
RECONCILIATION OF CAPITAL COSTS CENTERS			Provider Co	CN: 15-0005	Peri od: From 01/01/2019 To 12/31/2019		pared:
		SUMMARY OF CAPITAL					9 pili
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	25, 801, 328	0		0	0	1. 00
3.00	Total (sum of lines 1-2)	25, 801, 328	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	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 WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	25, 801, 328				1. 00
3.00	Total (sum of lines 1-2)	0	25, 801, 328				3. 00

Health Financial	Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	552-10
RECONCILIATION C	OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
				1 '	From 01/01/2019 Fo 12/31/2019	Part III Date/Time Prep	pared.
						7/21/2020 4: 19	
		COMF	PUTATION OF RAT	T 0S	ALLOCATION OF	OTHER CAPITAL	
Cost	t Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
COST	Center Description	GIUSS ASSELS	Leases	for Ratio	instructions)	Trisul ance	
			200303	(col. 1 - col.	,		
				2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	- RECONCILIATION OF CAPITAL COSTS C				_		
	EL COSTS-BLDG & FLXT	475, 074, 508		475, 074, 508		0	1. 00
3.00 Total (su	m of lines 1-2)	475, 074, 508		475, 074, 508		0	3. 00
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost	t Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
		4 00	d Costs	through 7)	0.00	10.00	
DADT III	- RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10. 00	
	- RECONCILIATION OF CAPITAL COSTS CI EL COSTS-BLDG & FLXT	INTERS	0		25, 874, 703	0	1. 00
	m of lines 1-2)	0	0	}	25, 874, 703		3. 00
3.00   Total (Su	iii or rriies r-z)	U	<u> </u>	IYMMARY OF CAPI		U	3.00
			30	MINIART OF CALL	IAL		
Cost	t Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
DART III	DECOMOL	11.00	12. 00	13. 00	14. 00	15. 00	
	- RECONCILIATION OF CAPITAL COSTS CI					05 (00 017	
	EL COSTS-BLDG & FLXT	-246, 486			0	25, 628, 217	1.00
3.00 Total (su	m of lines 1-2)	-246, 486	0		0	25, 628, 217	3. 00

				To	rom 01/01/2019 o 12/31/2019			
				Expense Classification on		772172020 4. 1	9 pili	
				To/From Which the Amount is	to be Adjusted			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	В	-246, 486	NEW CAP REL COSTS-BLDG & FLXT	1.00	11	1. 00	
2. 00	2)   Investment income - CAP REL   COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2. 00	0	2. 00	
3.00	Investment income - other (chapter 2)	А		NEW CAP REL COSTS-BLDG & FLXT	1. 00	11	3. 00	
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 stations excluded) (chapter		0		0. 00	0	7. 00	
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00	
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -10, 894, 370		0. 00	O O		
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11. 00	
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00	
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee and others		-1, 114, 539 0	CAFETERI A	11. 00 0. 00	0		
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00	
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00	
18. 00	patients Sale of medical records and		0		0.00	0	18. 00	
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00	
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00	
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0. 00	0	ı	
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00	
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00	
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00	
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00	
26. 00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00	
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL			FIXT *** Cost Center Deleted ***	2. 00	0	27. 00	
28. 00	1 3		0	*** Cost Center Deleted ***	19. 00		28. 00	
29. 00 30. 00	3	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00	
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99	
31. 00		A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00	
32. 00			0		0.00	0	32. 00	
	Depreciation and Interest							

From 01/01/2019

				To	0 12/31/2019		
				Expense Classification on	Worksheet A	772172020 4. 1	9 piii
				To/From Which the Amount is	to be Adjusted		
		D 1 (0 1 (0)					
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
33. 00	1993 CARRYFORWARD	A A		NEW CAP REL COSTS-BLDG &	1.00	9.00	33. 00
			,	FIXT			
33. 01	1994 CARRYFORWARD	A	3, 288	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 01
33. 07	ADMITTING TELEPHONE	A	-9 164	FIXT ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
00.07	(EQUI PMENT)		,, 101	TION WE A SENERAL	0.00		00.07
33. 08	ADMITTING TELEPHONE (SALARY)	Α		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 09	MARKETING DEPARTMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10 33. 11	PHYSICIAN RECRUITMENT   IHA LOBBYING EXPENSE	A A		ADMINISTRATIVE & GENERAL	5. 00 5. 00	0 0	33. 10 33. 11
34. 00	AHA LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00	0	
35. 00	HOSPITAL ASSESSMENT FEE	A		ADMINISTRATIVE & GENERAL	5.00	0	35. 00
36. 00	HIP ASSESSMENT FEE	A		ADMI NI STRATI VE & GENERAL	5. 00	0	36.00
37. 00	MEALS ON WHEELS	A	-493, 708	le l	10. 00	Ö	37. 00
38. 00	REVENUE OTHER OPERATING	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38. 00
39. 00	HRH BENEFITS EXPENSE	В	-246, 019	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	39. 00
40. 00	HRH WELLNESS	В	-116, 182	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40. 00
41. 00	JURY DUTY	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	41. 00
43.00	REVENUE OTHER OPERATING	В		ADMINISTRATIVE & GENERAL	5. 00	0	
44.00	CHAPLAI NCY	В		ADMINISTRATIVE & GENERAL	5. 00	0	
45. 00	FINANCIAL SERVICES	В	•	ADMINISTRATIVE & GENERAL	5. 00	0	45. 00
45. 01 45. 03	GLET SHOP	B B	•	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	45. 01
45. 03 45. 04	ANSWERING SERVICE REVENUE - OTHER OPERATING	В		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	45. 03 45. 04
45. 05	OPERATIONAL EXCELLENCE	В		ADMINISTRATIVE & GENERAL	5. 00	0	45. 05
45. 06	REVENUE CYCLE	В		ADMINISTRATIVE & GENERAL	5. 00	o o	45. 06
45. 07	VOLUNTEER SERVICES	В		ADMINISTRATIVE & GENERAL	5. 00	0	
45. 08	REVENUE OTHER OPERATING	В	-318, 963	OPERATION OF PLANT	7. 00	0	45. 08
45. 09	REVENUE - OTHER OPERATING	В	-398	OPERATION OF PLANT	7. 00	0	45. 09
45. 10	SUPPORT SERVI CE	В		HOUSEKEEPI NG	9. 00	0	45. 10
45. 11	EDUCATIONAL SERVICES	В		NURSING ADMINISTRATION	13. 00	0	45. 11
45. 12	REVENUE - OTHER OPERATING	В		NURSING ADMINISTRATION	13. 00	0	45. 12
45. 13 45. 14	MATERIALS MANAGEMENT	B B		CENTRAL SERVICES & SUPPLY	14.00	0 0	45. 13
45. 14	PHARMACY   REVENUE OTHER OPERATING	В		PHARMACY MEDICAL RECORDS & LIBRARY	15. 00 16. 00	0	45. 14 45. 15
45. 16	REVENUE OTHER OPERATING	В		SOCIAL SERVICE	17. 00	0	i
45. 17	TRANSITION OF CARE	В		SOCI AL SERVI CE	17. 00	9	1
45. 18	CHILD BIRTH CENTER	В		ADULTS & PEDIATRICS	30. 00	0	
45. 19	REVENUE OTHER OPERATING	В	-13	ADULTS & PEDIATRICS	30.00	0	45. 19
45. 21	REVENUE - OTHER OPERATING	В	•	RADI OLOGY-DI AGNOSTI C	54.00	0	45. 21
45. 22	ONCOLOGY INFUSION CENTER	В		RADI ATI ON-ONCOLOGY	54. 01	0	45. 22
45. 23	REVENUE - OTHER OPERATING	В		RADI ATI ON-ONCOLOGY	54. 01	0	
	LABORATORY	В		LABORATORY THERAPY	60.00		
45. 26 45. 27	RESPIRATORY THERAPY HRH SPORTS MEDICINE PHYSICIAN	B B		RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00 66. 00	0	
45. 27	PHYSICAL THERAPY	В		PHYSICAL THERAPY	66. 00	0	
45. 29	PHYSICAL THERAPY - AVON	В		PHYSI CAL THERAPY	66.00	0	
45. 30	PHYSI CAL THERAPY - BROWNSBURG	В		PHYSI CAL THERAPY	66.00	Ö	45. 30
45. 31	PHYSICAL THERAPY - PLAINFIELD	В		PHYSI CAL THERAPY	66. 00	0	45. 31
45. 32	SPORTS MEDICINE	В		PHYSICAL THERAPY	66.00	0	45. 32
45. 33	REVENUE - OTHER OPERATING	В		PHYSICAL THERAPY	66.00	0	45. 33
45. 34	OCCUPATIONAL THERAPY REHAB	В		OCCUPATI ONAL THERAPY	67. 00	0	
45. 36	REVENUE - OTHER OPERATING	В		ULTRA SOUND	73. 01	0	
45. 37	HI BBELN SURGERY CENTER	В		CLINIC	90.00	0	
45. 38 45. 39	EMERGENCY DEPARTMENT EMS PROGRAM	B B		EMERGENCY EMERGENCY	91. 00 91. 00	0	45. 38 45. 39
50. 00	TOTAL (sum of lines 1 thru 49)	1	- 79, 658 - 36, 318, 161	LIVILINGLING	91.00		50.00
55. 66	(Transfer to Worksheet A,		55, 510, 101				55. 55
	column 6, line 200.)						

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

<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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0005

Peri od: Worksheet A-8-2 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

7/21/2020 4:19 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3. 00 4.00 5. 00 6. 00 7. 00 30.00 ADULTS & PEDIATRICS 50, 400 1. 00 1.00 3, 307, 286 407 3, 357, 686 174,600 2.00 30.00 ADULTS & PEDIATRICS 524, 550 524, 550 2.00 0 3.00 50. 00 OPERATING ROOM 3.00 50, 733 50, 733 206, 300 338 4.00 53. 00 ANESTHESI OLOGY 5, 575, 668 233, 500 4.00 5, 575, 668 0 0 5.00 54. 00 RADI OLOGY-DI AGNOSTI C 83, 322 83, 322 0 265, 200 5.00 6.00 54. 00 RADI OLOGY-DI AGNOSTI C 20, 865 265, 200 0 20, 865 6.00 0 17, 451 7.00 54. 00 RADI OLOGY-DI AGNOSTI C 17, 451 0 206, 300 7.00 54. 01 RADI ATI ON-ONCOLOGY 12, 775 12, 775 8.00 0 206, 300 8.00 0 9.00 60. 00 LABORATORY 72, 694 72, 694 253, 900 9.00 10.00 66. 00 PHYSI CAL THERAPY 474, 747 474, 747 206, 300 0 10.00 69. 00 ELECTROCARDI OLOGY 0 50, 442 50.442 206, 300 11.00 11.00 91. 00 EMERGENCY 429, 569 625, 913 206, 300 12.00 1, 055, 482 3.682 12.00 13.00 91. 00 EMERGENCY 206, 300 0 13.00 14.00 91. 00 EMERGENCY 73, 980 73, 980 206, 300 435 14.00 200.00 11, 370, 395 10, 569, 369 4,862 801,026 200.00 Cost Center/Physician Provi der Wkst. A Line # Unadjusted RCE 5 Percent of Cost of Physician Cost Identi fi er Li mi t Unadjusted RCE Memberships & Component of Malpractice Li mi t Conti nui ng Share of col Insurance Educati on 12 2.00 8.00 9.00 14.00 1.00 12.00 13.00 1.00 30.00 ADULTS & PEDIATRICS 34, 165 1,708 0 0 1 00 0 2.00 30.00 ADULTS & PEDIATRICS 0 2.00 3.00 50. 00 OPERATING ROOM 33, 524 1,676 0 0 3.00 0 0 0 0 0 53. 00 ANESTHESI OLOGY 0 0 4.00 4.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 5.00 0 0 5.00 6.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 6.00 54. 00 RADI OLOGY-DI AGNOSTI C 7.00 7.00 8.00 54. 01 RADI ATI ON-ONCOLOGY 0 0 8.00 60. 00 LABORATORY 9.00 0 0 0 9.00 0 66. 00 PHYSI CAL THERAPY 10.00 10.00 0 11.00 69. 00 ELECTROCARDI OLOGY 0 11.00 0 91. 00 EMERGENCY 0 12.00 365, 191 18, 260 C 12.00 13.00 0 91. 00 EMERGENCY 13.00 0 14.00 91. 00 EMERGENCY 43, 145 2, 157 14.00 476, 025 0 200.00 200.00 23, 801 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE **RCE** Adjustment I denti fi er Component Di sal I owance Li mi t Share of col. 14 15.00 1.00 2.00 16.00 17.00 18.00 30.00 ADULTS & PEDIATRICS 3, 323, 521 1.00 0 34, 165 16, 235 1.00 2.00 30.00 ADULTS & PEDIATRICS 0 524, 550 2.00 50. 00 OPERATING ROOM 3.00 0 33, 524 17, 209 17, 209 3.00 53. 00 ANESTHESI OLOGY 0 4.00 5, 575, 668 4.00 5.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 83, 322 5.00 6.00 54. 00 RADI OLOGY-DI AGNOSTI C 20,865 6.00 7.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 17, 451 7.00 0 54. 01 RADI ATI ON-ONCOLOGY 8.00 0 0 0 12, 775 8.00 9.00 60. 00 LABORATORY 0 0 0 72,694 9.00 66. 00 PHYSI CAL THERAPY 0 474, 747 10.00 0 0 10.00 69. OO ELECTROCARDI OLOGY 0 11.00 50.442 11.00 91. 00 EMERGENCY 0 12.00 365, 191 260, 722 690, 291 12.00 13.00 91. 00 EMERGENCY 13.00 14.00 91. 00 EMERGENCY 43, 145 30,835 30,835 14.00 200.00 476, 025 325,001 10, 894, 370 200.00

Heal th Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0005
Period: From 01/01/2019 To 12/31/2019
Part I Date/Time Prepared: 7/21/2020 4: 19 pm

Cost Center Description

Net Expenses For Cost Allocation Cost Allocation Cost Center Description

Net Expenses For Cost Allocation Cost Center Description

Net Expenses For Cost Allocation Center Description

HENDRICKS REGIONAL HEALTH

In Lieu of Form CMS-2552-10

Worksheet B Part I Date/Time Prepared: 7/21/2020 4: 19 pm

CAPITAL RELATED COSTS

NEW BLDG & FIXT BENEFITS DEPARTMENT

ADMINISTRATIVE & GENERAL

						1/21/2020 4:1	9 pm
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		col. 7)					
		0	1. 00	4.00	4A	5. 00	
GENE	RAL SERVICE COST CENTERS		<u> </u>				
	NEW CAP REL COSTS-BLDG & FIXT	25, 628, 217	25, 628, 217				1.00
	OO EMPLOYEE BENEFITS DEPARTMENT	30, 414, 063					4.00
	OO ADMINISTRATIVE & GENERAL	49, 429, 452			53, 621, 105	53, 621, 105	5. 00
	O OPERATION OF PLANT	11, 247, 789			15, 112, 418		7. 00
	O LAUNDRY & LINEN SERVICE	832, 077			1, 194, 298		8. 00
	O HOUSEKEEPI NG	3, 652, 543			4, 368, 912		9. 00
	O DI ETARY	713, 823			1, 340, 842		1
	O CAFETERI A	1, 413, 034			1, 796, 335		11. 00
	OO NURSI NG ADMI NI STRATI ON	4, 956, 867			6, 049, 083		1
	O CENTRAL SERVICES & SUPPLY	1, 833, 289			2, 534, 057	481, 947	14. 00
	O PHARMACY	2, 406, 982			3, 190, 602		
	00 MEDICAL RECORDS & LIBRARY	1, 742, 538			2, 090, 685		
	00 SOCIAL SERVICE	2, 259, 591			2, 775, 686		1
	TIENT ROUTINE SERVICE COST CENTERS	2, 239, 391	111, 418	404, 677	2, 773, 000	527, 902	17.00
	OO ADULTS & PEDIATRICS	11 220 100	2 205 050	2 722 474	16, 268, 814	2 004 122	30.00
	OO INTENSIVE CARE UNIT	11, 330, 180 2, 758, 869					31.00
	NURSERY	1			3, 460, 192		1
		1, 207, 329			1, 475, 464		
	O SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
	LLARY SERVICE COST CENTERS OO OPERATING ROOM	0.454.144	/FO 2F/	E/1 071	10 // 5 501	2 020 447	50.00
		9, 454, 164			10, 665, 591	2, 028, 467 397, 468	
	01 ENDOSCOPY 00 RECOVERY ROOM	1, 419, 871	450, 133 793, 683		2, 089, 869		
		1, 765, 998			2, 864, 800		51.00
	DO DELIVERY ROOM & LABOR ROOM	3, 858, 442			4, 708, 126		
	OO ANESTHESI OLOGY	1, 091, 699		1, ===, =. =	2, 312, 575		53.00
	OO RADI OLOGY - DI AGNOSTI C	8, 483, 601	952, 298		10, 737, 954		1
	01 RADI ATI ON-ONCOLOGY	24, 799, 071	570, 093		25, 648, 329		54. 01
	O RADI OI SOTOPE	0	0	1	0	_	56.00
	NUCLEAR MEDICINE	385, 007	15, 259		444, 102		
	O CARDI AC CATHETERI ZATI ON	885, 488			1, 280, 851	243, 602	59. 00
	O LABORATORY	8, 845, 048			9, 853, 588		1
	O I NTRAVENOUS THERAPY	1, 390, 562			1, 684, 556		
	O RESPIRATORY THERAPY	3, 264, 321	367, 872		4, 170, 186		1
	O PHYSI CAL THERAPY	7, 916, 718			9, 856, 767		
	O OCCUPATIONAL THERAPY	576, 605			862, 222		67. 00
	O SPEECH PATHOLOGY	329, 116			459, 257	87, 345	
	O ELECTROCARDI OLOGY	1, 109, 022	121, 205		1, 421, 155		69. 00
	OT CARDI AC REHAB	717, 466			991, 648		
	OO ELECTROENCEPHALOGRAPHY	154, 181	77, 657		260, 763		70.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	,		0	_	71.00
	OO I MPL. DEV. CHARGED TO PATIENT	8, 477, 517			8, 477, 517		
	DO DRUGS CHARGED TO PATIENTS	9, 892, 690		0	9, 892, 690		
	DI ULTRA SOUND	658, 734			806, 098		
	O RENAL DIALYSIS	300, 471	0	25	300, 496	57, 151	74. 00
	ATLENT SERVICE COST CENTERS	/ 027 222	F02 047	255 204	6, 976, 475	1 22/ 042	90.00
	00 CLI NI C 00 EMERGENCY	6, 037, 232					1
	OO OBSERVATION BEDS (NON-DISTINCT PART)	6, 951, 942	929, 974	1, 133, 781	9, 015, 697		1
	I AL PURPOSE COST CENTERS				0		92.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	260, 591, 609	17, 163, 859	19, 540, 238	241, 059, 805	35, 648, 590	110 00
	EIMBURSABLE COST CENTERS	200, 371, 007	17, 103, 037	19, 540, 236	241, 037, 003	33, 040, 370	1118.00
	00 PHYSI CLANS' PRI VATE OFFI CES	62, 831, 778	7, 095, 978	9, 427, 491	79, 355, 247	15, 092, 539	102 00
	11 HEALTH TRACKS	4, 071, 215			5, 099, 433		1
	O PRIMARY CARE CLINIC	2, 327, 524		· ·	2, 947, 917		
	11 PARTNERS IN CARE	3, 186			25, 626		194. 00
	2 OCCUPATIONAL MEDICINE	932, 288			1, 129, 443		
	3 FOUNDATION	187, 989			236, 406		194. 02
	44 SCHOOL & TOWN CLINICS	2, 237, 080			2, 588, 237		
	55 MANAGED FACILITY	643, 079			712, 116		1
	66 RENTAL PROPERTIES	138, 143			138, 143		
	7 SNF NON CERTIFIED	1, 593, 941	382, 784	-	2, 265, 459		
200. 00	Cross Foot Adjustments	1, 373, 741	302, 704	200, 734	2, 200, 409		200. 00
201.00	Negative Cost Centers		0	0	0		200.00
202. 00	TOTAL (sum lines 118 through 201)	335, 557, 832			335, 557, 832		
202.00	1.5 (Sum 111105 110 till bugir 201)	1 000,001,002	20,020,217	1 00,007,004	333, 337, 632	1 55, 521, 105	1-02.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0005

				To	12/31/2019		pared:
Cost Center	Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	7/21/2020 4: 1 CAFETERI A	9 pm
cost denter	beschi pti on	PLANT	LINEN SERVICE	11003EREELTING	DIEIMI	OALLIERIA	
		7. 00	8. 00	9. 00	10. 00	11. 00	
GENERAL SERVICE C		T		1			
	. COSTS-BLDG & FLXT					ı	1.00
4. 00   00400   EMPLOYEE BE 5. 00   00500   ADMI NI STRAT	NEFITS DEPARTMENT					ı	4. 00 5. 00
7. 00 00700 OPERATION 0		17, 986, 619				ı	7. 00
8. 00   00800   LAUNDRY & L		0	1, 421, 439			ı	8. 00
9. 00 00900 HOUSEKEEPI N		236, 205	0			ı	9. 00
10. 00   01000 DI ETARY		926, 674	0	55, 554	2, 578, 082	1	10.00
11. 00   01100   CAFETERI A		164, 569	0	0	0	2, 302, 545	
13.00 01300 NURSING ADM		478, 992	0		0	116, 872	1
14.00   01400   CENTRAL SER	VICES & SUPPLY	857, 030			0	49, 302	1
15. 00 01500 PHARMACY	CODDC 0 LIDDADY	489, 115	1, 852		0	73, 986	1
16. 00   01600   MEDI CAL REC 17. 00   01700   SOCI AL SERV		300, 262 0	0	,	0	42, 582 72, 861	16. 00 17. 00
	E SERVICE COST CENTERS		0	2,036	<u> </u>	12,001	17.00
30. 00 03000 ADULTS & PE		3, 892, 840	381, 937	2, 551, 352	1, 824, 294	370, 198	30. 00
31. 00 03100 I NTENSI VE C		487, 400	53, 333	1	247, 265	73, 856	1
43. 00   04300 NURSERY		92, 269	20, 241	1	301, 077	30, 634	1
44.00 04400 SKILLED NUR	SING FACILITY	0	0	0	0	0	44. 00
ANCILLARY SERVICE							
50. 00   05000   OPERATING R	OOM	1, 242, 480		1	0	101, 999	1
50. 01   05001   ENDOSCOPY 51. 00   05100   RECOVERY RO	OM	859, 962	52, 260		0	35, 153	1
51. 00   05100   RECOVERY RO 52. 00   05200   DELI VERY RO		1, 516, 301 312, 930	106, 058 74, 656		0	45, 312 95, 576	1
53. 00 05300 ANESTHESI OL		312, 730	/4, 030 	4, 115	o	52, 524	1
54. 00 05400 RADI OLOGY - D		962, 575	156, 969		Ö	212, 458	1
54. 01   05401 RADI ATI ON-0		0	9, 804		Ö	49, 694	1
56. 00 05600 RADI 0I SOTOP	E	0	0	0	o	0	56. 00
56. 01   05601 NUCLEAR MED		29, 152	0	6, 173	0	6, 633	
59. 00   05900   CARDI AC   CAT	HETERI ZATI ON	527, 339	0	_	0	21, 161	
60. 00   06000   LABORATORY	TUEDADY	499, 072	170		0	154, 508	1
64. 00 06400 I NTRAVENOUS		184, 040	5, 749		0	27, 191	1
65. 00   06500   RESPI RATORY 66. 00   06600   PHYSI CAL TH		567, 444 578, 065	96, 613	10, 288 296, 286	0	88, 538 226, 386	1
67. 00 06700 OCCUPATI ONA		23, 952	70, 013		o	16, 993	1
68. 00   06800   SPEECH PATH		131, 378	0	·	ő	9, 511	1
69. 00 06900 ELECTROCARD		231, 558	22, 867		0	51, 401	1
69. 01 06901 CARDI AC REH		163, 518	496	1	О	22, 094	69. 01
70. 00 07000 ELECTROENCE		148, 361	1, 197	28, 806	0	5, 767	70. 00
	PLIES CHARGED TO PATIENTS	0	0		0	0	
	CHARGED TO PATIENT	0	0	0	0	0	
73. 00   07300   DRUGS CHARG 73. 01   07301   ULTRA SOUND	ED TO PATTENTS	0	0   0	( 172	0	17 742	73.00
74. 00 07400 RENAL DIALY		37, 726 0	175		0	17, 743 0	1
OUTPATIENT SERVICE			173	0, 230	<u> </u>		74.00
90. 00 09000 CLI NI C		0	91, 940	119, 338	0	0	90.00
91.00 09100 EMERGENCY		1, 250, 944	184, 608	1	o	190, 683	91. 00
92. 00 09200 OBSERVATI ON	BEDS (NON-DISTINCT PART)						92. 00
SPECIAL PURPOSE C							
	SUM OF LINES 1 through 117)	17, 192, 153	1, 356, 424	4, 837, 287	2, 372, 636	2, 261, 616	118. 00
NONREI MBURSABLE O		63, 172	20.004	140 214	ما	0	100.00
192. 00 19200 PHYSI CI ANS' 192. 01 19201 HEALTH TRAC		03, 172	39, 804 8, 401	1	0		192. 00 192. 01
194. 00 07950 PRI MARY CAR		0	711	·	0		194. 00
194. 01 07951 PARTNERS IN		0	925		ő		194. 01
194. 02 07952 OCCUPATI ONA		0	2, 502		o	_	194. 02
194. 03 07953 FOUNDATI ON		0	0	2, 058	o	0	194. 03
194.04 07954 SCHOOL & TO		0	523		o		194. 04
194. 05 07955 MANAGED FAC		0	0	0	0	_	194. 05
194. 06 07956 RENTAL PROP		0	0	0	0		194. 06
194. 07 07957 SNF NON CER		731, 294	12, 149	0	205, 446	40, 929	194. 07
200.00 Cross Foot 201.00 Negative Co	Adjustments	_	_				200. 00 201. 00
	lines 118 through 201)	17, 986, 619	1, 421, 439	5, 436, 032	2, 578, 082		
202.00    TOTAL (30III		17, 700, 017	1, 721, 437	0, 400, 002	2, 370, 302	2, 302, 343	1202.00

Provider CCN: 15-0005

			To	12/31/2019	Date/Time Pre 7/21/2020 4:1	pared:
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	) piii
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
	13.00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	17. 00	
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00	17.00	
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 O0700 OPERATION OF PLANT						7. 00
8.00   00800   LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9.00
10. 00   01000   DI ETARY						10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG ADMI NI STRATI ON	7, 813, 928					11. 00 13. 00
14. 00   01400 CENTRAL SERVICES & SUPPLY	7,013,420	3, 980, 386				14. 00
15. 00 01500 PHARMACY	0	0, 700, 000	4, 374, 714			15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	o	0	2, 857, 900		16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	3, 378, 507	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	2, 019, 308	0	0	201, 183	2, 206, 745	30.00
31. 00 03100 I NTENSI VE CARE UNIT	402, 864	0	0	65, 612	299, 016	31.00
43. 00   04300   NURSERY 44. 00   04400   SKI LLED   NURSI NG   FACI LI TY	167, 100 0	0	0	49, 343	0	43. 00 44. 00
ANCI LLARY SERVI CE COST CENTERS	U	U	U	U	0	44.00
50. 00 05000 OPERATING ROOM	556, 372	3, 980, 386	0	521, 289	543, 188	50.00
50. 01   05001 ENDOSCOPY	191, 749	0	0	92, 425	0	50. 01
51.00   05100   RECOVERY ROOM	247, 163	О	0	82, 671	0	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	521, 339	0	0	117, 890	0	52. 00
53. 00   05300   ANESTHESI OLOGY	286, 504	0	0	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 158, 894	0	0	134, 268	0	54.00
54. 01   05401   RADI ATI ON-ONCOLOGY	0	0	0	198, 591	0	54. 01
56. 00   05600   RADI OI SOTOPE 56. 01   05601   NUCLEAR   MEDI CI NE	0	0	0	0	0	56. 00 56. 01
59. 00   05900   CARDI AC   CATHETERI ZATI ON	115, 425	0	0	154, 874	0	59. 00
60. 00   06000   LABORATORY	113, 423	0	0	386, 996	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	Ö	0	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	482, 947	ō	0	119, 776	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	О	0	80, 041	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	12, 193	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	10, 391	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	280, 374	0	0	62, 106	0	69. 00
69. 01   06901   CARDI AC   REHAB	120, 517	0	0	11, 367	0	69. 01
70.00   07000   ELECTROENCEPHALOGRAPHY 71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	70. 00 71. 00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATTENTS	0	0	0	0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0	4, 374, 714	0	0	73. 00
73. 01 07301 ULTRA SOUND	O	ō	0	0	0	73. 01
74. 00 07400 RENAL DIALYSIS	0	o	0	3, 412	0	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	0	0	0		90.00
91. 00 09100 EMERGENCY	1, 040, 116	0	0	553, 472	329, 558	
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   SPECIAL PURPOSE COST CENTERS						92. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 590, 672	3, 980, 386	4, 374, 714	2, 857, 900	3, 378, 507	118 00
NONREI MBURSABLE COST CENTERS	7,070,072	0, 700, 000	1, 0, 1, , 11	2,007,700	0, 0, 0, 001	1110.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00
192. 01 19201 HEALTH TRACKS	0	O	0	0	0	192. 01
194.00 07950 PRIMARY CARE CLINIC	0	0	0	0		194. 00
194. 01 07951 PARTNERS IN CARE	0	0	0	0		194. 01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	0	0	0	0		194. 02
194. 03 07953 FOUNDATION	0	0	0	0		194. 03 194. 04
194.04 07954 SCHOOL & TOWN CLINICS 194.05 07955 MANAGED FACILITY		0	0	O		194. 04 194. 05
194.06 07956 RENTAL PROPERTIES		0	0	0		194. 05
194. 07 07957 SNF NON CERTIFIED	223, 256	0	0	n		194. 07
200.00 Cross Foot Adjustments	223, 233	Ĭ		Ĭ		200. 00
201.00 Negative Cost Centers	0	o	0	o		201. 00
202.00   TOTAL (sum lines 118 through 201)	7, 813, 928	3, 980, 386	4, 374, 714	2, 857, 900	3, 378, 507	202. 00

HENDRICKS REGIONAL HEALTH

Peri od: Worksheet B
From 01/01/2019 Part I
To 1/21/2019 Part I
To 1/21/2019 Part II
To 1/21/2019 Part II Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0005

			To		
Cost Center Description	Subtotal	Intern &	Total	7/21/2020 4: 1	piii
	Re	esi dents Cost			
		& Post Stepdown			
		Adjustments			
GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1. 00   O0100   NEW CAP REL COSTS-BLDG & FLXT					1.00
4.00   00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL					5. 00
7.00   00700   OPERATION OF PLANT 8.00   00800   LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG ADMI NI STRATI ON					11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00   01500   PHARMACY					15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE					16. 00 17. 00
INPATIENT ROUTINE SERVICE COST CENTERS					17.00
30. 00 03000 ADULTS & PEDI ATRI CS	32, 810, 804	0	32, 810, 804		30. 00
31. 00   03100   I NTENSI VE CARE UNI T 43. 00   04300   NURSERY	6, 142, 674 2, 424, 974	0	6, 142, 674 2, 424, 974		31. 00 43. 00
44. 00   04400   SKI LLED   NURSI NG   FACI LI TY	2, 424, 974	0	2, 424, 974		44. 00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATING ROOM 50. 01   05001   ENDOSCOPY	19, 942, 644 3, 797, 073	0	19, 942, 644 3, 797, 073		50. 00 50. 01
51. 00   05100   RECOVERY ROOM	5, 444, 192	0	5, 444, 192		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 828, 823	0	6, 828, 823		52. 00
53. 00   05300   ANESTHESI OLOGY	3, 095, 542	0	3, 095, 542		53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C 54. 01   05401   RADI ATI ON - ONCOLOGY	15, 635, 793 30, 866, 724	0	15, 635, 793 30, 866, 724		54. 00 54. 01
56. 00   05600   RADI 0I SOTOPE	0	O	0		56. 00
56. 01   05601 NUCLEAR MEDICINE	570, 523	0	570, 523		56. 01
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY	2, 343, 252 12, 924, 741	0	2, 343, 252 12, 924, 741		59. 00 60. 00
64. 00 06400 I NTRAVENOUS THERAPY	2, 228, 091	Ö	2, 228, 091		64. 00
65. 00 06500 RESPIRATORY THERAPY	6, 232, 298	0	6, 232, 298		65. 00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	13, 008, 797 1, 110, 207	0	13, 008, 797 1, 110, 207		66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	704, 055	Ö	704, 055		68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 372, 669	0	2, 372, 669		69. 00
69. 01   06901   CARDI AC REHAB 70. 00   07000   ELECTROENCEPHALOGRAPHY	1, 512, 643 494, 488	0	1, 512, 643 494, 488		69. 01 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	10, 089, 839	0	10, 089, 839		72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS 73. 01   07301   ULTRA SOUND	16, 148, 875 1, 021, 050	0	16, 148, 875 1, 021, 050		73. 00 73. 01
74. 00 07400 RENAL DIALYSIS	369, 464	0	369, 464		74. 00
OUTPATIENT SERVICE COST CENTERS		-			
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	8, 514, 595 14, 524, 603	0	8, 514, 595 14, 524, 603		90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	14, 324, 003	0	14, 524, 603		92.00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	221, 159, 433	0	221, 159, 433		118. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	94, 991, 076	0	94, 991, 076		192. 00
192. 01 19201 HEALTH TRACKS	6, 168, 217	0	6, 168, 217		192. 01
194. 00 07950 PRI MARY CARE CLINIC	3, 527, 804	0	3, 527, 804		194. 00
194. 01 07951 PARTNERS IN CARE 194. 02 07952  OCCUPATIONAL MEDICINE	31, 425 1, 389, 960	0	31, 425 1, 389, 960		194. 01 194. 02
194. 03 07953 FOUNDATI ON	283, 426	0	283, 426		194. 03
194.04 07954 SCHOOL & TOWN CLINICS 194.05 07955 MANAGED FACILITY	3, 085, 127	0	3, 085, 127		194. 04
194.06 07955 MANAGED FACILITY 194.06 07956 RENTAL PROPERTIES	847, 552 164, 416	0	847, 552 164, 416		194. 05 194. 06
194.07 07957 SNF NON CERTIFIED	3, 909, 396	Ö	3, 909, 396		194. 07
200.00 Cross Foot Adjustments	0	0	0		200. 00
201.00   Negative Cost Centers 202.00   TOTAL (sum lines 118 through 201)	335, 557, 832	0	0 335, 557, 832		201. 00 202. 00
1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		31			

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To | 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0005

				To	12/31/2019	Date/Time Pre 7/21/2020 4:1	
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	7 PIII
		0	1.00	2A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
4. 00 5. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	193, 621 1, 480, 377 3, 269, 327	1, 480, 377	193, 621 17, 150 3, 765		1. 00 4. 00 5. 00 7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY	0	275, 419 123, 637 485, 053	275, 419 123, 637	3, 763 549 3, 749 898	6, 344 23, 208	8. 00 9. 00 10. 00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0 0 0	86, 141 250, 721 468, 230	86, 141 250, 721	1, 880 5, 323 1, 471	9, 542 32, 133	11. 00 13. 00 14. 00
16. 00 17. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0 0 0	256, 019 189, 365 111, 418	189, 365	3, 337 1, 004 2, 560	11, 106	15. 00 16. 00 17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	2, 205, 958	2, 205, 958	17, 285	86, 420	30.00
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY 04400 SKILLED NURSING FACILITY	0		255, 122 48, 297	2, 822 1, 391	18, 381 7, 838	31. 00 43. 00 44. 00
	ANCILLARY SERVICE COST CENTERS			<u> </u>			1 44.00
	05000 OPERATING ROOM	0	,		3, 549	l	50.00
	O5001   ENDOSCOPY   O5100   RECOVERY   ROOM	0	450, 133 793, 683		1, 391 1, 930	11, 101 15, 218	50. 01 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	163, 798 0	163, 798	4, 338 7, 722	25, 010	
54. 00	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI ATI ON-ONCOLOGY	0	952, 298 570, 093		8, 236 1, 766	57, 040	54. 00 54. 01
56. 00	05600 RADI OI SOTOPE 05601 NUCLEAR MEDI CI NE	0	0 15, 259	0	0 277	1	56. 00 56. 01
59. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	276, 027 335, 964	276, 027	755 4, 254	6, 804	59. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	96, 333 367, 872	96, 333	1, 250 3, 403	8, 948	1
66. 00	06600 PHYSI CAL THERAPY	0	675, 055	675, 055	8, 002	52, 359	66. 00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	175, 206 68, 768		698 388	1	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	0	121, 205		1, 208		69. 00
	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY		141, 879 77, 657		837 183		1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ō	0	0	52, 550	73. 00
74. 00	07301 ULTRA SOUND 07400 RENAL DI ALYSI S	0	19, 747 0		807 0	4, 282 1, 596	
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	583, 847	583, 847	2, 248	37, 059	90. 00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			7, 172	l	91. 00 92. 00
118. 00		0	17, 163, 859	17, 163, 859	123, 598	995, 675	118. 00
192. 00	NONREI MBURSABLE COST CENTERS  19200 PHYSI CI ANS' PRI VATE OFFI CES  19201 HEALTH TRACKS	0	7, 095, 978 359, 765		59, 650 4, 228		
	07950 PRIMARY CARE CLINIC	0	419, 122		1, 273		
	07951 PARTNERS IN CARE 07952 OCCUPATIONAL MEDICINE	0	22, 440	22, 440	0	l	194. 01
	07952 OCCUPATIONAL MEDICINE 07953 FOUNDATION		137, 044 13, 985		380 218	l	194. 02 194. 03
194. 04	07954 SCHOOL & TOWN CLINICS	0	33, 240		2, 011	13, 749	194. 04
	07955 MANAGED FACILITY	0	0	-	437		194. 05
	07956 RENTAL PROPERTIES 07957 SNF NON CERTIFIED		0 382, 784	0 382, 784	0 1, 826	l	194. 06 194. 07
200.00	Cross Foot Adjustments			0			200. 00
201. 00 202. 00		0	0 25, 628, 217	0 25, 628, 217	0 193, 621	l e	201. 00 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To 12/31/2019 | Date/Time Prepared:

					To	12/31/2019	Date/Time Pre 7/21/2020 4:1	
		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	7 DIII
		South South Parkers	PLANT	LINEN SERVICE		5.2.7	0,11 2 1 2 1 1 1 1 1	
			7. 00	8. 00	9. 00	10. 00	11. 00	
		AL SERVICE COST CENTERS						
1.00	1	NEW CAP REL COSTS-BLDG & FIXT						1. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	2 252 240					5. 00 7. 00
8.00	1	LAUNDRY & LINEN SERVICE	3, 353, 369	282, 312				8.00
9. 00		HOUSEKEEPI NG	44, 037	202, 312				9.00
10.00		DI ETARY	172, 766	0		667, 829		10.00
11. 00		CAFETERI A	30, 682	Ö		0	128, 245	1
13.00	01300	NURSING ADMINISTRATION	89, 302	0	663	o	6, 509	1
14.00	01400	CENTRAL SERVICES & SUPPLY	159, 782	87	2, 063	O	2, 746	14. 00
15. 00	1	PHARMACY	91, 189	368		0	4, 121	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	55, 980			0	2, 372	1
17. 00		SOCIAL SERVICE	0	0	74	0	4, 058	17. 00
20.00		ENT ROUTINE SERVICE COST CENTERS	705 7/7	75 057	01 240	470 5/7	20 (10	20.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	725, 767 90, 869	75, 857 10, 592		472, 567 64, 052	20, 619	1
43. 00		NURSERY	17, 202			77, 991	4, 114 1, 706	
44. 00	1	SKILLED NURSING FACILITY	17, 202			77, 771	1, 700	
11.00		LARY SERVICE COST CENTERS	0		<u> </u>	<u> </u>		11.00
50.00		OPERATI NG ROOM	231, 644	18, 880	7, 440	0	5, 681	50.00
50. 01		ENDOSCOPY	160, 329	10, 379	2, 799	o	1, 958	50. 01
51.00	05100	RECOVERY ROOM	282, 694	21, 064	1, 326	0	2, 524	51.00
52.00		DELIVERY ROOM & LABOR ROOM	58, 342	14, 827		0	5, 323	1
53. 00	1	ANESTHESI OLOGY	0	0		0	2, 925	1
54. 00	1	RADI OLOGY-DI AGNOSTI C	179, 460			0	11, 833	1
54. 01 56. 00	1	RADI ATI ON-ONCOLOGY RADI OI SOTOPE	0	1, 947		0	2, 768 0	1
56. 00		NUCLEAR MEDICINE	5, 435	0		0	369	56. 00
59. 00		CARDI AC CATHETERI ZATI ON	98, 315	Ö		Ö	1, 179	1
60.00		LABORATORY	93, 045	34		ol	8, 606	1
64.00	1	INTRAVENOUS THERAPY	34, 312	1, 142	221	О	1, 514	64. 00
65.00	06500	RESPI RATORY THERAPY	105, 793	0	368	o	4, 931	65. 00
66. 00		PHYSI CAL THERAPY	107, 773	19, 188	10, 608	0	12, 609	66. 00
67. 00		OCCUPATI ONAL THERAPY	4, 466	0		0	946	1
68. 00	1	SPEECH PATHOLOGY	24, 494	0		0	530	1
69. 00	1	ELECTROCARDI OLOGY	43, 171	4, 542		0	2, 863	1
69. 01 70. 00	1	CARDI AC REHAB ELECTROENCEPHALOGRAPHY	30, 486	98 238		0	1, 231	69. 01 70. 00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 660	230		0	321 0	1
72.00		IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	1
73. 00		DRUGS CHARGED TO PATIENTS	0	Ö		ol	0	1
73. 01	1	ULTRA SOUND	7, 034	0	221	o	988	
74.00	07400	RENAL DIALYSIS	0	35	295	0	0	74. 00
		TIENT SERVICE COST CENTERS						
90.00		CLI NI C	0	18, 260		0	0	
91.00		EMERGENCY	233, 222	36, 665	8, 766	0	10, 621	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	3, 205, 251	269, 399	173, 194	614, 610	125, 965	118 00
110.00		IMBURSABLE COST CENTERS	3, 203, 231	207, 377	173, 174	014, 010	123, 703	1110.00
192.00		PHYSICIANS' PRIVATE OFFICES	11, 778	7, 905	15, 765	ol	0	192. 00
		HEALTH TRACKS	0	1, 669		Ö		192. 01
194.00	07950	PRIMARY CARE CLINIC	0	141		o	0	194. 00
		PARTNERS IN CARE	0	184		0		194. 01
		OCCUPATIONAL MEDICINE	0	497		0		194. 02
	1	FOUNDATI ON	0	0		0		194. 03
		SCHOOL & TOWN CLINICS	0	104		0		194. 04
		MANAGED FACILITY RENTAL PROPERTIES	0	0	-	0		194. 05 194. 06
		SNF NON CERTIFIED	136, 340	·	1	53, 219		194. 06
200.00	1	Cross Foot Adjustments	130, 340	2,413	١	55, 219	2, 200	200. 00
200.00		Negative Cost Centers	n	n	0	n	n	201.00
202.00		TOTAL (sum lines 118 through 201)	3, 353, 369	282, 312	194, 631	667, 829	128, 245	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0005

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2019 | Part II |
| To 12/31/2019 | Date/Time Prepared: | 7/21/2020 4:19 pm |

				12/31/2019	7/21/2020 4: 1	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
CENEDAL CEDIMACE COCT CENTEDO	13. 00	14. 00	15. 00	16. 00	17. 00	
GENERAL SERVICE COST CENTERS  1.00   OO100   NEW CAP REL COSTS-BLDG & FIXT						1 00
1.00   00100 NEW CAP REL COSTS-BLDG & FIXT 4.00   00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 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 O1300 NURSING ADMINISTRATION	384, 651					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	647, 840				14. 00
15. 00   01500   PHARMACY	0	0	372, 424			15. 00
16.00 O1600 MEDICAL RECORDS & LIBRARY	0	0	0	260, 785		16. 00
17. 00 01700 SOCI AL SERVI CE	0	0	0	0	132, 854	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	99, 402	0	0	18, 360	86, 777	30. 00
31. 00 03100 INTENSIVE CARE UNIT	19, 831	0	0	5, 988	11, 758	31. 00
43. 00   04300   NURSERY	8, 226	0	0	4, 503	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	27, 388	647, 840	0	47, 573	21, 360	50.00
50. 01   05001   ENDOSCOPY	9, 439	0	0	8, 435	0	50. 01
51.00   05100   RECOVERY ROOM	12, 167	0	0	7, 545	0	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	25, 664	0	0	10, 759	0	52. 00
53. 00   05300   ANESTHESI OLOGY	14, 104	0	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	57, 048	0	0	12, 253	0	54.00
54. 01   05401   RADI ATI ON-ONCOLOGY	0	0	0	18, 124	0	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	0	0	0	56. 00
56. 01   05601 NUCLEAR MEDICINE	O	0	0	0	0	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 682	o	0	14, 134	0	59. 00
60. 00   06000   LABORATORY	o	o	0	35, 317	0	60.00
64.00 06400 INTRAVENOUS THERAPY	o	o	0	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	23, 774	o	0	10, 931	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	o	o	0	7, 305	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	ol	o	0	1, 113	0	67. 00
68.00 06800 SPEECH PATHOLOGY	ol	o	0	948	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	13, 802	o	0	5, 668	0	69. 00
69. 01   06901   CARDI AC   REHAB	5, 933	ol	0	1, 037	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	o	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	ol	o	0	o	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	l ol	ol	0	o	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	ol	o	372, 424	0	0	73. 00
73. 01   07301   ULTRA SOUND	ol	o	0	0	0	73. 01
74.00 07400 RENAL DIALYSIS	ol	o	0	311	0	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
91. 00 09100 EMERGENCY	51, 201	o	0	50, 481	12, 959	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS	<u>'</u>					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	373, 661	647, 840	372, 424	260, 785	132, 854	118. 00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
192. 01 19201 HEALTH TRACKS	0	0	0	0	0	192. 01
194.00 07950 PRIMARY CARE CLINIC	0	0	0	0	0	194. 00
194. 01 07951 PARTNERS IN CARE	o	o	0	0	0	194. 01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	o	o	0	0	0	194. 02
194. 03 07953 FOUNDATI ON	o	o	0	0	0	194. 03
194.04 07954 SCHOOL & TOWN CLINICS	o	o	0	0	0	194. 04
194.05 07955 MANAGED FACILITY	0	o	0	o	0	194. 05
194. 06 07956 RENTAL PROPERTIES	0	ol	0	ol		194. 06
194. 07 07957 SNF NON CERTIFIED	10, 990	ol	Ō	o		194. 07
200.00 Cross Foot Adjustments	.,	آ				200. 00
201.00 Negative Cost Centers	o	ol	0	o		201. 00
202.00 TOTAL (sum lines 118 through 201)	384, 651	647, 840	372, 424	260, 785		
, , ,					•	•

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS In Lieu of Form CMS-2552-10 HENDRICKS REGIONAL HEALTH Worksheet B
Part II
Date/Time Prepared:
7/21/2020 4:19 pm Provider CCN: 15-0005 Peri od: From 01/01/2019 To 12/31/2019 Cost Center Description Total Subtotal Intern & Residents Cost

			& Post		
			Stepdown		
			Adjustments		
		24. 00	25. 00	26. 00	
GENEI	RAL SERVICE COST CENTERS	211.00	20.00	20.00	
	NEW CAP REL COSTS-BLDG & FIXT				1.00
	DEMPLOYEE BENEFITS DEPARTMENT				4. 00
	O ADMINISTRATIVE & GENERAL				5. 00
	O OPERATION OF PLANT				7. 00
	D LAUNDRY & LINEN SERVICE				8. 00
	HOUSEKEEPI NG				9. 00
	D DI ETARY				10.00
	O CAFETERI A				11. 00
	NURSING ADMINISTRATION				13. 00
	O CENTRAL SERVICES & SUPPLY				14. 00
	D PHARMACY				15. 00
	MEDICAL RECORDS & LIBRARY				16. 00
	SOCIAL SERVICE				17. 00
	TIENT ROUTINE SERVICE COST CENTERS				17.00
	D ADULTS & PEDIATRICS	3, 900, 361	0	3, 900, 361	30.00
	INTENSIVE CARE UNIT	497, 673	0	497, 673	31. 00
	NURSERY	171, 469	0	171, 469	43. 00
	O SKILLED NURSING FACILITY	171, 407	0	171, 409	44. 00
	LLARY SERVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	1 44.00
	O OPERATING ROOM	1, 718, 367	0	1, 718, 367	50.00
	1 ENDOSCOPY	655, 964	0	655, 964	50. 01
	RECOVERY ROOM	1, 138, 151	0	1, 138, 151	51.00
	D DELIVERY ROOM & LABOR ROOM	311, 744	0	311, 744	52. 00
	O ANESTHESI OLOGY	37, 182	0	37, 182	53. 00
	RADI OLOGY-DI AGNOSTI C	1, 317, 595	0	1, 317, 595	54. 00
	1 RADI ATI ON-ONCOLOGY	733, 889	0	733, 889	54. 01
	D RADI OI SOTOPE	733, 869	0	733, 889	56. 00
	NUCLEAR MEDICINE	23, 920	0	23, 920	56. 01
	CARDI AC CATHETERI ZATI ON	402, 896	0	402, 896	59. 00
	D LABORATORY	535, 161	0	535, 161	60.00
	O INTRAVENOUS THERAPY	143, 720	0	143, 720	64. 00
	RESPIRATORY THERAPY	539, 224	0	539, 224	65. 00
	PHYSI CAL THERAPY	892, 899	0	892, 899	66. 00
	O OCCUPATIONAL THERAPY	188, 114	0	188, 114	67. 00
	SPEECH PATHOLOGY	97, 789	0	97, 789	68. 00
	D ELECTROCARDI OLOGY	201, 187	0	201, 187	69. 00
	1 CARDI AC REHAB	187, 285	0	187, 285	69. 01
	DELECTROENCEPHALOGRAPHY	108, 475	0	108, 475	70. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	100, 473	0	100, 473	71.00
	IMPL. DEV. CHARGED TO PATIENT	45, 033	0	45, 033	72.00
	D DRUGS CHARGED TO PATIENTS	424, 974	0	424, 974	73. 00
	1 ULTRA SOUND	33, 079	0	33, 079	73. 00
	RENAL DIALYSIS	2, 237	0	2, 237	74. 00
	ATIENT SERVICE COST CENTERS	2, 231	<u> </u>	2, 231	74.00
90. 00 0900		645, 687	0	645, 687	90. 00
91. 00 0910		1, 388, 952	0	1, 388, 952	91. 00
	O OBSERVATION BEDS (NON-DISTINCT PART)	1,000,702	0	1,000,702	92.00
	AL PURPOSE COST CENTERS		<u> </u>		72.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	16, 343, 027	0	16, 343, 027	118. 00
	EI MBURSABLE COST CENTERS	10/010/02/	<u>~</u> _	10/010/02/	1
192. 00 1920	PHYSICIANS' PRIVATE OFFICES	7, 612, 489	0	7, 612, 489	192. 00
	1 HEALTH TRACKS	395, 991	0	395, 991	192. 01
194. 00 0795	PRIMARY CARE CLINIC	436, 858	o	436, 858	194. 00
	1 PARTNERS IN CARE	22, 760	o	22, 760	194. 01
	2 OCCUPATIONAL MEDICINE	145, 468	o	145, 468	194. 02
	3 FOUNDATION	15, 533	o	15, 533	194. 03
	4 SCHOOL & TOWN CLINICS	49, 251	O	49, 251	194. 04
	5 MANAGED FACILITY	4, 220	O	4, 220	194. 05
	6 RENTAL PROPERTIES	734	O	734	194. 06
	7 SNF NON CERTIFIED	601, 886	0	601, 886	194. 07
200. 00	Cross Foot Adjustments	0	0	0	200.00
201. 00	Negative Cost Centers	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	25, 628, 217	0	25, 628, 217	202. 00
1			-1		

						o 12/31/2019		
			CAPI TAL				7/21/2020 4:1	9 pm
			RELATED COSTS					
		Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliation	ADMI NI STRATI VE		
			FIXT	BENEFITS		& GENERAL	PLANT	
			(SQUARE	DEPARTMENT		(ACCUM. COST)	(SQUARE	
			FEET)	(GROSS SALARI ES)			FEET)	
			1.00	4. 00	5A	5. 00	7. 00	
	GENER	AL SERVICE COST CENTERS						
1.00	1	NEW CAP REL COSTS-BLDG & FIXT	885, 108					1. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	6, 687	148, 355, 655		004 004 707		4.00
5. 00 7. 00	1	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	51, 127 112, 911	13, 141, 568 2, 885, 433			325, 154	5. 00 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE	9, 512	420, 731			0 325, 154	1
9. 00		HOUSEKEEPI NG	4, 270	2, 872, 976			4, 270	1
10.00		DI ETARY	16, 752	688, 112			16, 752	1
11. 00		CAFETERI A	2, 975	1, 440, 338			2, 975	1
13.00	1	NURSI NG ADMI NI STRATI ON	8, 659	4, 078, 728	1		8, 659	1
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	16, 171 8, 842	1, 127, 115			15, 493	1
16. 00	1	MEDICAL RECORDS & LIBRARY	6, 540	2, 557, 283 769, 619		-,,	8, 842 5, 428	1
17. 00		SOCIAL SERVICE	3, 848	1, 961, 469				1
		IENT ROUTINE SERVICE COST CENTERS		, , , , , ,				
30.00		ADULTS & PEDIATRICS	76, 186	13, 245, 293			70, 373	1
31.00		INTENSIVE CARE UNIT	8, 811	2, 162, 739			8, 811	1
43. 00 44. 00		NURSERY SKILLED NURSING FACILITY	1, 668	1, 065, 558 0	•		1, 668 0	•
44.00		LARY SERVICE COST CENTERS	<u> </u>			1 0		1 44. 00
50.00	05000	OPERATING ROOM	22, 461	2, 719, 515	C	10, 665, 591	22, 461	50.00
50. 01		ENDOSCOPY	15, 546	1, 065, 688			15, 546	•
51.00		RECOVERY ROOM	27, 411	1, 478, 914			27, 411	•
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	5, 657	3, 324, 493 5, 917, 589			5, 657 0	•
54. 00		RADI OLOGY-DI AGNOSTI C	32, 889	6, 311, 067			17, 401	
54. 01	1	RADI ATI ON-ONCOLOGY	19, 689	1, 353, 113			0	1
56.00	05600	RADI OI SOTOPE	o	0	C	0	0	56. 00
56. 01	1	NUCLEAR MEDICINE	527	212, 471			527	
59. 00		CARDI AC CATHETERI ZATI ON	9, 533	578, 424			9, 533	1
60. 00 64. 00		LABORATORY INTRAVENOUS THERAPY	11, 603	3, 259, 978			9, 022	1
65. 00	1	RESPIRATORY THERAPY	3, 327 12, 705	958, 066 2, 607, 656			3, 327 10, 258	
66. 00	1	PHYSI CAL THERAPY	23, 314	6, 131, 429			10, 450	
67. 00		OCCUPATIONAL THERAPY	6, 051	535, 164	[ c	862, 222	433	67. 00
68. 00	1	SPEECH PATHOLOGY	2, 375	297, 475	•		2, 375	1
69. 00		ELECTROCARDI OLOGY	4, 186	925, 429				1
69. 01 70. 00		CARDI AC REHAB ELECTROENCEPHALOGRAPHY	4, 900 2, 682	641, 271 140, 198			2, 956 2, 682	1
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	2,002	140, 170	1		2,002	1
72. 00		IMPL. DEV. CHARGED TO PATIENT	ō	0		_	0	1
73. 00	07300	DRUGS CHARGED TO PATIENTS	o	0	C	9, 892, 690	0	73. 00
	1	ULTRA SOUND	682	618, 561				73. 01
74. 00		RENAL DIALYSIS TIENT SERVICE COST CENTERS	0	123	C	300, 496	0	74. 00
90. 00		CLINIC	20, 164	1, 722, 604		6, 976, 475	0	90.00
91. 00		EMERGENCY	32, 118	5, 495, 439			22, 614	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
110 00		AL PURPOSE COST CENTERS	F00 770	04 711 (00	E2 /04 40F	107 400 700	240 700	110 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	592, 779	94, 711, 629	-53, 621, 105	187, 438, 700	310, 792	]118.00
192.00		PHYSI CLANS' PRI VATE OFFI CES	245, 070	45, 695, 158	C	79, 355, 247	1, 142	192. 00
	1	HEALTH TRACKS	12, 425	3, 239, 995				192. 01
		PRIMARY CARE CLINIC	14, 475	975, 559	C	2, 947, 917		194. 00
		PARTNERS IN CARE	775	0	C	,		194. 01
		OCCUPATIONAL MEDICINE FOUNDATION	4, 733 483	291, 360 166, 892		1, 129, 443 236, 406		194. 02 194. 03
		SCHOOL & TOWN CLINICS	1, 148	1, 540, 945		2, 588, 237		194. 03
		MANAGED FACILITY	', ' . o	334, 624		712, 116		194. 05
		RENTAL PROPERTIES	o	0		138, 143		194. 06
		SNF NON CERTIFIED	13, 220	1, 399, 493	0	2, 265, 459	13, 220	194. 07
200.00	1	Cross Foot Adjustments						200.00
201. 00 202. 00		Negative Cost Centers Cost to be allocated (per Wkst. B,	25, 628, 217	30, 607, 684		53, 621, 105	17, 986, 619	201.00
202.00		Part I)	20,020,217	50, 007, 004		55, 621, 105	17, 700, 019	202.00
203.00	)	Unit cost multiplier (Wkst. B, Part I)	28. 954904	0. 206313		0. 190188	55. 317231	203. 00
204.00	)	Cost to be allocated (per Wkst. B,		193, 621		1, 497, 527	3, 353, 369	204. 00
	1	Part II)	ı İ		I		I	I

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 01/01/2019 To 12/31/2019		
Cost Center Description	CAPITAL RELATED COSTS  NEW BLDG & FIXT (SQUARE FEET)	BENEFITS DEPARTMENT (GROSS	Reconciliatio	n ADMI NI STRATI VE & GENERAL (ACCUM. COST)	PLANT	
	1.00	SALARI ES) 4. 00	5A	5. 00	7. 00	
205.00 Unit cost multiplier (Wkst. B, Part	1.00	0. 001305		0. 005312		205. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0005

| Period: | Worksheet B-1 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared:

				To	12/31/2019	Date/Time Pre 7/21/2020 4:1	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	y pili
		LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(PATI ENT DAYS)	(MANHOURS)	ADMI NI STRATI ON	
		LAUNDRY)	02	511.0)		(DI RECT	
		8.00	9.00	10.00	11. 00	NRSING HRS) 13.00	
	GENERAL SERVICE COST CENTERS	0.00	7. 00	10.00	11.00	13.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 5. 00	OO400						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 227, 497					8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	2, 642 27	24, 721			9.00
11. 00	01100 CAFETERI A	0	0	24, 721	1, 827, 724		11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	9	0	92, 771	1, 137, 108	
14. 00	01400 CENTRAL SERVICES & SUPPLY	379	28	0	39, 135	0	14. 00
15. 00 16. 00	01500   PHARMACY   01600   MEDICAL RECORDS & LIBRARY	1, 599 0	6 13	0	58, 729 33, 801	0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE		13	0	57, 836	l .	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	329, 825	1, 240	17, 493	293, 856	1	1
31. 00 43. 00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	46, 056 17, 479	192 4	2, 371 2, 887	58, 626 24, 317	58, 626 24, 317	31. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	o O	2, 667	21,017	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 50. 01	05000   OPERATI NG ROOM   05001   ENDOSCOPY	82, 090 45, 130	101 38	0	80, 965 27, 904	80, 965 27, 904	
51. 00	05100 RECOVERY ROOM	91, 587	18	0	35, 968		
52.00	05200 DELIVERY ROOM & LABOR ROOM	64, 470	50	0	75, 867	75, 867	52. 00
53.00	05300 ANESTHESI OLOGY	0	2	0	41, 693	l	
54. 00 54. 01	05400  RADI OLOGY-DI AGNOSTI C   05401  RADI ATI ON-ONCOLOGY	135, 552 8, 466	112 40	0	168, 646 39, 446		54. 00 54. 01
56. 00	05600 RADI OI SOTOPE	0, 400	0	0	0	0	56.00
56. 01	05601 NUCLEAR MEDICINE	o	3	0	5, 265	0	56. 01
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	16, 797	16, 797	
60. 00 64. 00	06000  LABORATORY  06400  I NTRAVENOUS THERAPY	147 4, 965	76 3	0	122, 646 21, 584	l	60.00
65. 00	06500 RESPIRATORY THERAPY	0	5	Ö	70, 280	l	
66. 00	06600 PHYSI CAL THERAPY	83, 431	144	0	179, 702	0	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	15 3	0	13, 489	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	19, 747	3 16	0	7, 550 40, 801	40, 801	
69. 01	06901 CARDI AC REHAB	428	7	Ö	17, 538		
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 034	14	0	4, 578	l	70.00
71. 00 72. 00	O7100   MEDICAL SUPPLIES CHARGED TO PATIENTS   O7200   MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
73. 01	07301 ULTRA SOUND	O	3	Ö	14, 084	Ö	73. 01
74. 00	07400 RENAL DIALYSIS	151	4	0	0	0	74. 00
90. 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	79, 396	58	O	0	0	90.00
91.00	09100 EMERGENCY	159, 420	119	0	151, 361	151, 361	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
118. 00	SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)	1, 171, 352	2, 351	22, 751	1, 795, 235	1, 104, 619	110 00
118.00	NONREIMBURSABLE COST CENTERS	1, 1/1, 352	2, 351	22, 751	1, 795, 235	1, 104, 619	]118.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	34, 373	214	0	0		192. 00
	19201 HEALTH TRACKS	7, 255	44	0	0		192. 01
	07950  PRIMARY CARE CLINIC  07951  PARTNERS IN CARE	614 799	9	0	0		194. 00 194. 01
	07952 OCCUPATIONAL MEDICINE	2, 161	21	Ö	0		194. 02
	07953 FOUNDATI ON	O	1	0	0		194. 03
	07954 SCHOOL & TOWN CLINICS	452	2	0	0		194. 04
	07955 MANAGED FACILITY 07956 RENTAL PROPERTIES	0	0	0	0		194. 05 194. 06
	07957 SNF NON CERTIFIED	10, 491	o	1, 970	32, 489	l e	
200.00	, ,						200. 00
201.00		1 421 420	E 424 022	2 570 000	2 202 545	7 012 020	201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 421, 439	5, 436, 032	2, 578, 082	2, 302, 545	7, 813, 928	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 157998	2, 057. 544285	104. 287124	1. 259788	6. 871755	203. 00
204.00		282, 312	194, 631	667, 829	128, 245	384, 651	204. 00
205. 00	Part II)   Unit cost multiplier (Wkst. B, Part	0. 229990	73. 668055	27. 014643	0. 070167	0. 338271	205 00
200.00	II)	0. 22 77 70	73.000033	27.014043	5. 570107	0.330271	
		·	·	·			

Heal th Finan	cial Systems	HENDRI CKS REG	ONAL HEALTH		In Lie	eu of Form CMS-2	2552-10
COST ALLOCAT	TION - STATISTICAL BASIS		Provi der C	CN: 15-0005	Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019		
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERI A (MANHOURS)	NURSI NG ADMI NI STRATI ON	
		LAUNDRY)	ŕ	ŕ		(DI RECT NRSI NG HRS)	
		8.00	9. 00	10.00	11. 00	13.00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

-	Cost Center Description	CENTRAL SERVICES &	PHARMACY	MEDI CAL	SOCIAL SERVICE	7/21/2020 4:19 pm
-		SERVICES &			OLIVI OL	
-		SUPPLY	(100%	RECORDS & LI BRARY	(TIME	
-		(100%	ALLOCATION)	(GROSS	SPENT)	
-		ALLOCATION)		CHARGES)	,	
-	GENERAL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	
	00100 NEW CAP REL COSTS-BLDG & FIXT					1. 00
1	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
- 1	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5. 00 7. 00
1	00800 LAUNDRY & LINEN SERVICE					8. 00
1	00900 HOUSEKEEPI NG					9. 00
- 1	01000 DI ETARY 01100 CAFETERI A					10.00
1	01300 NURSING ADMINISTRATION					13. 00
	01400 CENTRAL SERVICES & SUPPLY	100				14. 00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	100 0	442, 035, 979		15. 00 16. 00
	01700 SOCIAL SERVICE	0	0	442, 033, 979		17. 00
]	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	0	0	31, 118, 840		30.00
	03100 INTENSIVE CARE UNIT 04300 NURSERY	0	0	10, 148, 759 7, 632, 251	1, 821 0	31. 00 43. 00
44.00	04400 SKILLED NURSING FACILITY	0	Ö	0		44. 00
	ANCILLARY SERVICE COST CENTERS	100	ما	00 (22 400	2 200	F0.0
	05000 OPERATING ROOM 05001 ENDOSCOPY	100	0	80, 632, 489 14, 296, 150		50. 00 50. 0
51.00	05100 RECOVERY ROOM	O	O	12, 787, 408	1	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	18, 235, 140	1	52. 00
1	05300  ANESTHESI OLOGY 05400  RADI OLOGY-DI AGNOSTI C	0	ol Ol	0 20, 768, 461	0	53. 00 54. 00
1	05400 RADI ATI ON-ONCOLOGY	o o	o	30, 717, 923		54. 0
1	05600 RADI OI SOTOPE	0	o	0	_	56. 00
- 1	05601 NUCLEAR MEDICINE 05900 CARDIAC CATHETERIZATION	0	0 0	0 23, 955, 781	0	56. 0° 59. 00
1	06000 LABORATORY	0	0	59, 860, 108	_	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	О	0	O	64. 00
	06500 RESPI RATORY THERAPY	0	0	18, 526, 807	0	65. 00
- 1	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0	12, 380, 597 1, 885, 928		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	O	Ō	1, 607, 248	_	68. 00
	06900 ELECTROCARDI OLOGY	0	0	9, 606, 457		69. 00
	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	0	0	1, 758, 207 0	0	69. 0° 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	Ö	Ō	o	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS 07301 ULTRA SOUND	0	100 0	0	0	73. 00 73. 0
	07400 RENAL DIALYSIS	0	o	527, 724		74. 00
	OUTPATIENT SERVICE COST CENTERS		-1			
	09000 CLINIC 09100 EMERGENCY	0	0	0 85, 589, 701	- 1	90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	J	S <sub>1</sub>	00,007,701	2,007	92. 00
	SPECIAL PURPOSE COST CENTERS	100	100	442 025 070	20 575	110.0
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	100	100	442, 035, 979	20, 575	118. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0		
192. 01	19201 HEALTH TRACKS 07950 PRIMARY CARE CLINIC	0	0	0		
	07950 PRIMARY CARE CLINIC 07951 PARTNERS IN CARE	0	0	0		194. 00 194. 0
194. 02	07952 OCCUPATIONAL MEDICINE	0	ő	Ö		194. 02
	07953 FOUNDATION	0	O	0	_	194. 0
	07954 SCHOOL & TOWN CLINICS 07955 MANAGED FACILITY	0	0	0	_	194. 04 194. 05
- 1	07956 RENTAL PROPERTIES		o	0		194. 0
194. 07	07957 SNF NON CERTIFIED	0	О	0	0	194. 0
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers					200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	3, 980, 386	4, 374, 714	2, 857, 900	3, 378, 507	201.00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	39, 803. 860000 647, 840	43, 747. 140000 372, 424	0. 006465 260, 785	1	203. 00 204. 00
204.00	Part II)	047, 040	372,424	200, 700	132, 034	204.00
205. 00	Unit cost multiplier (Wkst. B, Part	6, 478. 400000	3, 724. 240000	0. 000590	6. 457060	205. 00

Heal th Financial	Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS	-2552-10
COST ALLOCATION	- STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B	-1
				11.2	From 01/01/2019 Fo 12/31/2019	Date/Time Pr 7/21/2020 4:	
Cost	Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		SERVICES &	(100%	RECORDS &			
		SUPPLY	ALLOCATION)	LI BRARY	(TIME		
		(100%		(GROSS	SPENT)		
		ALLOCATION)		CHARGES)			
		14.00	15. 00	16.00	17. 00		
206. 00 NAHE	adjustment amount to be allocated						206. 00
(per	Wkst. B-2)						
207. 00 NAHE	unit cost multiplier (Wkst. D,						207. 00
Part	s III and IV)						

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Period: Worksheet C From 01/01/2019 Part I
		To 12/31/2019 Date/Time Prepared:

					To 12/31/2019	Date/Time Pre 7/21/2020 4:1	pared: 9 pm
			Title	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	
	TIENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	32, 810, 804		32, 810, 80	4 16, 235	32, 827, 039	30. 00
31.00 03100	INTENSIVE CARE UNIT	6, 142, 674		6, 142, 67	4 0	6, 142, 674	31. 00
43.00 04300	NURSERY	2, 424, 974		2, 424, 97	4 0	2, 424, 974	43. 00
44.00 04400	SKILLED NURSING FACILITY	0			0	0	44. 00
	LARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	19, 942, 644		19, 942, 64	4 17, 209	19, 959, 853	50. 00
50. 01 05001	ENDOSCOPY	3, 797, 073		3, 797, 07	3 0	3, 797, 073	50. 01
51.00 05100	RECOVERY ROOM	5, 444, 192		5, 444, 19	2 0	5, 444, 192	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	6, 828, 823		6, 828, 82	3 0	6, 828, 823	52. 00
53.00 05300	ANESTHESI OLOGY	3, 095, 542		3, 095, 54	2 0	3, 095, 542	53. 00
54.00 05400	RADI OLOGY-DI AGNOSTI C	15, 635, 793		15, 635, 79	3 0	15, 635, 793	54.00
54. 01 05401	RADI ATI ON-ONCOLOGY	30, 866, 724		30, 866, 72	4 0	30, 866, 724	54. 01
56. 00 05600	RADI OI SOTOPE	0			0 0	0	56. 00
56. 01 05601	NUCLEAR MEDICINE	570, 523		570, 52	3 0	570, 523	56. 01
59.00 05900	CARDI AC CATHETERI ZATI ON	2, 343, 252		2, 343, 25		2, 343, 252	
60.00 06000	LABORATORY	12, 924, 741		12, 924, 74		12, 924, 741	60.00
	I NTRAVENOUS THERAPY	2, 228, 091		2, 228, 09		2, 228, 091	64. 00
65. 00 06500	RESPI RATORY THERAPY	6, 232, 298	0			6, 232, 298	65. 00
66. 00 06600	PHYSI CAL THERAPY	13, 008, 797	0	13, 008, 79		13, 008, 797	
67. 00 06700	OCCUPATIONAL THERAPY	1, 110, 207	0	1, 110, 20		1, 110, 207	
	SPEECH PATHOLOGY	704, 055	0	704, 05		704, 055	
	ELECTROCARDI OLOGY	2, 372, 669		2, 372, 66		2, 372, 669	
	CARDI AC REHAB	1, 512, 643		1, 512, 64		1, 512, 643	
	ELECTROENCEPHALOGRAPHY	494, 488		494, 48		494, 488	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	1
	IMPL. DEV. CHARGED TO PATIENT	10, 089, 839		10, 089, 83	9 0	10, 089, 839	
	DRUGS CHARGED TO PATIENTS	16, 148, 875		16, 148, 87		16, 148, 875	
	ULTRA SOUND	1, 021, 050		1, 021, 05		1, 021, 050	
•	RENAL DIALYSIS	369, 464		369, 46		369, 464	
	TIENT SERVICE COST CENTERS					2217 121	1
	CLINIC	8, 514, 595		8, 514, 59	5 0	8, 514, 595	90.00
	EMERGENCY	14, 524, 603		14, 524, 60		14, 816, 160	
	OBSERVATION BEDS (NON-DISTINCT PART)	5, 638, 430		5, 638, 43		5, 638, 430	
200.00	Subtotal (see instructions)	226, 797, 863	0			227, 122, 864	
201.00	Less Observation Beds	5, 638, 430	· ·	5, 638, 43		5, 638, 430	
202. 00	Total (see instructions)	221, 159, 433	0				
					/		

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Period: Worksheet C From 01/01/2019 Part I

Title XVIII						Part I Date/Time Pre	pared:	
Charges							7/21/2020 4:1	9 pm
Inpatient   Outpatient   Outpatient   Total (col.   Cost or other Ratio   Inpatient   Ratio   Inpatient   Ratio   Inpatient   Ratio   Inpatient   Ratio   Inpatient   Inpati					XVIII	Hospi tal	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS								
INPATI ENT ROUTH NE SERVICE COST CENTERS   33, 830, 253   34, 830, 253   34, 83		Cost Center Description	I npati ent	Outpati ent				
INPATI ENT ROUTI NE SERVICE COST CENTERS   33, 830, 253   33, 830, 253   30, 00					+ col. 7)	Ratio		
IMPATI ENT ROUTI NE SERVICE COST CENTERS   33,830,253   33,830,253   30,00   310,0			4 00	7.00				
30. 00		INDATIENT DOUTINE CEDVICE COCT CENTERS	6.00	7.00	8.00	9.00	10.00	
31.00   03100   INTENSIVE CARE UNIT   9,637,177   7,632,251   31.00   04300   NURSERY   7,632,251   43.00   04400   04400   SKI LLED RUIRSING FACILITY   0	20.00		22 020 252		22 020 25	2		20.00
43.00								1
44.00   ANCILLARY SERVICE COST CENTERS								1
ANCILLARY SERVICE COST CENTERS								
SOLIC   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05100   05000   05100   05000   05100   05000   05100   05000   05100   05000   0510	44.00		l ol			<u>U</u>		44.00
So. 01   OSOO1   ENDOSCOPY   920, 446   13, 193, 587   14, 114, 033   0, 269028   0, 000000   50, 01	50 00		23 017 914	13 607 720	67 615 57	3 0 204042	0.00000	50.00
51.00   05100   RECOVERY ROOM   17, 823, 517, 761   9, 269, 647   12, 787, 408   0, 425746   0, 000000   51.00			1 1					
52.00   05200   DELI VERY ROOM & LABOR ROOM   17, 823, 216   411, 924   18, 235, 140   0. 374487   0. 000000   52.00   53.00   05300   ANESTHESI OLOGY   6, 082, 669   11, 167, 459   17, 250, 128   0. 179450   0. 000000   53.00   54.01   05401   RADII OLOGY-DI AGNOSTI C   11, 591, 423   70, 018, 564   81, 609, 987   0. 191592   0. 000000   54.00   56.01   05401   RADII OLOGY-DI AGNOSTI C   17, 591, 423   70, 018, 564   81, 609, 987   0. 191592   0. 000000   54.00   56.01   05601   NUCLEAR MEDI CI NE   633, 567   6, 638, 436   7, 272, 003   0. 078455   0. 000000   56.01   59.00   05600   CARDII AC CATHETERI ZATI ON   9, 208, 697   11, 207, 323   20, 416, 020   0. 114775   0. 000000   59.00   64.00   06000   LABORATORY   14, 470, 663   5, 596, 277   68, 066, 940   0. 189883   0. 000000   65.00   65.00   06500   RADII OLOGY   4, 70, 663   65.00   65.00   06600   PHYSI CAL THERAPY   2, 292, 071   21, 323, 562   23, 615, 633   0. 550855   0. 000000   65.00   66.00   06600   PHYSI CAL THERAPY   1, 181, 085   1, 458, 597   2, 639, 682   0. 420584   0. 000000   65.00   66.00   06600   ELECTROCARDI OLOGY   4, 594, 978   13, 263, 283   17, 858, 261   0. 132861   0. 000000   69.00   69.01   06901   CARDII AC REHAB   35, 236   31, 497, 599   31, 84, 995   0. 474928   0. 000000   69.00   69.01   06901   CARDII AC REHAB   35, 236   31, 497, 599   31, 84, 995   0. 474928   0. 000000   69.01   69.01   07300   DRUGS CHARGED TO PATI ENTS   1, 889, 273   8, 442, 739   10, 302, 012   0. 099112   0. 000000   73.00   69.00   07300   07300   DRUGS CHARGED TO PATI ENTS   2, 288, 467   24, 557, 107   0. 200075   0. 000000   90.00   69.00   09000   CLINIC   0. 000000   0.								
53.00   05300   ANESTHESI OLOGY   6, 082, 669   11, 167, 459   17, 250, 128   0. 179450   0. 000000   53.00			1					
54. 00   05400   RADI OLOGY-DI AGNOSTI C   11, 591, 423   70, 018, 564   81, 609, 987   0. 191592   0. 000000   54. 01   54. 01   05401   RADI ATI ON-ONCOLOGY   474, 990   92, 896, 538   93, 371, 528   0. 330580   0. 0000000   56. 00   1   1   0. 000000   0. 0000000   56. 00   1   1   0. 000000   0. 0000000   56. 00   1   1   0. 000000   0. 0000000   56. 00   1   1   0. 000000   0. 0000000   56. 00   0. 000000   56. 00   0. 000000   56. 00   0. 000000   56. 00   0. 000000   56. 00   0. 0000000   0. 0000000   0. 0000000   0. 00000000								
54. 01   05401   RADI ATI ON-ONCOLOGY   474, 990   92, 896, 538   93, 371, 528   0.330580   0.000000   54. 01   56. 00   05600   RADI OI SOTOPE   0   1   1   0.000000   56. 00   56. 01   05601   NUCLEAR MEDI CI NE   633, 567   6, 638, 436   7, 272, 003   0.078455   0.000000   56. 01   59. 00   05900   CARDI AC CATHETERI ZATI ON   9, 208, 697   11, 207, 323   20, 416, 020   0.114775   0.000000   59. 00   60. 00   05000   LABORATORY   14, 470, 663   53, 596, 277   68, 066, 940   0.18983   0.000000   64. 00   64. 00   06400   INTRAVENIOUS THERAPY   94, 909   10, 986, 994   11, 081, 903   0.201057   0.000000   65. 00   65. 00   06500   RESPI RATORY THERAPY   8, 518, 305   10, 625, 721   19, 144, 026   0.325548   0.000000   65. 00   66. 00   06600   PHYSI CAL THERAPY   2, 292, 071   21, 323, 562   23, 615, 633   0.550855   0.000000   67. 00   68. 00   06800   SPEECH PATHOLOGY   463, 466   1, 682, 083   2, 145, 549   0.328147   0.000000   69. 00   69. 00   06900   CARDI AC REHAB   35, 236   31,49, 759   3, 184, 995   0.474928   0.000000   69. 01   70. 00   07000   ELECTROCARDI OLOGY   4, 594, 978   13, 263, 283   17, 858, 261   0.132861   0.000000   69. 01   71. 00   07100   O7100   CARDI AC REHAGED TO PATI ENTS   13, 688, 790   5, 816, 342   19, 505, 132   0.517292   0.000000   72. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   13, 688, 790   5, 816, 342   19, 505, 132   0.517292   0.000000   74. 00   74. 00   07400   RENAL DI ALYSI S   462, 532   65, 192   527, 724   0.700108   0.000000   74. 00   74. 00   07400   RERGEDKCY   20, 238, 461   90, 871, 136   111, 109, 597   0.130723   0.000000   90. 00   74. 00   09100   DEBERGENCY   20, 238, 461   90, 871, 136   111, 109, 597   0.130723   0.000000   91. 00   74. 00   09100   DEBERGENCY   20, 238, 461   90, 871, 136   111, 109, 597   0.130723   0.000000   91. 00   74. 00   09100   DEBERGENCY   20, 238, 461   90, 871, 136   111, 109, 597   0.130723   0.000000   91. 00   74. 00   09100   DEBERGENCY   20, 238, 461   90, 871, 136   111, 109, 597   0.130723   0.00								
56. 00   05600   RADI OI SOTOPE   0   0   1   1   0   0   0   0   0   0								
56. 01   05601   NUCLEAR MEDICINE   633, 567   6, 638, 436   7, 272, 003   0. 078455   0. 000000   56. 01   59. 00   05900   CARDI AC CATHETERIZATION   9, 208, 697   11, 207, 323   20, 416, 020   0. 114775   0. 000000   59. 00   60. 00   06000   LABORATORY   14, 470, 663   53, 596, 277   68, 066, 940   0. 189883   0. 000000   60. 00   64. 00   06400   INTRAVENOUS THERAPY   94, 909   10, 986, 994   11, 081, 903   0. 201057   0. 000000   64. 00   65. 00   06500   RESPIRATORY THERAPY   8, 518, 305   10, 625, 721   19, 144, 026   0. 325548   0. 000000   65. 00   66. 00   06600   PHYSI CAL THERAPY   2, 292, 071   21, 323, 562   23, 615, 633   0. 550855   0. 000000   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   1, 181, 085   1, 458, 597   2, 639, 682   0. 420584   0. 000000   67. 00   68. 00   06800   SPECH PATHOLOGY   463, 466   1, 682, 083   2, 145, 549   0. 328147   0. 000000   69. 00   69. 01   06901   CARDI AC REHAB   35, 234   35, 234   317, 858, 261   0. 132861   0. 000000   69. 01   69. 01   06901   CARDI AC REHAB   35, 234   33, 149, 759   3, 184, 995   0. 474928   0. 000000   69. 01   69. 00   07000   ELECTROCARDI OLOGY   4, 594, 978   13, 263, 283   17, 858, 261   0. 132861   0. 000000   69. 01   69. 01   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0. 000000   0. 000000   0. 000000   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   13, 688, 790   5, 816, 342   19, 505, 132   0. 517292   0. 000000   72. 00   73. 01   07301   ULTRA SOUND   1, 859, 273   8, 442, 739   10, 302, 012   0. 099112   0. 000000   73. 01   74. 00   07400   RENAL DI ALYSI S   462, 532   65, 192   527, 724   0. 700108   0. 000000   74. 00   74. 00   09000   CLI NI C   32, 687   42, 524, 420   42, 557, 107   0. 200075   0. 000000   91. 00   74. 00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   1, 061, 629   3, 550, 637   4, 612, 266   1. 222486   0. 000000   92. 00   74. 00   09000   OSERVATI ON BEDS (NON-DI STI NCT PART)   1, 061, 629   3, 550, 637   4, 612, 266   1. 222486   0. 000000   92. 00   75. 00			1 1	12, 070, 330	75, 571, 52			
59. 00   05900   CARDIAC CATHETERIZATION   9, 208, 697   11, 207, 323   20, 416, 020   0. 114775   0. 000000   59. 00   60. 00			1	6 638 436	7 272 00			
60. 00   06000   LABORATORY   14, 470, 663   53, 596, 277   68, 066, 940   0. 189883   0. 000000   60. 00   60. 00   60. 00   60. 00   60. 00   60. 00   10   10   10   10   10   10   10								
64. 00								
65. 00			1 1					
66. 00								
67. 00								
68. 00								
69. 00								
69. 01 06901 CARDI AC REHAB 35, 236 3, 149, 759 3, 184, 995 0. 474928 0. 000000 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 298, 132 479, 548 777, 680 0. 635850 0. 000000 70. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0. 000000 0. 000000 0. 000000 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 13, 688, 790 5, 816, 342 19, 505, 132 0. 517292 0. 000000 72. 00 73. 01 07301 ULTRA SOUND 13, 859, 273 8, 442, 739 10, 302, 012 0. 099112 0. 000000 73. 01 74. 00 07400 RENAL DI ALYSI S 462, 532 65, 192 527, 724 0. 700108 0. 000000 74. 00 07400 RENAL DI ALYSI S 09000 CLI NI C 32, 687 42, 524, 420 42, 557, 107 0. 200075 0. 000000 74. 00 09100 EMERGENCY 20, 238, 461 90, 871, 136 111, 109, 597 0. 130723 0. 000000 19. 00 09200 BESERVATI ON BEDS (NON-DI STI NCT PART) 1, 061, 629 3, 550, 637 4, 612, 266 1. 222486 0. 000000 201. 00 Less Observati on Beds								
70. 00	69. 01	06901 CARDI AC REHAB					0. 000000	69. 01
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   13, 688, 790   5, 816, 342   19, 505, 132   0. 517292   0. 000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   13, 985, 469   21, 099, 823   35, 085, 292   0. 460275   0. 000000   73. 00   73. 01   74. 00   07400   RENAL DIALYSIS   462, 532   65, 192   527, 724   0. 700108   0. 000000   74. 00   000000   00000   000000   000000   000000	70.00	07000 ELECTROENCEPHALOGRAPHY					0. 000000	70. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   13, 985, 469   21, 099, 823   35, 085, 292   0. 460275   0. 000000   73. 00   73. 01   74. 00   07400   RENAL DIALYSIS   462, 532   65, 192   527, 724   0. 700108   0. 000000   74. 00   000000   000000   0000000   000000	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0		0.000000	0.000000	71. 00
73. 01   07301   ULTRA SOUND   1,859,273   8,442,739   10,302,012   0.099112   0.000000   73. 01   74. 00   07400   RENAL DI ALYSI S   462,532   65,192   527,724   0.700108   0.000000   74. 00   000000   000000	72.00	07200 IMPL. DEV. CHARGED TO PATIENT	13, 688, 790	5, 816, 342	19, 505, 13	0. 517292	0.000000	72. 00
74. 00 07400 RENAL DIALYSIS 462, 532 65, 192 527, 724 0. 700108 0. 000000 74. 00 000000 CLI NI C 32, 687 42, 524, 420 42, 557, 107 0. 200075 0. 000000 91. 00 09100 EMERGENCY 20, 238, 461 90, 871, 136 111, 109, 597 0. 130723 0. 000000 91. 00 09200 08SERVATI ON BEDS (NON-DISTINCT PART) 1, 061, 629 3, 550, 637 4, 612, 266 1. 222486 0. 000000 201. 00 Less Observation Beds 200, 00 201. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	13, 985, 469	21, 099, 823	35, 085, 29	0. 460275	0.000000	73. 00
90. 00   O9000   CLI NI C   32, 687   42, 524, 420   42, 557, 107   0. 200075   0. 000000   90. 00   91. 00   O9100   EMERGENCY   20, 238, 461   90, 871, 136   111, 109, 597   0. 130723   0. 000000   91. 00   92. 00   O9200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   1, 061, 629   3, 550, 637   4, 612, 266   1. 222486   0. 000000   92. 00   201. 00   Less Observation Beds   208, 547, 950   547, 437, 321   755, 985, 271   200. 00   201. 00   2	73. 01	07301 ULTRA SOUND	1, 859, 273	8, 442, 739	10, 302, 01	2 0. 099112	0. 000000	73. 01
90. 00	74.00	07400 RENAL DIALYSIS	462, 532	65, 192	527, 72	0. 700108	0. 000000	74. 00
91. 00   09100   EMERGENCY   20, 238, 461   90, 871, 136   111, 109, 597   0. 130723   0. 000000   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   208, 547, 950   547, 437, 321   755, 985, 271   200. 00   201. 00   2								
92. 00   09200   08SERVATI ON BEDS (NON-DISTINCT PART)   1,061,629   3,550,637   4,612,266   1.222486   0.000000   92. 00   200. 00   201. 00   Less Observation Beds   208,547,950   547,437,321   755,985,271   200. 00   201. 0								
200. 00         Subtotal (see instructions)         208, 547, 950         547, 437, 321         755, 985, 271         200. 00           201. 00         Less Observation Beds         201. 00         201. 00						0. 130723		
201.00 Less Observation Beds 201.00							0. 000000	
	200.00		208, 547, 950	547, 437, 321	755, 985, 27	'1		
202.00   Total (see instructions)   208,547,950   547,437,321   755,985,271   202.00								
	202.00	Total (see instructions)	208, 547, 950	547, 437, 321	755, 985, 27	'1		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: 15-0005	Peri od: Worksheet C From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared: 7/21/2020 4:19 pm		

Cost Center Description PF	PS Inpatient	Title XVIII	Hospi tal	7/21/2020 4:19 pm PPS
Cost Center Description PF	PS Innatient			FF3
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.
31. 00   03100   INTENSIVE CARE UNIT				31.
43. 00   04300   NURSERY				43.
44. 00 04400 SKILLED NURSING FACILITY				44.
ANCI LLARY SERVI CE COST CENTERS	0.005404			
50. 00   05000   OPERATI NG ROOM	0. 295196			50.
50. 01   05001   ENDOSCOPY	0. 269028			50.
51. 00 05100 RECOVERY ROOM	0. 425746			51.
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 374487			52.
53. 00 05300 ANESTHESI OLOGY	0. 179450			53.
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 191592			54.
54. 01   05401   RADI ATI ON-ONCOLOGY	0. 330580			54.
56. 00   05600   RADI OI SOTOPE	0. 000000			56.
56. 01 05601 NUCLEAR MEDICINE	0. 078455			56.
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 114775			59.
60. 00   06000   LABORATORY	0. 189883			60.
64. 00   06400   I NTRAVENOUS THERAPY 65. 00   06500   RESPIRATORY THERAPY	0. 201057 0. 325548			65.
66. 00   06600 PHYSI CAL THERAPY	0. 325548			66.
67. 00 06700 OCCUPATI ONAL THERAPY	0. 420584			67.
68. 00 06800 SPEECH PATHOLOGY	0. 420364			68.
69. 00   06900   ELECTROCARDI OLOGY	0. 328147			69.
69. 01   06901   CARDI AC   REHAB	0. 474928			69.
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 635850			70.
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 517292			72.
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 460275			73.
73. 01 07301 ULTRA SOUND	0. 099112			73.
74. 00   07400   RENAL DI ALYSI S	0. 700108			74.
OUTPATIENT SERVICE COST CENTERS	3. 733.30			,
90. 00 09000 CLINIC	0. 200075			90.
91. 00   09100   EMERGENCY	0. 133347			91.
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 222486			92.
200.00 Subtotal (see instructions)				200.
201.00 Less Observation Beds				201.
202.00 Total (see instructions)				202.

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0005	Peri od: Worksheet C
		From 01/01/2019   Part I
		To 12/21/2010   Doto/Time December

						To 12/31/2019	Date/Time Prep 7/21/2020 4:19	
				Titl	e XIX	Hospi tal	Cost	
						Costs		
		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		<b>'</b>	(from Wkst. B,	Adj .		Di sal I owance		
			Part I, col.	,				
			26)					
			1.00	2.00	3.00	4. 00	5. 00	
	INPATI	ENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32, 810, 804		32, 810, 80	16, 235	32, 827, 039	30. 00
31.00	03100	INTENSIVE CARE UNIT	6, 142, 674		6, 142, 67	74 0	6, 142, 674	
43.00	04300	NURSERY	2, 424, 974		2, 424, 97		2, 424, 974	43.00
44. 00		SKILLED NURSING FACILITY	0			0	0	44.00
		ARY SERVICE COST CENTERS	-1				-	
50.00		OPERATI NG ROOM	19, 942, 644		19, 942, 64	17, 209	19, 959, 853	50.00
50. 01		ENDOSCOPY	3, 797, 073		3, 797, 07		3, 797, 073	
51. 00		RECOVERY ROOM	5, 444, 192		5, 444, 19		5, 444, 192	
52. 00		DELIVERY ROOM & LABOR ROOM	6, 828, 823		6, 828, 82		6, 828, 823	
53. 00		ANESTHESI OLOGY	3, 095, 542		3, 095, 54		3, 095, 542	53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	15, 635, 793		15, 635, 79		15, 635, 793	ı
54. 01		RADI ATI ON-ONCOLOGY	30, 866, 724		30, 866, 72		30, 866, 724	54. 01
56. 00		RADI OI SOTOPE	00,000,724		30, 000, 72	0 0	0 000, 724	56.00
56. 01		NUCLEAR MEDICINE	570, 523		570, 52	-	570, 523	56. 01
59. 00		CARDI AC CATHETERI ZATI ON	2, 343, 252		2, 343, 25		2, 343, 252	59.00
60.00		LABORATORY	12, 924, 741		12, 924, 74		12, 924, 741	60.00
64. 00		INTRAVENOUS THERAPY	2, 228, 091		2, 228, 09		2, 228, 091	64. 00
65. 00		RESPI RATORY THERAPY	6, 232, 298	0			6, 232, 298	1
66. 00		PHYSI CAL THERAPY	1	0				1
67. 00		OCCUPATIONAL THERAPY	13, 008, 797	0			13, 008, 797	66.00
			1, 110, 207	0	1, 110, 20		1, 110, 207	67. 00
68. 00		SPEECH PATHOLOGY	704, 055	0	704, 05		704, 055	1
69. 00		ELECTROCARDI OLOGY	2, 372, 669		2, 372, 66		2, 372, 669	l
69. 01		CARDI AC REHAB	1, 512, 643		1, 512, 64		1, 512, 643	l .
70.00		ELECTROENCEPHALOGRAPHY	494, 488		494, 48		494, 488	ł
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENT	10, 089, 839		10, 089, 83		10, 089, 839	ł
73. 00		DRUGS CHARGED TO PATIENTS	16, 148, 875		16, 148, 87		16, 148, 875	
73. 01	1	ULTRA SOUND	1, 021, 050		1, 021, 05		1, 021, 050	•
74. 00		RENAL DIALYSIS	369, 464		369, 46	0	369, 464	74. 00
		TIENT SERVICE COST CENTERS						
	09000		8, 514, 595		8, 514, 59			
91. 00		EMERGENCY	14, 524, 603		14, 524, 60		14, 816, 160	
		OBSERVATION BEDS (NON-DISTINCT PART)	5, 638, 430		5, 638, 43	80	5, 638, 430	
200.00		Subtotal (see instructions)	226, 797, 863	0	226, 797, 86	325, 001	227, 122, 864	
201.00		Less Observation Beds	5, 638, 430		5, 638, 43	80	5, 638, 430	
202.00	)	Total (see instructions)	221, 159, 433	0	221, 159, 43	325, 001	221, 484, 434	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: 15-0005	Peri od: Worksheet C

					From 01/01/2019 To 12/31/2019	Part I Date/Time Pre 7/21/2020 4:1	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA 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	33, 830, 253		33, 830, 253			30. 00
31. 00	03100 INTENSIVE CARE UNIT	9, 637, 177		9, 637, 17	7		31. 00
43.00	04300 NURSERY	7, 632, 251		7, 632, 251	1		43. 00
44.00	04400 SKILLED NURSING FACILITY	0		(			44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	23, 917, 814	43, 697, 729			0.000000	
50. 01	05001  ENDOSCOPY	920, 446	13, 193, 587			0.000000	50. 01
51.00	05100 RECOVERY ROOM	3, 517, 761	9, 269, 647			0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	17, 823, 216	411, 924			0.000000	ł
53.00	05300 ANESTHESI OLOGY	6, 082, 669	11, 167, 459			0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 591, 423	70, 018, 564			0.000000	54.00
54. 01	05401 RADI ATI ON-ONCOLOGY	474, 990	92, 896, 538	93, 371, 528		0.000000	54. 01
56.00	05600 RADI 0I SOTOPE	0	1	•	0.000000	0.000000	56. 00
56. 01	05601 NUCLEAR MEDICINE	633, 567	6, 638, 436			0.000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	9, 208, 697	11, 207, 323			0.000000	59. 00
60.00	06000 LABORATORY	14, 470, 663	53, 596, 277			0.000000	60.00
64. 00	06400 I NTRAVENOUS THERAPY	94, 909	10, 986, 994			0.000000	64. 00
65.00	06500 RESPI RATORY THERAPY	8, 518, 305	10, 625, 721	19, 144, 026		0.000000	
66. 00	06600 PHYSI CAL THERAPY	2, 292, 071	21, 323, 562			0.000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 181, 085	1, 458, 597			0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	463, 466	1, 682, 083			0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	4, 594, 978	13, 263, 283			0.000000	
69. 01	06901 CARDI AC REHAB	35, 236	3, 149, 759			0.000000	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	298, 132	479, 548	777, 680		0.000000	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0.00000	0.000000	l
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	13, 688, 790	5, 816, 342	19, 505, 132	0. 517292	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	13, 985, 469	21, 099, 823	35, 085, 292		0.000000	73. 00
73. 01	07301 ULTRA SOUND	1, 859, 273	8, 442, 739		0. 099112	0.000000	73. 01
74.00	07400 RENAL DIALYSIS	462, 532	65, 192	527, 724	0. 700108	0.000000	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	32, 687	42, 524, 420			0. 000000	90. 00
91. 00	09100 EMERGENCY	20, 238, 461	90, 871, 136			0.000000	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 061, 629	3, 550, 637			0.000000	
200.00		208, 547, 950	547, 437, 321	755, 985, 27 <i>°</i>	1		200. 00
201.00							201. 00
202.00	Total (see instructions)	208, 547, 950	547, 437, 321	755, 985, 27	1		202. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0005	Peri od: Worksheet C Part I To 12/31/2019 Date/Time Prepared: 7/21/2020 4:19 pm		

			10 12/31/2019	7/21/2020 4: 19	
		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
44. 00 04400 SKILLED NURSING FACILITY					44. 00
ANCILLARY SERVICE COST CENTERS	0.00000				
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. 01   05401   RADI ATI ON-ONCOLOGY	0. 000000				54. 01
56. 00   05600   RADI OI SOTOPE	0.000000				56. 00
56. 01   05601 NUCLEAR MEDICINE 59. 00   05900 CARDIAC CATHETERIZATION	0.000000				56. 01
	0. 000000 0. 000000				59. 00 60. 00
60. 00   06000   LABORATORY 64. 00   06400   INTRAVENOUS THERAPY	0. 000000				64. 00
65. 00   06500   RESPI RATORY   THERAPY	0. 000000				65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 000000				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 000000				69. 00
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 I MPL. 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	HENDRICKS REGIONAL HEALTH			In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2019 To 12/31/2019		pared: 9 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col.	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
LABORT FAIT DOUTLAS DEDIVIDE COOT OFFITEDO	1.00	2.00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.000.074		0.000.04	1 00 077	101 11	00.00
30. 00 ADULTS & PEDIATRICS	3, 900, 361		3, 900, 36			
31. 00 INTENSIVE CARE UNIT	497, 673	ł .	497, 67			
43. 00 NURSERY	171, 469		171, 46			
44.00 SKILLED NURSING FACILITY	0			0	0.00	
200.00 Total (lines 30 through 199)	4, 569, 503		4, 569, 50	3 25, 635		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	4.00	6)				
LAIDATH FAIT DOUTLAIF CERVILOE COCT OFATERS	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	/ 755	1 202 075	I			20.00
30. 00 ADULTS & PEDIATRICS	6, 755		1			30.00
31. 00 INTENSIVE CARE UNIT	1, 137	238, 656				31.00
43. 00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	7 000	0				44.00
200.00 Total (lines 30 through 199)	7, 892	1, 531, 631	1			200. 00

Health Financial Systems	HENDRI CKS REG	IONAL HEALTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2019 To 12/31/2019		
			XVIII	Hospi tal	PPS	
Cost Center Description	(from Wkst. B, Part II, col. 26)	8)	to Charges (col. 1 ÷ col 2)	Program . Charges	Capital Costs (column 3 x column 4)	
ANOLILABLY OFFICE OF COST OFFITEDS	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1 710 2/7	/7 /15 540	0.00544	10 500 505	2/0.250	F0 00
50.00   05000   0PERATING ROOM 50.01   05001   ENDOSCOPY	1, 718, 367		1		· ·	
51. 00   05100   RECOVERY ROOM	655, 964					50. 01 51. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	1, 138, 151 311, 744				132, 506	
53. 00   05300   ANESTHESI OLOGY	37, 182		1			
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 317, 595					
54. 01   05401   RADI ATI ON-ONCOLOGY	733, 889		l .			
56. 00   05600   RADI OI SOTOPE	733,007		0.00000		0	
56. 01   05601 NUCLEAR MEDICINE	23, 920				1, 062	
59. 00 05900 CARDI AC CATHETERI ZATI ON	402, 896				73, 834	
60. 00   06000   LABORATORY	535, 161					
64. 00 06400 I NTRAVENOUS THERAPY	143, 720				4	1
65. 00 06500 RESPIRATORY THERAPY	539, 224			3, 743, 233	105, 436	65.00
66. 00 06600 PHYSI CAL THERAPY	892, 899	23, 615, 633	0. 03781	0 1, 166, 338	44, 099	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	188, 114	2, 639, 682	0. 07126	602, 015	42, 902	67. 00
68. 00 06800 SPEECH PATHOLOGY	97, 789	2, 145, 549	0. 04557	'8 250, 782	11, 430	68. 00
69. 00 06900 ELECTROCARDI OLOGY	201, 187	17, 858, 261	0. 01126	2, 222, 614	25, 040	69. 00
69. 01   06901   CARDI AC   REHAB	187, 285	3, 184, 995	0. 05880	11, 814	695	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	108, 475	777, 680	0. 13948	158, 479	22, 105	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000	0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	45, 033		1			
73.00 07300 DRUGS CHARGED TO PATIENTS	424, 974				· ·	
73.01  07301 ULTRA SOUND	33, 079					73. 01
74 00 07400 RENAL DIALYSIS	2 237	527 724	. 0 00423	236 351	1 1 002	74 00

2, 237

645, 687

669, 930

1, 388, 952

12, 443, 454

42, 557, 107 111, 109, 597

4, 612, 266

704, 885, 590

527, 724

9, 745, 672

61, 411, 389

586, 850

236, 351

121, 831

90. 00 91. 00

1,002 74.00

85, 240 92. 00

1, 175, 613 200. 00

0.004239

0. 015172 0. 012501

0. 145250

74.00 07400 RENAL DIALYSIS

91. 00 09100 EMERGENCY

200.00

OUTPATIENT SERVICE COST CENTERS

90. 00 O9000 CLINIC

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

Total (lines 50 through 199)

Health Financial Systems HENDRICKS REGIONAL HEALTH	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS   Provider CCN: 15-0005   Period: From 01.	Worksheet D   Part III     Wars   Part   Part
Title XVIII Hosp	oi tal PPS
Cost Center Description  Nursing School Nursing School Allied Health Allied Post-Stepdown Adjustments  Nursing School Nursing School Post-Stepdown Allied Health Allied Allied Health Allied Allied Health Allied C	Health All Other ost Medical Education Cost
1A 1.00 2A 2	. 00 3. 00
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 0 0	0 0 30.00
31.00   03100   INTENSIVE CARE UNIT   0 0 0	0 0 31.00
43. 00   04300   NURSERY   0   0   0	0 43.00
44.00 04400 SKILLED NURSING FACILITY 0 0 0	0 44.00
200.00   Total (lines 30 through 199) 0 0 0	0 0 200.00
Cost Center Description   Swing-Bed   Total Costs   Total Patient Per Di	
	col. 6) Program Days
Amount (see   1 through 3,   instructions)   minus col. 4)	
	. 00 8. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	. 00   8. 00
30. 00   03000  ADULTS & PEDI ATRI CS   0   0   20, 377	0.00 6,755 30.00
31. 00   03100   I NTENSI VE CARE UNI T	0.00 1,137 31.00
43. 00   04300  NURSERY	0.00 0 43.00
44. 00   04400  SKI LLED NURSI NG FACI LI TY	0.00
200.00 Total (lines 30 through 199) 0 25, 635	7, 892 200. 00
Cost Center Description Inpatient	1, 6,2 250. 60
Program	
Pass-Through	
Cost (col. 7 x	
col . 8)	

30. 00 31. 00

43. 00 44. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY 200. 00 Total (lines 30 through 199)

Health Financial Systems	HENDRICKS REGION	IAL HEALTH	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIE	NT ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0005	Peri od:	Worksheet D
TUDOUGU COCTO			From 01/01/2010	Dart IV

THROUGH COSTS To 12/31/2019 Date/Time Prepared: 7/21/2020 4:19 pm Title XVIII Hospi tal PPS Cost Center Description Non Physician Nursing School Nursing School Allied Health Allied Health Post-Stepdown Anesthetist Post-Stepdown Cost Adjustments Adjustments 3. 00 2.00 1.00 2A 3A ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 50. 01 05001 ENDOSCOPY 0 0 0 0 0 50. 01 05100 RECOVERY ROOM 51.00 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 54.00 0 54.01 05401 RADI ATI ON-ONCOLOGY 0 54.01 56.00 05600 RADI OI SOTOPE 0 0 56.00 05601 NUCLEAR MEDICINE 05900 CARDIAC CATHETERIZATION 0 0 56.01 56. 01 0 01 59.00 0 59.00 0 60.00 06000 LABORATORY 0 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0 69.00 0 69. 01 06901 CARDI AC REHAB 69.01 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENT OI 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 73.00 07301 ULTRA SOUND 0 73.01 73. 01 0 07400 RENAL DIALYSIS 0 o 74.00 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09100 EMERGENCY 0 0 0 0 0 91.00 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0

0 200. 00

200.00

Total (lines 50 through 199)

Heal th	Financial Systems	HENDRI CKS REG	ΙΟΝΔΙ ΗΕΔΙΤΗ		In lie	eu of Form CMS-2	2552_10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS				Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV	pared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other Medical	Total Cost (sum of cols.	Total Outpatient	Total Charges (from Wkst. C,	Ratio of Cost to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
		Luucati on cost	1, 2, 3, and 4)	col s. 2, 3,	8)	7)	
			"/	and 4)		(see	
				l and 1)		instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0 67, 615, 543	0.000000	50.00
50. 01	05001 ENDOSCOPY	0	0		0 14, 114, 033	0.000000	50. 01
51.00	05100 RECOVERY ROOM	0	0		0 12, 787, 408	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 18, 235, 140	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0 17, 250, 128	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 81, 609, 987	0.000000	54. 00
54.01	05401 RADI ATI ON-ONCOLOGY	0	0		0 93, 371, 528	0.000000	54. 01
56.00	05600 RADI OI SOTOPE	0	0		0 1	0.000000	56. 00
	05601   NUCLEAR MEDICINE	0	0		0 7, 272, 003		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 20, 416, 020		
60.00	06000 LABORATORY	0	0		0 68, 066, 940		
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 11, 081, 903		1
65.00	06500 RESPI RATORY THERAPY	0	0		0 19, 144, 026		1
66.00	06600 PHYSI CAL THERAPY	0	0		0 23, 615, 633		
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 2, 639, 682		
68. 00	06800 SPEECH PATHOLOGY	0	0		0 2, 145, 549		
	06900 ELECTROCARDI OLOGY	0	0		0 17, 858, 261		1
	06901 CARDI AC REHAB	0	0		0 3, 184, 995		1
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 777, 680		1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0. 000000	
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	1	0 19, 505, 132		
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 35, 085, 292		1
	07301 ULTRA SOUND	0	0		0 10, 302, 012		1
74. 00	07400 RENAL DIALYSIS	0	0		0 527, 724	0. 000000	74. 00

0 0 0

0 0 0

42, 557, 107 111, 109, 597

704, 885, 590

4, 612, 266

0.000000

0.000000

0.000000

90.00

91.00

92.00

200. 00

0 0 0

OUTPATIENT SERVICE COST CENTERS

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

Total (lines 50 through 199)

200.00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

Heal th	Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-25						
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS	Provider CO		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 7/21/2020 4:1	pared: 9 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 000000	10, 598, 505		0 7, 157, 020	•	
50. 01	05001 ENDOSCOPY	0. 000000	324, 918		0 4, 615, 692	. 0	50. 01
51.00	05100 RECOVERY ROOM	0. 000000	1, 488, 749		0 1, 591, 455	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 2, 926	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	2, 274, 956		0 2, 184, 830	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	5, 158, 706		0 14, 741, 915	0	54.00
54.01	05401 RADI ATI ON-ONCOLOGY	0. 000000	151, 098		0 28, 022, 245	0	54. 01
56.00	05600 RADI OI SOTOPE	0. 000000	0		0	0	56.00
56. 01	05601 NUCLEAR MEDICINE	0. 000000	322, 887		0 2, 029, 499	0	56. 01
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	3, 741, 471		0 3, 075, 402	. 0	59. 00
60.00	06000 LABORATORY	0. 000000	5, 727, 339		0 4, 301, 169	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	334		0 3, 374, 307	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	3, 743, 233		0 2, 927, 713	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	1, 166, 338		0 2, 417, 289	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	602, 015		0 5, 688	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	250, 782		0 11, 185	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	2, 222, 614		0 3, 303, 961	0	69. 00
69. 01	06901 CARDI AC REHAB	0. 000000	11, 814		0 1, 444, 911	0	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	158, 479		0 2, 101		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	6, 124, 839		0 1, 297, 854		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	6, 029, 753		0 8, 578, 784		
73. 01	07301 ULTRA SOUND	0. 000000	743, 686		0 1, 630, 943		1
74. 00	07400 RENAL DIALYSIS	0. 000000	236, 351		0 21, 586		
50	OUTDATIENT SERVICE COST CENTERS						1

0. 000000 0. 000000

0.000000

9, 745, 672

61, 411, 389

586, 850

8, 066, 102 15, 852, 720 1, 077, 974 117, 735, 271

0 0 0

0 90.00 0 91.00

0 92.00 0 200.00

91. 00 09100 EMERGENCY

200.00

OUTPATIENT SERVICE COST CENTERS

90. 00 O9000 CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

Health Financial Systems	HENDRI CKS REG	IONAL HEALTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Period: From 01/01/2019	Worksheet D Part V	
				To 12/31/2019	Date/Time Pre 7/21/2020 4:1	pared:
		Title	: XVIII	Hospi tal	PPS	<i>у</i> Ып
			Charges	110001 141	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
'	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 294942			0 454	2, 110, 906	
50. 01   05001   ENDOSCOPY	0. 269028			0 19	1, 241, 750	
51.00   05100   RECOVERY ROOM	0. 425746			0	677, 556	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 374487			0	1, 096	
53. 00   05300   ANESTHESI OLOGY	0. 179450			0	392, 068	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 191592	14, 741, 915		0	2, 824, 433	54.00
54. 01   05401   RADI ATI ON-ONCOLOGY	0. 330580	28, 022, 245		0 76, 747	9, 263, 594	54. 01
56. 00   05600   RADI 0I SOTOPE	0. 000000	0		0	0	56. 00
56. 01   05601   NUCLEAR MEDICINE	0. 078455	2, 029, 499		0	159, 224	56. 01
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 114775	3, 075, 402		0	352, 979	59. 00
60. 00  06000 LABORATORY	0. 189883	4, 301, 169	1, 32	8 0	816, 719	60.00
64.00   06400   I NTRAVENOUS THERAPY	0. 201057	3, 374, 307		0	678, 428	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 325548	2, 927, 713		0	953, 111	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 550855	2, 417, 289		0 718	1, 331, 576	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0. 420584	5, 688		0	2, 392	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 328147	11, 185		0	3, 670	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 132861	3, 303, 961		0	438, 968	69. 00
69. 01   06901   CARDI AC   REHAB	0. 474928	1, 444, 911		0	686, 229	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 635850	2, 101		0	1, 336	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 517292	1, 297, 854		0	671, 369	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 460275	8, 578, 784		0 39, 129	3, 948, 600	73. 00
73. 01   07301   ULTRA SOUND	0. 099112	1, 630, 943		0	161, 646	73. 01
74. 00 07400 RENAL DIALYSIS	0. 700108	21, 586		0	15, 113	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 200075			0 47	1, 613, 825	
91. 00   09100   EMERGENCY	0. 130723			0 77	2, 072, 315	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 222486			0	1, 317, 808	
200.00 Subtotal (see instructions)		117, 735, 271	1, 32	8 117, 191	31, 736, 711	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201. 00
Only Charges						
202.00   Net Charges (line 200 - line 201)		117, 735, 271	1, 32	8 117, 191	31, 736, 711	202. 00

Health Financial Systems	HENI	DRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	S AND VAC	CINE COST	Provi der (	CCN: 15-0005	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prep 7/21/2020 4:19	
			Ti tl	e XVIII	Hospi tal	PPS	
		Cos	sts				
Cost Center Description		Cost	Cost				

			7/21/2020 4:19 pm
		Title XVI	PPS
	Costs	S	
Cost Center Description	Cost	Cost	
	Rei mbursed	Rei mbursed	
		Services Not	
		Subj ect To	
		ed. & Coins.	
		(see inst.)	
	6. 00	7. 00	
ANCILLARY SERVICE COST CENTERS			
50. 00   05000   OPERATING ROOM	0	134	50.00
50. 01   05001   ENDOSCOPY	0	5	50. 01
51. 00   05100   RECOVERY ROOM	0	0	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	54. 00
54. 01   05401   RADI ATI ON-ONCOLOGY	0	25, 371	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	56. 00
56. 01   05601   NUCLEAR   MEDI CI NE	0	0	56. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	59. 00
60. 00   06000   LABORATORY	252	0	60. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	65. 00
66. 00   06600   PHYSI CAL THERAPY	0	396	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	69. 00
69. 01   06901   CARDI AC   REHAB	0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	18, 010	73.00
73. 01 07301 ULTRA SOUND	0	0	73. 01
74. 00 07400 RENAL DIALYSIS	0	0	74. 00
OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC		0	00.00
	0	9	90.00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)		10	91. 00 92. 00
200.00 Subtotal (see instructions)	252	43, 935	200.00
201.00 Less PBP Clinic Lab. Services-Program	252	43, 733	200.00
Only Charges	١		201.00
202.00 Net Charges (line 200 - line 201)	252	43, 935	202. 00
202.00	1 232	40, 700	1202.00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0005	Peri od: From 01/01/2019	Worksheet D-1	
		To 12/31/2019	Date/Time Pre 7/21/2020 4:1	
	Title XVIII	Hospi tal	PPS	
Cost Center Description	· ·			
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

	Title XVIII Hospital	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	20, 377	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	20, 377	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4 00	do not complete this line.	14 077	4. 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	16, 877 0	5. 00
5.00	reporting period	١	3.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private 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 days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	١	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	6, 755	9. 00
	newborn days) (see instructions)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions)  Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٥	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	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
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
18. 00	reporting period	0.00	18. 00
16.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	16.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	32, 827, 039	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)	-	
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
0.4.00	x line 18)		04.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	32, 827, 039	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	Ö	29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)	0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33. 00		0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	32, 827, 039	
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 (10 00	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)	1, 610. 98 10, 882, 170	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	10, 862, 170	40. 00
	Total Program general inpatient routine service cost (line 39 + line 40)	10, 882, 170	
	•		

	Financial Systems	HENDRI CKS REGI			In Lie	eu of Form CMS-2			
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Peri od: From 01/01/2019	Worksheet D-1			
					To 12/31/2019	Date/Time Pre			
-			Ti +l c	e XVIII	Hospi tal	7/21/2020 4: 1 <sup>o</sup> PPS	9 pm		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost			
	, , , , , , , , , , , , , , , , , , ,	Inpatient Cost		Diem (col. 1		(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 0	5. 00	42. 00		
12.00	Intensive Care Type Inpatient Hospital Units				<u> </u>		12:00		
43. 00	INTENSIVE CARE UNIT	6, 142, 674	2, 371	2, 590. 7	5 1, 137	2, 945, 683			
44. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00		
45. 00 46. 00	1						46. 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 17, 636, 866	48. 00		
	Total Program inpatient costs (sum of lines			ons)		31, 464, 719			
	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, 531, 631	50.00		
51. 00	<pre>                                    </pre>	atient ancillar	v services (fr	om Wkst D s	um of Parts II	1, 175, 613	51.00		
2 00	and IV)		, (11			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
52.00	Total Program excludable cost (sum of lines					2, 707, 244			
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ıaτeα, non-phy	sician anesth	etist, and	28, 757, 475	53. 00		
	TARGET AMOUNT AND LIMIT COMPUTATION	52)							
	Program di scharges					0			
	Target amount per discharge					0.00			
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	rget amount (1	ine 56 minus	line 53)	0			
58. 00	Bonus payment (see instructions)	g ooot and ta	got amount (			Ö			
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, ι	updated and co	mpounded by the	0.00	59. 00		
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost renort un	dated by the m	narket hasket		0.00	60.00		
61. 00	If line 53/54 is less than the lower of line				the amount by	0.00			
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target				
62.00	amount (line 56), otherwise enter zero (see instructions)								
	00 Relief payment (see instructions) 00 Allowable Inpatient cost plus incentive payment (see instructions)								
	PROGRAM I NPATIENT ROUTI NE SWI NG BED COST								
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64. 00		
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	ost reportina	period (See	0	65. 00		
	instructions)(title XVIII only)								
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVII	l only). For	0	66. 00		
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	of the cost re	porting period	0	67. 00		
07.00	(line 12 x line 19)	o ooo to tiii ougi.	. 2000201		por cring por rod		07.00		
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00		
69 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + line	4 68)		0	69.00		
07.00	PART III - SKILLED NURSING FACILITY, OTHER N						37.00		
70.00	Skilled nursing facility/other nursing facil	-					70.00		
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00		
73. 00	Medically necessary private room cost applications		(line 14 x li	ne 35)			73. 00		
74. 00	Total Program general inpatient routine serv						74. 00		
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from V	Vorksheet B, P	art II, column		75. 00		
76. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00		
77. 00	Program capital -related costs (line 9 x line	,					77. 00		
	Inpatient routine service cost (line 74 minu			1->			78. 00		
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.				us line 79)		79. 00 80. 00		
81. 00	Inpatient routine service costs for comp		Triiii tatii Oi	. (11110-70-111111			81. 00		
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .				82. 00		
83.00	Reasonable inpatient routine service costs (		s)				83.00		
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ins)				84. 00 85. 00		
	Total Program inpatient operating costs (sum						86.00		
07	PART IV - COMPUTATION OF OBSERVATION BED PASS								
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			3, 500 1, 610. 98			
	Observation bed cost (line 87 x line 88) (se	•	11110 2)			5, 638, 430			
		,							

Health Financial Systems HENDRICKS REGIONAL				In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019	Date/Time Pre	narod:
				10 12/31/2019	7/21/2020 4: 1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	3, 900, 361	32, 827, 039	0. 11881	5, 638, 430	669, 930	90.00
91.00 Nursing School cost	0	32, 827, 039	0.00000	5, 638, 430	0	91.00
92.00 Allied health cost	0	32, 827, 039	0.00000	5, 638, 430	0	92.00
93.00 All other Medical Education	0	32, 827, 039	0.00000	5, 638, 430	0	93.00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0005	Peri od: From 01/01/2019	Worksheet D-1	
		To 12/31/2019	Date/Time Pre 7/21/2020 4:1	
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

do not complete this line.  4. 00 Semi-private room days (excluding swing-bed and observation bed days)  7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost period (if calendar year, enter 0 on this line)  8. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days after December 31 of the cost period (in calendar year, enter 0 on this line)  10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  8. 00 Total Inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  8. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  8. 00 Swing-bed SNF type inpatient days applicable to the SNF type inpatient days applicable to sNF type inp			Title XIX	Hospi tal	Cost	<u>, Бііі                                  </u>
IMPATIENT DAYS		Cost Center Description			1. 00	
Impattent days (Including private room days and safing-bed days, excluding newborn)						
Impatient days (including private room days, excluding swing-bed and newborn days)   20,377   20,000	1 00		a avaludi na nawbarn)		20. 277	1 00
Private room days (excluding swing-bed and observation bed days). If you have only private room days.  4.00 Semi-private room days (excluding swing-bed and observation bed days).  5.00 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period (if call endary year, enter 0 on this line).  7.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endary year, enter 0 on this line).  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endary year, enter 0 on this line).  8.00 Float swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (in light private room days) after December 31 of the cost reporting period (in light private room days) after December 31 of the cost reporting period (in light private room days) after December 31 of the cost reporting period (see instructions).  8.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions).  8.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (in call endary year, enter 0 on this line).  8.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including year, enter 0 on this line).  8.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including year, enter 0 on this line).  8.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days).  9.10 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days).  9.11 Swing-bed NF type inpatient days applicable to ti						
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost open for poper ting period or swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of		Private room days (excluding swing-bed and observation bed day		vate room days,		3. 00
Total swing-Bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00  7.0	4 00	·	ed days)		16 877	4 00
Total swing-bed SNF type inpatient days (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)		Total swing-bed SNF type inpatient days (including private roo		31 of the cost		5. 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Secondary   Sec	6. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3°	1 of the cost	0	6. 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   10.00	7.00	Total swing-bed NF type inpatient days (including private room	m days) through December 3	31 of the cost	0	7. 00
10.00   Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and newborn days)   0.00   0.0	8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
10.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   10.00	9. 00	Total inpatient days including private room days applicable to	o the Program (excluding s	swing-bed and	532	9. 00
11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Mursery days (title V or XIX only) 17.00 Mursery days (title V or XIX only) 18.00 Swing-Bed SNF services applicable to the Program (excluding swing-bed days) 18.00 Swing-Bed SNF services applicable to services through December 31 of the cost 18.00 Total swing-bed SNF services applicable to services after December 31 of the cost 18.00 Total cale are rate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 Swing-Bed SNF services applicable to services after December 31 of the cost 18.00 Swing-bed cost applicable to Services after December 31 of the cost 18.00 Swing-bed Cost applicable to SNF type services after December 31 of the cost 18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost such a value of the cost reporting period (line 6 x x line 18) 18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x x line 18) 18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x x line 19) 18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x x line 19) 18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x x line 18) 18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x x line 18) 18.00 Swing-bed cost (see instructions) 18.00 Swing-bed cost	10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days)	0	10. 00
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including swing-bed days)  10.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  10.00 Total nursery days (title V or XIX only)  10.00 Nursery days (title V or XIX only)  10.00 Nursery days (title V or XIX only)  10.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 10.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 10.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 10.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 10.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 10.00 Total general Inpatient routine service cost (see instructions) 10.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29) 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29) 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29) 10.00 Swing-bed cost applicable to NF type services after December 31 o	11. 00			om days) after	0	11. 00
through December 31 of the cost reporting period  13.00 Sing-bed NT type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Newsery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 reporting period  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  20.00 reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  20.00 reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  20.00 medical drate for swing-bed NF services applicable to services after December 31 of the cost  20.00 medical drate for swing-bed NF services applicable to services after December 31 of the cost  20.00 medical drate for swing-bed NF services applicable to services after December 31 of the cost  20.00 medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x line 17)  20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29)  20.00 Total swing-bed cost (see Instructions)  20.00 Medically necessary December 31 of the cost reporting period (line 8 x line 20)  20.00 Total swing-bed cost (see Instructions)  20.00 Medically necessary (s	12. 00	December 31 of the cost reporting period (if calendar year, en	nter O on this line)		0	12. 00
after December 31 of the cost reporting period (if callendar year, enter 0 on this line)   0   14.00   15.00   Total nursery days (title V or XIX only)   2,887   15.00   16		through December 31 of the cost reporting period	3 .	,		
15.00 Total nursery days (title V or XIX only)  16.00 Nesery days (title V or XIX only)  17.00 SNING BED ADJUSTNEMT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period with the cost reporting period of the cost reporting period period period rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period period period rate for swing-bed NF services applicable to services after December 31 of the cost reporting period period reporting period period reporting period period reporting reporting reporting period reporting period reporting reporting reporting reporting reporting period reporting period reporting repo		after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line)	)		
16.00 Nursery days (title V or XIX only)  SNING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line or reporting period reporting period (line or reporting period reporting period (line or swing-bed NF services applicable to services after December 31 of the cost (line or reporting period (line or swing-bed NF services applicable to services after December 31 of the cost (line or reporting period (line or reporting period (line or swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line or swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line or swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line or line or l			am (excluding swing-bed da	ays)	-	
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 19.00 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.		Nursery days (title V or XIX only)				16. 00
18.00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period of reporting period period period period on Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period on Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period on Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line porting period on Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line Six line 17) on Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Six line 18) on Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line Six line 18) on Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line Six line 18) on Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line Six line 18) on Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line Six line 18) on Swing-bed cost (see instructions) on Swing-bed cost reporting period (line Six line 19) on Swing-bed cost (see instructions) on Swing-bed cost reporting period (line Six line 19) on Swing-bed cost (see instructions) on Swing-bed cost reporting period (line Six line 19) on Swing-bed cost (see instructions) on Swing-bed cost reporting period (line Six line 19) on Swing-bed cost reporting period (line Six line 19) on Swing-bed cost reporting period (line Six line 19) on Swing-bed cost reporting period (line Six line 19) on Swing-bed cost reporting period (line Six line 19) on Swing-bed cost reporting period (line Six line 19) on Swing-bed cost reporting period (line Six line 19) on Swing-bed cost reporting period (line Six line 19) on Swing-bed cost reporting period (line Six line 19) on Swing-bed cost reporting period (	17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 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) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service cost net of swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 3) 31.00 Average per diem private room per diem charge (line 30 + line 4) 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 37.00 General inpatient routine service cost inferential (line 34 x line 31) 38.00 Average per diem private room charge differential (line 34 x line 31) 39.00 Program general inpatient routine service cost per diem (see instructions) 30.01 Segorgman INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Program general inpatient routine s	18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of th	ne cost	0.00	18. 00
20.00 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)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  31.00 Average per diem private room per diem charge (line 30 + line 4)  32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  32.00 Semi-private room charge differential (line 32 minus line 33)  33.00 Average per diem private room charge differential (line 34 x line 31)  34.00 Forestal inpatient routine service cost net of swing-bed cost and private room cost differential (line 32 minus line 33)  35.00 Average per diem private room cost differential (line 32 minus line 33)  36.00 Private room cost differential (line 32 minus line 33)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 32 minus line 33)  38.00 Average per diem private room cost differential (line 32 minus li	19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average perivate room per diem charge (line 29 + line 3)  33.00 Average per diem private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 3 x line 35)  35.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of the	e cost	0. 00	20. 00
5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service charges ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  36.00 Private room cost differential (line 3 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 x line 31)  38.00 Average per diem private room cost motharge differential (line 3 x line 31)  39.00 Prover room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 32 x line 31)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		Total general inpatient routine service cost (see instructions			32, 810, 804	21. 00
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting 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 x line 20)  26.00 Total swing-bed cost (see instructions) 0 26.00 Total swing-bed cost (see instructions) 0 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 32, 810, 804 77.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 31.00 32.00 Average private room per diem charge (line 30 + line 3) 0.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 34.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 Average per diem private room cost differential (line 34 x line 35) 0.00 Private room cost differential djustment (line 34 x line 35) 0.00 Private room cost differential djustment (line 35 x line 35) 0.00 PRATI II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,610.19 85,621 89.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 40.00	22. 00		er 31 of the cost reportin	ng period (line	0	22. 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 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  32.00 Average semi-private room per diem charge (line 30 + line 4)  32.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 32, 810, 804)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 32, 810, 804)  38.00 Alyerage per diem private room cost differential (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 32, 810, 804)  38.00 Alyerage per diem private room cost differential (line 3 x line 35)  38.00 Alyerage per diem private room cost differential (line 3 x line 35)  38.00 Alyerage per diem private room cost differential (line 3 x line 35)  39.00 Program general inpatient routine service cost per diem (see instructions)  38.00 Alyerage per diem decential dipus membral routine service cost (line 9 x line 38)  38.00 Alyerage per diem decential dipus membral routine service cost (line 9 x line 38)  38.00 Alyerage per diem decential dipus membral routine service cost (line 9 x line 38)  38.00 Alyerage per diem decential dipus membral routine	23. 00		31 of the cost reporting	period (line 6	0	23. 00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)	24. 00		າ 31 of the cost reportino	g period (line	0	24. 00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 36)  40.00 Average per diem private room cost differential (line 3	25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting p	period (line 8	0	25. 00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 29.00 30.00 Semi - pri vate room charges (excluding swing-bed charges) 30.00 Semi - pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average pri vate room per diem charge (line 29 ÷ line 3) 33.00 Average semi - pri vate room per diem charge (line 30 ÷ line 4) 34.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem pri vate room cost differential (line 34 x line 31) 36.00 Pri vate room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 32, 810, 804 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Average general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary pri vate room cost applicable to the Program (line 14 x line 35)  0 28.00 29.00 29.00 29.00 30.00 29.00 20.0		Total swing-bed cost (see instructions)	(lino 21 minus lino 26)		-	26. 00
29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 32, 810, 804)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29. 00 30. 00  30. 00 30. 00  31. 00  29. 00 30. 00  30. 00  31. 00  32. 00  32. 00  32. 00  32. 00  32. 00  33. 00  34. 00  35. 00  36. 00  37. 00  38. 00  39. 00  40. 00	27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,			
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Average per diem private room cost differential (line 3 x line 31) 37.00 Frivate room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 32, 810, 804)  Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 30.00 0.00 32.00 0.00 32.00 0.00 33.00 0.00 0			d and observation bed chai	rges)	-	
31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 32, 810, 804)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Average per diem private room cost differential (line 32, 810, 804)  37. 00  37. 00  Average per diem private room cost differential (line 33, 800)  Average per diem private room cost differential (line 34, 800)  36. 00 Program general inpatient routine service cost per diem (see instructions)  38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0. 00 000000  31. 00  0. 00 32. 00  32. 00  33. 00  0. 00 33. 00  0. 00 34. 00  34. 00  35. 00  0. 00 35. 00  36. 00  37. 00  38. 00  39. 00 Program general inpatient routine service cost per diem (see instructions)  38. 00 Average per diem private room cost applicable to the Program (line 14 x line 35)  0. 00 000000  31. 00  32. 00  32. 00  33. 00  34. 00  34. 00  35. 00  36. 00  37. 00  38. 00  39. 00  39. 00  40. 00						
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 32, 810, 804)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00 32.00 32.00 33.00 34.00 35.00 36.00 37.00 36.00 37.00 37.00 38.00 37.00			: line 28)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 32, 810, 804)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00  34.00  35.00  36.00  37.00  38.00  39.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 40.00		, ,	,			32. 00
35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 32, 810, 804)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						33. 00
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00 32, 810, 804 37.00 3	34.00			ons)	0. 00	34. 00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00  37.00  37.00  37.00  37.00  38.00  40.00	35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	35. 00
27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,610.19 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00					0	36. 00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,610.19 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00		and private room cost dif	ferential (line	32, 810, 804	37. 00
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,610.19 38.00 Program general inpatient routine service cost (line 9 x line 38)  856,621 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		PART II - HOSPITÁL AND SUBPROVIDERS ONLY	ICTMENITO			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 856,621 39.00 40.00	20 00			1	1 (10 10	20 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		, , , , , , , , , , , , , , , , , , , ,	*			
	41. 00	1 3 1	,			

27.00   OTHER SPECIAL CARE (SPECIFY)		Financial Systems	HENDRI CKS REG				eu of Form CMS-2	
Cost Center Description	COMPUT	TATION OF INPATIENT OPERATING COST		Provi der Co				
Total   Tropical   Program Royal   Program Cost							Date/Time Pre	pared:
Total   Program Days   Program Day	-			Ti tl	e XIX	Hospi tal		9 pm
Col.		Cost Center Description	Total			· · · · · · · · · · · · · · · · · · ·	+'	
1.00   2.00   3.00   4.00   5.00   0.00   2.00   3.00   4.00   5.00   0.00   2.00   3.00   4.00   5.00   0.00   2.00   3.00   4.00   5.00   0.00   2.00   3.00   4.00   5.00   0.00   2.00   3.00   4.00   5.00   0.00   2.00   3.00   4.00   5.00   4.00   3.00   4.00   5.00   5.00			Inpatient Cost	Inpatient Days		+		
			1 00	2 00		4 00		
	42. 00							42. 00
44.00   CORONARY CARE UNIT   45.00   RIMBIT RESIDE CE CARE UNIT   45.0								
45.00   SUBRIC LINTENSIVE CARE UNIT   45.00			6, 142, 674	2, 371	2, 590. 7	0	0	
46.00   SURGICAL INTENSIVE CARE INNIT								
Cost Center Boscription								46. 00
1	47. 00							47. 00
Program inpatient and lilary service cost (Mist. D-3, col. 3, line 200)   48,00   Program inpatient costs (sum of lines 4, lithrough 4B) (see Instructions)   1, 397, 582   48,00   Program inpatient costs (sum of lines 4, lithrough 4B) (see Instructions)   1, 397, 582   48,00   Program inpatient costs (sum of lines 4, lithrough 4B) (see Instructions)   1, 397, 582   48,00   Program inpatient costs (sum of lines 50 and 51)   50,00   Program inpatient costs (sum of lines 50 and 51)   51,00   70,00		Cost Center Description					1 00	
1,397,582   40.00   Poss through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and D. 50.00   110	48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)				48. 00
50.00   Passs through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and III)   15.00   11.00					ns)			1
111   51	F0 00				W 1 D	6.5. 1. 1. 1.		F0 00
51.00   pass through costs applicable to Program inpatient ancillary services (from Wkst. 0, sum of Parts II   o   o   o   o   o   o   o   o   o	50.00		atient routine	services (Trom	WKST. D, SUM	or Parts I and	0	50.00
Total Program excludable cost (sum of lines 50 and 51)	51.00		atient ancillar	y services (fr	om Wkst. D, su	um of Parts II	0	51.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and needed education costs (line 49 minus line 52)  TARGET ANDUNT AND LIMIT COMPUTATION  54.00 Program discharges  56.00 Program discharges  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  59.00 Lesser of lines 53/54 or 55 from prior year cost reporting period ending 1996, updated and compounded by the 10.00 S8.00 Cost of the second of the 10.00 S8.00 Cost of the 10.00 Cost of 1		1 ,					_	
medical education costs (line 49 intos line 52)				alated non-phy	sician anosth	atist and	1	
5.4.00   Program discharges   0.00   55.00   55.00   Target amount per discharges   0.00   55.00   55.00   Target amount per discharges   0.00   55.00   55.00   75.00   17   17   17   17   17   18   18   19   19   19   19   19   19	55.00			erateu, non-pny	Si Ci ali allestile	etist, and		33.00
55.00   Target amount per discharge   0.00   55.00   55.00   57.00								1
56.00   Target amount (line 54 x line 55)   0.56.00   56.00   57.00   Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0.57.00   58.00								
57.00   Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0   57.00   59.00   Bobs payment (see instructions)   0   58.00   59.00   Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket   0.00   60.00   Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket   0.00   60.00   60.00   In the 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)   0   62.00   62.00   Relief payment (see instructions)   0   63.00   63.00   Allowable Inpatient cost plus incentive payment (see instructions)   0   63.00   64.00   Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)   66.00   65.00   Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For   0   66.00   66.00   Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions)   67.00   Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)   69.00   Total 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								1
1.59.00   Lesser of I lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the narket basket   0.00   60.00			ing cost and ta	arget amount (I	ine 56 minus l	ine 53)		
market basket  0.00 (bl.00 if lines 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 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)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) et instructions) et it le XVII only only  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) et it let XVII 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 (In 21 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (In 13 x line 20)  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 PART III - SKILLED NURSING FACILITY, ORTHEN NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Program routine service cost (line 9 x line 71)  70.00 Program routine service cost (line 9 x line 71)  70.00 Program routine service cost (line 9 x line 77)  70.00 Program capital-related costs (line 9 x line 77)  70.00 Program capital-related costs (line 9 x line 78)  70.00 Program capital-related costs (line 9 x line 79)  70.00 Program capital-related costs (line 9 x line 70)  70.00 Program capital-related costs (line 9 x line 70)  70.00 Program capital related								
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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)  82.00 Relief payment (see instructions)  83.00 Allowable Inpatient cost plus incentive payment (see instructions)  84.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only)  85.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)  86.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Cost (see instructions) (title XVIII only) and (see instructions) (title XVIII only) are costs (line 64 plus line 65) (title XVIII only). For Cost (see instructions)  87.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  88.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  89.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  99.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  99.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37)  70.00 Program routine service cost (line 9 x line 71)  70.00 Program routine service cost (line 9 x line 71)  71.00 Algusted general inpatient routine service costs (from Worksheet 8, Part II, column 26, line 45)  72.00 Program ageneral inpatient routine service costs (from provider records)  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 (line 76 + line 2)  76.00 Program capital -related costs (line 77 + line 79)  77.00 Program capital -related costs (line 78 minus line 77)  78.00 Program capital -related cost (line 78 minus line 77)  78.00 Program capital -related cost (l	60. 00		cost report, up	dated by the m	arket basket		0.00	60.00
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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 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 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 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) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  73.00 74.00 74.00 74.00 74.00 74.00 75.00 74.00 75		, ,		c ,o . iiile	-/			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)  76.00 Program capital-related costs (line 9 x line 76)  77.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  81.00 Reasonable inpatient routine service costs (see instructions)  82.00 Reasonable inpatient ancillary services (see instructions)  83.00 Program inpatient ancillary services (see instructions)  84.00 Part IV - Computation of Observation BED PASS THROUGH COST  75.00  76.00  77.00  78.00  79.00  87.00  88.00 Adjusted general inpatient routine service and limitation (line 78 minus line 79)  88.00  87.00  88.00 Adjusted general inpatient routine service costs (see instructions)  87.00  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00								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)  Roundatient routine service cost (line 74 minus line 77)  80.00  Roundatient routine service cost (line 74 minus line 77)  80.00  Roundatient routine service costs (from provider records)  80.00  Roundatient routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00  Roundatient routine service costs per diem limitation  81.00  Roundatient routine service cost limitation (line 9 x line 81)  82.00  Reasonable inpatient routine service costs (see instructions)  83.00  Roundatient routine service costs (see instructions)  84.00  Roundatient routine service costs (see instructions)  85.00  Roundatient routine service costs (see instructions)  86.00  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  Roundatient routine service cost limitation (line 27 ÷ line 2)  Roundatient routine service cost (see instructions)  87.00  Roundatient routine service cost (see instructions)  88.00  Roundatient routine service cost (see instructions)  89.00  Roundatient routine service cost (see instructions)  80.00  Roundatient routine service cost (see instructions)  81.00  Roundatient routine service cost (see instructions)  82.00  Roundatient routine service cost (see instructions)  83.00  Roundatient routine service cost (see instructions)  84.00  Roundatient routine service cost (see instructions)  85.00  Roundatient routine service cost (see instructions)  86.00  Roundatient routine service cost (see instructions)  87.00  Roundatient routine service cost (see instructions)  88.00			•			art II column		1
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) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 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  76.00 77.00 77.00 78.00 79.00 80.00 Inpatient routine service costs (from provider records) 81.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service (see instructions) 84.00 Dispatient routine service costs (see instructions) 85.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00	75.00		TOUTTHE SELVICE	CUSIS (II UIII W	OINSTITUTE D. PE	art II, COLUMN		/3.00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 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) 87.00 Racial Deservation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Racial Deservation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Racial Program inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Racial Program inpatient routine cost per diem (line 27 ÷ line 2)		Per diem capital-related costs (line 75 ÷ li	. *					76. 00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Reasonable inpatient routine service cost (see instructions)  79.00 Reasonable inpatient routine service see instructions)  79.00 Reasonable inpatient routine service cost (see instructions)  81.00 Reasonable inpatient routine service see instructions)  82.00 Reasonable inpatient routine service see instructions)  83.00 Reasonable inpatient oncillary services (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  75.00 Total Program inpatient operating costs (sum of lines 83 through 85)  87.00 RAT IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  75.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  779.00 Records in inpatient 79  80.00  81.00  81.00  82.00  83.00  84.00  85.00  86.00		, ,						
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 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Willization review - physician compensation (see instructions) 83.00 Reasonable inpatient noutine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Willization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  87.00 RAT 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) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Total observation bed days (see instructions) 89.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		1 .	•	provi der record	s)			1
82.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  83.00 Program inpatient ancillary services (see instructions)  84.00 Total Program inpatient operating costs (sum of lines 83 through 85)  85.00 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)  82.00 Reasonable inpatient routine service costs (see instructions)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Reasonable inpatient routine service costs (see instructions)  85.00 Reasonable inpatient routine service costs (see instructions)  86.00 Reasonable inpatient routine service costs (see instructions)  87.00 Reasonable inpatient routine service costs (see instructions)  87.00 Reasonable inpatient routine service costs (see instructions)  87.00 Reasonable inpatient routine service costs (see instructions)  88.00 Reasonable inpatient routine services (see instruc						ıs 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 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Reasonable inpatient routine service costs (see instructions)  84.00 84.00 85.00 86.00		•						81.00
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 Representation of the servation of the servatio		1 .		· * .				1
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 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  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)				13)				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)  1,610.19 88.00		Utilization review - physician compensation	(see instructio					85. 00
87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  3,500 87.00  1,610.19 88.00	86. 00			nrough 85)				86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,610.19 88.00	87. 00						3.500	87. 00
89.00   Observation bed cost (line 87 x line 88) (see instructions) 5,635,665   89.00	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				1, 610. 19	88. 00
	89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				5, 635, 665	89.00

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	3, 900, 361	32, 810, 804	0. 11887	4 5, 635, 665	669, 934	90.00
91.00 Nursing School cost	0	32, 810, 804	0.00000	5, 635, 665	0	91.00
92.00 Allied health cost	0	32, 810, 804	0.00000	5, 635, 665	0	92.00
93.00 All other Medical Education	0	32, 810, 804	0.00000	5, 635, 665	0	93. 00

Health F	Financial Systems HENDRICKS REGIONA	I HFALTH		In lie	eu of Form CMS-	2552-10
		Provi der CO	CN: 15-0005	Peri od:	Worksheet D-3	
				From 01/01/2019		
				To 12/31/2019	7/21/2020 4:1	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
li li	NPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	03000 ADULTS & PEDIATRICS			9, 686, 297		30.00
	03100 INTENSIVE CARE UNIT			4, 319, 308		31.00
	04300 NURSERY			4, 317, 300		43.00
	NCI LLARY SERVI CE COST CENTERS					43.00
	05000 OPERATI NG ROOM		0. 29519	96 10, 598, 505	3, 128, 636	50.00
	05001 ENDOSCOPY		0. 26902			1
4	05100 RECOVERY ROOM		0. 42574	·		
	05200 DELIVERY ROOM & LABOR ROOM		0. 37448			
4	05300 ANESTHESI OLOGY		0. 17945			
	05400 RADI OLOGY-DI AGNOSTI C		0. 19159			
4	05401 RADI ATI ON-ONCOLOGY		0. 33058			
4	05600 RADI 0I S0T0PE		0. 00000	•		1
4	05601 NUCLEAR MEDICINE		0. 07845		25, 332	1
59.00	D5900 CARDI AC CATHETERI ZATI ON		0. 11477	75 3, 741, 471	429, 427	59. 00
60.00	06000 LABORATORY		0. 18988	5, 727, 339	1, 087, 524	60.00
64.00	06400 INTRAVENOUS THERAPY		0. 20105	334	67	64.00
65.00	06500 RESPI RATORY THERAPY		0. 32554	18 3, 743, 233	1, 218, 602	65.00
66.00	06600 PHYSI CAL THERAPY		0. 55085	1, 166, 338	642, 483	66. 00
	06700 OCCUPATI ONAL THERAPY		0. 42058			
	06800 SPEECH PATHOLOGY		0. 32814	17 250, 782	82, 293	68. 00
4	06900 ELECTROCARDI OLOGY		0. 13286			
	06901 CARDI AC REHAB		0. 47492			
4	07000 ELECTROENCEPHALOGRAPHY		0. 63585	•		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000		_	
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 51729			
	07300 DRUGS CHARGED TO PATIENTS		0. 46027			
	07301 ULTRA SOUND		0. 09911			1
	07400 RENAL DIALYSIS		0. 70010	08 236, 351	165, 471	74. 00
	OUTPATIENT SERVICE COST CENTERS			-	1 -	
	09000 CLI NI C		0. 20007			
4	09100 EMERGENCY		0. 13334			1
4	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 22248	•		
200.00	Total (sum of lines 50 through 94 and 96 through 98)	(line (1)		61, 411, 389	17, 636, 866	
201.00	Less PBP Clinic Laboratory Services-Program only charges Net charges (line 200 minus line 201)	(Tine 61)		41 411 200		201. 00 202. 00
202. 00	INEL Charges (TITIE 200 IIII HUS TITIE 201)		I	61, 411, 389	I	J2U2. UU

	Financial Systems	HENDRICKS REGIONAL HEALTH			u of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (	CCN: 15-0005	Peri od: From 01/01/2019	Worksheet D-3	
				To 12/31/2019	Date/Time Pre	nared:
				10 12/01/2017	7/21/2020 4:1	
		Ti t	le XIX	Hospi tal	Cost	•
	Cost Center Description		Ratio of Cos	t Inpatient	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		1	
30.00	03000 ADULTS & PEDIATRICS			1, 955, 905		30.00
31.00	03100 INTENSIVE CARE UNIT			170, 474		31.00
43. 00	04300 NURSERY			0		43.00
	ANCILLARY SERVICE COST CENTERS		1 0 0010			
50.00	05000 OPERATING ROOM		0. 29494		84, 915	
50. 01	05001 ENDOSCOPY		0. 26902		2, 876	
51.00	05100 RECOVERY ROOM		0. 42574		14, 647	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 37448		536	
53.00	05300 ANESTHESI OLOGY		0. 17945		15, 567	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 19159			
54. 01	05401 RADI ATI ON-ONCOLOGY		0. 33058		9, 810	
56.00	05600 RADI OI SOTOPE		0.00000		0	56.00
56. 01	05601 NUCLEAR MEDICINE		0. 07845		1, 066	
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 11477		0	
60.00	06000 LABORATORY		0. 18988		70, 663	
64.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY		0. 20105		214	
65.00	06600 PHYSI CAL THERAPY		0. 32554		56, 486	
66. 00 67. 00	06700 OCCUPATIONAL THERAPY		0. 55085 0. 42058		11, 524 3, 360	
68. 00	06800 SPEECH PATHOLOGY		0. 32814		1, 566	
	06900 ELECTROCARDI OLOGY		1			
69. 00 69. 01	06901 CARDI AC REHAB		0. 13286			
70. 00			0. 47492			
70.00			0. 63585		6, 806	71.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT		0. 00000 0. 51729		0	•
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 51729		0 130, 357	
73. 00	07301 ULTRA SOUND		0. 4602		3, 885	1
	07400 RENAL DIALYSIS		0. 0991			
74.00	OUTPATIENT SERVICE COST CENTERS		0.70010	00 10, 033	1,444	1 /4.00
90. 00	09000 CLINIC		0. 20007	75 0	0	90.00
	09100 EMERGENCY		0. 2000		46, 618	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1 22248			

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)
202.00 Net charges (line 200 minus line 201)

1. 222486

2, 205, 824

2, 205, 824

90. 00 91. 00 92. 00

201. 00 202. 00

0 540, 961 200. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 7/21/2020 4:19 pm

			10 12/31/2019	7/21/2020 4: 19	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			_	
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurrin	ig prior to October 1 (s	see	0	1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurrin	a on or ofter October :	(600	10 042 077	1. 02
1.02	instructions)	ig on or arter october	(See	19, 962, 077	1.02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring i	orior to October	0	1. 03
1.03	1 (see instructions)	di schai ges occurring p	or to october	٥	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring	on or after	0	1. 04
	October 1 (see instructions)			-	
2.00	Outlier payments for discharges. (see instructions)				2. 00
2.01	Outlier reconciliation amount			0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instruction	ns)		0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (s	ee instructions)		0	2. 03
2.04	Outlier payments for discharges occurring on or after October 1	(see instructions)		690, 488	2. 04
3.00	Managed Care Simulated Payments			0	3. 00
4.00	Bed days available divided by number of days in the cost report	ing period (see instru	ctions)	123. 30	4. 00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most	recent cost reporting	period ending on	0. 00	5. 00
	or before 12/31/1996.(see instructions)				
6.00	FTE count for allopathic and osteopathic programs that meet the	e criteria for an add-o	n to the cap for	0.00	6. 00
	new programs in accordance with 42 CFR 413.79(e)				
7. 00	MMA Section 422 reduction amount to the IME cap as specified un			0.00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 4	2 CFR §412.105(f)(1)(i	/)(B)(2) If the	0. 00	7. 01
	cost report straddles July 1, 2011 then see instructions.				
8.00	Adjustment (increase or decrease) to the FTE count for allopath			0. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79	(C)(2)(IV), 64 FR 26340	) (May 12,		
0.01	1998), and 67 FR 50069 (August 1, 2002).		104 IE 111	0.00	0.01
8. 01	The amount of increase if the hospital was awarded FTE cap slot	s under § 5503 or the A	ACA. IT the cost	0. 00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slot	s from a closed teachin	na hosni tal	0.00	8. 02
0.02	under § 5506 of ACA. (see instructions)	s II olii a Ci osed teaciii i	ig nospi tai	0.00	0.02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines	(8 8 01 and 8 02)	:00	0.00	9. 00
7. 00	instructions)	(0, 0,01 and 0,02) (.	,,,,	0.00	7.00
10.00	FTE count for allopathic and osteopathic programs in the curren	it vear from your record	ls	0. 00	10.00
11. 00	FTE count for residents in dental and podiatric programs.				11.00
12. 00	Current year allowable FTE (see instructions)			0.00	
13. 00	Total allowable FTE count for the prior year.			0.00	
14. 00	Total allowable FTE count for the penultimate year if that year	ended on or after Sep	ember 30. 1997.	0.00	
	otherwise enter zero.				
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16.00	Adjustment for residents in initial years of the program			0.00	16. 00
17.00	Adjustment for residents displaced by program or hospital closu	ire		0.00	17. 00
	Adjusted rolling average FTE count			0.00	1
	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	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
22.00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE residen	it cap slots under 42 Cl	R 412. 105	0.00	23. 00
	(f)(1)(iv)(C).				
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
25.00	If the amount on line 24 is greater than -0-, then enter the lo	wer of line 23 or line	24 (see	0.00	25. 00
	instructions)				
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	
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days (see instruc	i ons)	1. 04	
31. 00	Percentage of Medicaid patient days (see instructions)			16. 49	
32. 00	Sum of lines 30 and 31			17. 53	
	Allowable disproportionate share percentage (see instructions)			4. 14	
34. 00	Disproportionate share adjustment (see instructions)			206, 608	34.00

	Financial Systems HENDRICKS REGION  ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0005	Peri od:	u of Form CMS-2 Worksheet E	∠טט∠- I
ONLOGE	STITUTE OF RETIREDUCEMENT SETTEMENT	11001461 0011. 10 0000	From 01/01/2019 To 12/31/2019	Part A	nared:
				7/21/2020 4:1	
		Title XVIII	Hospi tal Pri or to 10/1	PPS On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Adjustment				
35. 00 35. 01	,		8, 272, 872, 447 0, 000174211	8, 350, 599, 096 0. 000205375	•
35. 01		er zero on this line) (s			•
	instructions)				
35. 03 36. 00	1 ' '		1, 077, 957 1, 509, 052		35. 00 36. 00
00. 00	Additional payment for high percentage of ESRD beneficiary di				] 55. 5
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40. 0
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683 684 an 685 (see	0		41.0
11.00	instructions)	000, 001 dii 000. (300			11.00
41. 01	1 3	-DRGs 652, 682, 683, 68	4 0		41. 0
42. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not quali	ifv for adiustment)	0.00		42.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68		e 0		43.00
44. 00	instructions) Ratio of average length of stay to one week (line 43 divided	hy line 41 divided by 7	0. 000000		44. 0
44.00	days)	by Time 41 divided by 7	0.00000		44.0
45. 00			0.00		45. 0
46. 00 47. 00	Total additional payment (line 45 times line 44 times line 47 Subtotal (see instructions)	1.01)	22, 368, 225		46. 0 47. 0
48. 00	,	small rural hospitals	0		48. 0
	only. (see instructions)				
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions	s)		22, 368, 225	49. 0
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar		)	1, 751, 480	•
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii			0	
53. 00	Nursing and Allied Health Managed Care payment	, , , , , , , , , , , , , , , , , , , ,		0	1
54.00	Special add-on payments for new technologies			0	
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	69)		0	
56. 00	Cost of physicians' services in a teaching hospital (see intr	•		0	
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		through 35).	0	
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	IV, Col. II line 200)		0 24, 119, 705	
60.00	,			2, 774	
61.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		24, 116, 931	
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			2, 267, 756 4, 768	1
64. 00				83, 008	1
	Adjusted reimbursable bad debts (see instructions)			53, 955	
66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		28, 451	
68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (	see instructions)	21, 898, 362 0	1
59. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).		,	0	1
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	tration) adjustment (acc	i notruoti ono)	0	
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration	· •	rnstructions)	0	1
70. 88				0	70. 8
	Pioneer ACO demonstration payment adjustment amount (see inst	tructions)		_	70. 8
70. 89	, , , , , , , , , , , , , , , , , , , ,			0	1
70. 90	THOSE DOUGH DAVIDEDT HER AUTOSTILLED SUICIDIT 1755 TOST TOTAL TODAL				1 , 0. 7
	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70. 9
70. 90 70. 91	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 162, 393 -79, 971	70. 9

Heal th	Financial Systems	HENDRICKS REGIONAL HEALTH		In Lie	u of Form CMS-:	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C		Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Pre 7/21/2020 4:1	pared:
		Ti tl e	e XVIII	Hospi tal	PPS	, biii
				(уууу)	Amount	
				0	1.00	
70. 96	Low volume adjustment for federal fiscal year	(yyyy) (Enter in column 0		0	0	70. 96
	the corresponding federal year for the period	prior to 10/1)				
70. 97	Low volume adjustment for federal fiscal year			0	0	70. 97
	the corresponding federal year for the period	ending on or after 10/1)				
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)				0	1
71. 00	Amount due provider (line 67 minus lines 68 pl	us/minus lines 69 & 70)			21, 980, 784	1
71. 01	Sequestration adjustment (see instructions)				439, 616	
71. 02	1	sequestration			0	
71. 03	Sequestration adjustment-PARHM pass-throughs				04 700 700	71.03
	Interim payments				21, 780, 709	
	Interim payments-PARHM				0	72. 01
73.00	Tentative settlement (for contractor use only)				0	1 , 0, 00
73. 01 74. 00	Tentative settlement-PARHM (for contractor use	3,			220 E41	73. 01 74. 00
74.00	Balance due provider/program (line 71 minus li 73)	nes 71.01, 71.02, 72, and			-239, 541	74.00
74. 01	-/	uctions)				74. 01
75. 00	Balance due provider/program-PARHM (see instru Protested amounts (nonallowable cost report it				202, 153	
75.00	CMS Pub. 15-2, chapter 1, §115.2	ells) I'll accordance wi til			202, 155	/5.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 throug	h 96)				1
90.00	Operating outlier amount from Wkst. E, Pt. A,				0	90.00
	plus 2.04 (see instructions)					
91.00	Capital outlier from Wkst. Ĺ, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment am	nount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amou	int (see instructions)			0	93.00
94.00	The rate used to calculate the time value of m	oney (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (se	e instructions)			0	95.00
96. 00	Time value of money for capital related expens	ses (see instructions)		-	0	96. 00
					On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0. 0000000000	0.0000000000	
102.00	HVBP adjustment amount for HSP bonus payment (	see instructions)		0	0	102. 00
400.00	HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	400.00
	HRR adjustment factor (see instructions)			0.0000	0.0000	
104.00	HRR adjustment amount for HSP bonus payment (s Rural Community Hospital Demonstration Project	(\$4104 Demonstration) Adi:	ictmont	0	0	104. 00
200 00						200 00
∠UU. UU	Is this the first year of the current 5-year d Century Cures Act? Enter "Y" for yes or "N" fo		trie ZIST			200. 00
	Cost Reimbursement	ii IIO.				+
201 00	Medicare inpatient service costs (from Wkst. D	1-1 Pt II lino 40)		T		201. 00
	Medicare discharges (see instructions)	,-1, 1 t. 11, 11110 47 <i>)</i>				202.00
	Case-mix adjustment factor (see instructions)					203. 00
	sass x day astmort ractor (see riistractions)					

74. 01	(13)		l	l
	Balance due provider/program-PARHM (see instructions)			74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance with		202, 153	75. 00
	CMS Pub. 15-2, chapter 1, §115.2			
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90.00
	plus 2.04 (see instructions)			
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2. 00	
	HSP Bonus Payment Amount	1.00	2.00	
100 00	HSP bonus amount (see instructions)	0	0	100. 00
100.00	HVBP Adjustment for HSP Bonus Payment			100.00
101 00	HVBP adjustment factor (see instructions)	0.000000000	0.000000000	101 00
		0.000000000		102.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
400.00	HRR Adjustment for HSP Bonus Payment	0.0000	0.0000	100 0
	HRR adjustment factor (see instructions)	0.0000		
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104. 0
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.			ļ
	Cost Reimbursement			
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
			•	
202.00	Medicare discharges (see instructions)			202. 00
	Case-mix adjustment factor (see instructions)			202. 00
	,	5-year demonst	tration	202. 00
	Case-mix adjustment factor (see instructions)	5-year demonst	tration	202. 00
203.00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current	5-year demons	tration	202. 00 203. 00
203.00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current period)	5-year demons	tration	202. 00 203. 00 204. 00
203. 00 204. 00 205. 00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	5-year demonst	tration	202. 00 203. 00 204. 00 205. 00
203. 00 204. 00 205. 00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	5-year demons	tration	202. 00 203. 00 204. 00 205. 00
203. 00 204. 00 205. 00 206. 00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	5-year demonst	trati on	202. 00 203. 00 204. 00 205. 00 206. 00
204. 00 205. 00 206. 00 207. 00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	5-year demons	trati on	202. 00 203. 00 204. 00 205. 00 206. 00
203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current period)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Program reimbursement under the §410A Demonstration (see instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)	5-year demons	trati on	204. 00 205. 00 206. 00 207. 00 208. 00
203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current period)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Program reimbursement under the §410A Demonstration (see instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)  Adjustment to Medicare IPPS payments (see instructions)	5-year demonst	tration	202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current period)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Drogram reimbursement under the §410A Demonstration (see instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)  Adjustment to Medicare IPPS payments (see instructions)  Reserved for future use	5-year demons	tration	202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current period)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Drogram reimbursement under the §410A Demonstration (see instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)  Adjustment to Medicare IPPS payments (see instructions)  Reserved for future use  Total adjustment to Medicare IPPS payments (see instructions)	5-year demons	tration	202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	5-year demons	tration	204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00	Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current period)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Program reimbursement under the §410A Demonstration (see instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)  Adjustment to Medicare IPPS payments (see instructions)  Reserved for future use  Total adjustment to Medicare IPPS payments (see instructions)  Comparision of PPS versus Cost Reimbursement  Total adjustment to Medicare Part A IPPS payments (from line 211)	5-year demons	tration	202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00
203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 213. 00	Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current period)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Program reimbursement under the §410A Demonstration (see instructions)  Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)  Adjustment to Medicare IPPS payments (see instructions)  Reserved for future use  Jotal adjustment to Medicare IPPS payments (see instructions)  Comparision of PPS versus Cost Reimbursement  Total adjustment to Medicare Part A IPPS payments (from line 211)  Low-volume adjustment (see instructions)	5-year demons	tration	202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 209. 00 210. 00 211. 00 212. 00 213. 00
203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211)	5-year demons	tration	

In Lieu of Form CMS-2552-10

Period: Worksheet E
From 01/01/2019 Part A Exhibit 4
To 12/31/2019 Date/Time Prepared: 7/21/2020 4:19 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0005

						12/31/2019	7/21/2020 4: 1	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1.00	DRG amounts other than outlier	1. 00	0	2.00	0.00	4.00	0.00	1. 00
	payments			]			_	
1. 01	DRG amounts other than outlier payments for discharges	1. 01	0	0	0		0	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	19, 962, 077	0		19, 962, 077	19, 962, 077	1. 02
1 02	occurring on or after October  1	1.02		0	0		0	1 00
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	U	0		0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for	2. 00						2. 00
2. 01	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to	2. 03	0	0	0		0	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2. 04	690, 488	0		690, 488	690, 488	2. 03
3. 00	instructions) Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
	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)	22.00			0	0	0	/ 00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for	22. 00 22. 01	0	0	0	0	0	6. 00 6. 01
0.01	managed care (see instructions)		J	J	0	J	O	0.01
	Indirect Medical Education Adju							
7.00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see	28. 01	0	O	0	O	0	8. 01
9. 00	instructions) Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
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)							
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see	33.00	0. 0414	0. 0414	0. 0414	0. 0414		10.00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34.00	206, 608	0	0	206, 608	206, 608	11. 00
11. 01	Uncompensated care payments	36.00	1, 509, 052	di soborgos	1, 077, 957	431, 095	1, 509, 052	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00		ai scharges O	0	0	0	12.00
12.00	(see instructions)	40.00		٩	U	U	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47. 00 48. 00	22, 368, 225 0	0	1, 077, 957 0	21, 290, 268 0	22, 368, 225 0	13. 00 14. 00
15. 00	small rural hospitals only.) (see instructions) Total payment for inpatient	49. 00	22, 368, 225	0	1, 077, 957	21, 290, 268	22, 368, 225	15. 00
	operating costs (see instructions)							
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	1, 751, 480	O	0	1, 751, 480	1, 751, 480	16.00

	LUME CALCULATION EXHIBIT 4			Provider Co		From 01/01/2019 To 12/31/2019	7/21/2020 4:1	pared:
					XVIII	Hospi tal	PPS	
		· ·	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	Taranta da la caracteria de la caracteri	0	1. 00	2. 00	3. 00	4. 00	5. 00	
17. 00	Special add-on payments for new technologies	54.00	0	0		0 0	0	
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0		0 0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see	93. 00	0	0		0 0	0	18. 00
19. 00	instructions) SUBTOTAL			0	1, 077, 95	7 23, 041, 748	24, 119, 705	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, 615, 805	0		0 1, 615, 805	1, 615, 805	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	77, 344	0		0 77, 344	77, 344	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0361	0. 0361	0. 036	0. 0361		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	58, 331	0		0 58, 331	58, 331	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 751, 480	0		0 1, 751, 480	1, 751, 480	26. 00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 00000	0. 000000		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96				0	0	28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der CC		Period: From 01/01/2019 To 12/31/2019		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		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 discharges occurring prior to October 1	1. 01	0		0	0	
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	19, 962, 077		19, 962, 077		
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0		0	0	1.03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2.00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	0		0	0	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	690, 488		690, 488	690, 488	2. 03
3.00	Operating outlier reconciliation	2. 01	0		0		3. 00
4. 00	Managed care simulated payments	3. 00	0		0 0	0	4. 00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 00000	0. 000000		5.00
	(see instructions)		0.00000				
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	0		0 0		6. 00 6. 01
0.01	instructions)	22.01			0	0	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	8.00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01			0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	0		0	0	
9. 01	Total IME payment for managed care (sum of	29. 01	0		0	0	9. 01
	lines 6.01 and 8.01) Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage	33.00	0.0414	0. 041	4 0. 0414		10.00
	(see instructions)						
11. 00	Disproportionate share adjustment (see instructions)	34.00	206, 608		0 206, 608		
11. 01	Uncompensated care payments	36.00	1, 509, 052	1, 077, 95	7 431, 095	1, 509, 052	11. 01
12. 00	Additional payment for high percentage of ESF Total ESRD additional payment (see instructions)	46. 00	0 o		0 0	0	12. 00
13. 00	Subtotal (see instructions)	47.00	22, 368, 225	1, 077, 95	7 21, 290, 268	22, 368, 225	13. 00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48. 00	0	, , , , ,	0	0	1
15. 00	<pre>instructions) Total payment for inpatient operating costs (see instructions)</pre>	49. 00	22, 368, 225	1, 077, 95	7 21, 290, 268	22, 368, 225	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 751, 480		0 1, 751, 480	1, 751, 480	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	0		0	0	17. 00 17. 01
17. 01	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0		0	0	
18. 00	Capital outlier reconciliation adjustment	93. 00	0		0	0	18. 00
19. 00	amount (see instructions) SUBTOTAL			1, 077, 95	7 23, 041, 748	24, 119, 705	19. 00

Heal th	Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der CC	F	Period: From 01/01/2019 To 12/31/2019		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4.00	
20. 00	Capital DRG other than outlier	1.00	1, 615, 805	(	1, 615, 805	1, 615, 805	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(	0	0	20. 01
21. 00	Capital DRG outlier payments	2.00	77, 344	(	77, 344	77, 344	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(	0	0	21. 01
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	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0361	0. 036	0. 0361		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	58, 331	(	58, 331	58, 331	25. 00
26. 00	Total prospective capital payments (see	12.00	1, 751, 480	(	1, 751, 480	1, 751, 480	26. 00

26.00 Total prospective capital payments (see	12. 00	1, 751, 480	0	1, 751, 480	1, 751, 480	26 00
instructions)	12.00	1,701,100		1,701,100	1, 701, 100	20.00
	Wkst. E, Pt.	(Amt. from				
	A, line	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	162, 393	0	162, 393	162, 393	30. 00
30.01 HVBP payment adjustment for HSP bonus	70. 90	0	0	0	0	30. 01
payment (see instructions)						
31.00 HRR adjustment (see instructions)	70. 94	-79, 971	0	-79, 971	-79, 971	31. 00
31.01 HRR adjustment for HSP bonus payment (see	70. 91	0	0	0	0	31. 01
instructions)						
					(Amt. to Wkst.	
					E, Pt. A)	
	0	1. 00	2. 00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see	70. 99		0	0	0	32. 00
instructions)						
100.00 Transfer HAC Reduction Program adjustment to		N				100. 00
Wkst. E, Pt. A.						

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 7/21/2020 4:19 pm

		Title XVIII	Hospi tal	7/21/2020 4: 1 PPS	9 pm
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			44, 187	1.00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		31, 736, 711	2. 00
3.00	OPPS payments			22, 175, 983	3. 00
4.00	Outlier payment (see instructions)			172, 178 0	
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructi	ons)		0.000	
6. 00	Line 2 times line 5	onsy		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	9.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 44, 187	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			1 44, 107	11.00
	Reasonable charges				
12. 00	Ancillary service charges			118, 519	1
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			118, 519	14.00
15. 00	Customary charges Aggregate amount actually collected from patients liable for pay	wment for services on a	charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	
	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	ł
18. 00 19. 00	Total customary charges (see instructions)  Excess of customary charges over reasonable cost (complete only	if line 19 exceeds lin	20 11) (600	118, 519 74, 332	1
17.00	instructions)	II IIIle 16 exceeds III	ie II) (see	74, 332	19.00
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lin	ne 18) (see	0	20. 00
	instructions)				
21. 00	Lesser of cost or charges (see instructions)			44, 187	
22. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instruc	rtions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	2013)		22, 348, 161	•
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	
26. 00	Deductibles and Coinsurance amounts relating to amount on line 2			4, 242, 596	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pluinstructions)	us the sum of lines 22	and 23] (see	18, 149, 752	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	29. 00
	Subtotal (sum of lines 27 through 29)			18, 149, 752	
31.00	Primary payer payments			2, 101	1
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	3)		18, 147, 651	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	))		0	33. 00
	Allowable bad debts (see instructions)			308, 191	1
	Adjusted reimbursable bad debts (see instructions)			200, 324	
	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		203, 283	
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			18, 347, 975	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replaced	d devices (see instruct	tions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			10 240 020	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			18, 348, 039 366, 961	•
40. 02	Demonstration payment adjustment amount after sequestration			0	1
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
	Interim payments			17, 892, 754	1
	Interim payments-PARHM				41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			88, 324	ı
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2, o	chapter 1,	0	44. 00
	§115. 2				
90 00	TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	•
	The rate used to calculate the Time Value of Money				92.00
93. 00	Time Value of Money (see instructions)			0	
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems HEND ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: Provi der CCN: 15-0005

				10 12/31/2019	7/21/2020 4: 19	
		Title	: XVIII	Hospi tal	PPS	
		Inpatien	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	T	1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		21, 670, 82		17, 772, 173	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
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2019	109, 88		120, 581	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3.04				0	0	3. 04
3. 05	Danid dan ta Danisan			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		1	ol	0	3. 50
3. 50	ADJUSTIMENTS TO PROGRAM			0	0	3. 50
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3. 54				o	o l	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		109, 88	3	120, 581	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		21, 780, 70	9	17, 892, 754	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
г оо	TO BE COMPLETED BY CONTRACTOR		I			Г 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5.03
	Provider to Program			_		
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	O O	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER			0	88, 324	6. 01
6. 02	SETTLEMENT TO PROGRAM		239, 54	-	0	6. 02
7. 00	Total Medicare program liability (see instructions)	•	21, 541, 16		17, 981, 078	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.05		(	)	1. 00	2. 00	0.05
8.00	Name of Contractor					8. 00

Health Financial Systems	HENDRICKS REGIONAL HEALTH	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	From 01/01/2019 P To 12/31/2019 D	Worksheet E-3 Part VII Date/Time Prepared: 1/21/2020 4:19 nm

			10 12/31/2019	7/21/2020 4:1	
		Title XIX	Hospi tal	Cost	, biii
		II to Ala	Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	PVICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	COTOLS FOR TITLES V OR XII	K SERVICES		1
1. 00	Inpatient hospital/SNF/NF services		1, 397, 582		1.00
2. 00	Medical and other services		1, 377, 302	0	
3. 00	Organ acquisition (certified transplant centers only)		0	U	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		1, 397, 582	0	
5. 00	Inpatient primary payer payments		1, 377, 302	U	5.00
6. 00	Outpatient primary payer payments		0	0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		1 207 502	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		1, 397, 582	U	7.00
	Reasonable Charges				1
0.00					0.00
8.00	Routine service charges		2 205 024	0	8. 00
9.00	Ancillary service charges		2, 205, 824	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, 205, 824	0	12. 00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
45.00	a charge basis had such payment been made in accordance with	12 CFR §413.13(e)			45.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
16. 00	Total customary charges (see instructions)		2, 205, 824	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	808, 242	0	17. 00
	line 4) (see instructions)			_	
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
20. 00	Cost of physicians' services in a teaching hospital (see instr		0	0	1 20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		1, 397, 582	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide			
22. 00	Other than outlier payments		0	0	
	Outlier payments		0	0	
24. 00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		1, 397, 582	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	)	1, 397, 582	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	1, 397, 582	0	36. 00
37.00			0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		1, 397, 582	0	38. 00
39.00	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, 397, 582	0	40.00
41. 00	Interim payments		0	0	41.00
42. 00	Balance due provider/program (line 40 minus line 41)		1, 397, 582	0	
43. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub 15-2	0	0	
	chapter 1, §115.2			· ·	
	· · · · ·		'		•

Health Financial Systems HENDRICKS REGIONAL HEALTH In Lieu of Form CMS-2552-10

Health Financial Systems

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

Provider CCN: 15-0005 | Period: From 01/01/2

Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 7/21/2020 4:19 pm

oni y)				10 12/01/201/	7/21/2020 4:1	9 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS	0 704 400	.1	J .		
1.00	Cash on hand in banks	3, 721, 483		0	0	
2.00	Temporary investments Notes receivable	0		-	0	
4. 00	Accounts receivable	35, 907, 383	1		0	
5.00	Other recei vable	33, 707, 303		0	0	
6.00	Allowances for uncollectible notes and accounts receivable	Ö		o o	0	
7.00	Inventory	2, 871, 806		0	0	
8.00	Prepai d expenses	0	) (	0	0	8.00
9.00	Other current assets	52, 493, 877	' (	0	0	
10. 00	Due from other funds	0		0	0	1
11. 00	Total current assets (sum of lines 1-10)	94, 994, 549	) (	0	0	11. 00
40.00	FI XED ASSETS	10 (00 070				40.00
12.00	Land	19, 692, 970			0	1
13. 00 14. 00	Land improvements	9, 993, 537 -6, 784, 637	1			
15. 00	Accumulated depreciation Buildings	171, 025, 955	1		0	
16. 00	Accumulated depreciation	171,023,733	1		0	
17. 00	Leasehold improvements	Ö		-	ő	
18.00	Accumul ated depreciation	O		0	0	1
19.00	Fi xed equipment	0		0	0	19.00
20.00	Accumulated depreciation	0	) (	0	0	20.00
21.00	Automobiles and trucks	0	) (	0	0	
22. 00	Accumul ated depreciation	0		0	0	
23. 00	Major movable equipment	137, 998, 826		0	0	1
24. 00	Accumulated depreciation	-73, 025, 222	. (	0	0	
25. 00	Mi nor equipment depreciable	0		0	0	
26. 00 27. 00	Accumulated depreciation	0		0	0	
28. 00	HIT designated Assets Accumulated depreciation	0			0	
29. 00	Mi nor equi pment-nondepreci abl e		1		0	
30.00	Total fixed assets (sum of lines 12-29)	258, 901, 429	1	o o		
00.00	OTHER ASSETS	200,701,127	`	<u>,                                      </u>		1 00.00
31.00	Investments	229, 483, 367	' (	0	0	31.00
32.00	Deposits on Leases	0	) (	0	0	32.00
33.00	Due from owners/officers	11, 590, 101	(	0	0	33.00
34. 00	Other assets	26, 030, 668	•	1	0	
35. 00	Total other assets (sum of lines 31-34)	267, 104, 136	1	٥ -	0	1
36. 00	Total assets (sum of lines 11, 30, and 35)	621, 000, 114	. (	0	0	36. 00
37. 00	CURRENT LIABILITIES  Accounts payable	15, 605, 509	1	0	0	37. 00
38. 00	Salaries, wages, and fees payable	19, 116, 877	1		0	
39. 00	Payroll taxes payable	17, 110, 077	1		0	
40. 00	Notes and Loans payable (short term)	33, 290, 099	1		Ö	
41. 00	Deferred income	0		0	Ō	
42.00	Accel erated payments	O				42.00
43.00	Due to other funds	0	) (	0	0	43.00
44.00	Other current liabilities	19, 173, 452	2	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	87, 185, 937	' (	0	0	45. 00
	LONG TERM LIABILITIES					1
46. 00	Mortgage payable	118, 001, 768	1	٥ -	0	
47. 00	Notes payable	0	1	0		1
48. 00	Unsecured Loans	11 440 046			-	
49. 00	Other long term liabilities	11, 449, 046		0	0	1
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	129, 450, 814 216, 636, 751		0 0		
31.00	CAPITAL ACCOUNTS	210, 030, 731		<u>J</u>	0	31.00
52.00	General fund balance	404, 363, 363				52. 00
53.00	Specific purpose fund	, ,				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			0		56.00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
FO 00	replacement, and expansion	404 040 040		_	_	F0 00
59.00	Total fund balances (sum of lines 52 thru 58)	404, 363, 363		0	0	1
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	621, 000, 114	]	ا ا		60.00
	1~~/	I	1	1	I	1

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0005

0

19.00

Peri od: Worksheet G-1 From 01/01/2019

12/31/2019 Date/Time Prepared: 7/21/2020 4:19 pm 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 407, 727, 200 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) -3, 363, 837 2.00 3.00 Total (sum of line 1 and line 2) 404, 363, 363 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 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) 404, 363, 363 11.00 0 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 404, 363, 363 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 11.00 0 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

19.00

Fund balance at end of period per balance

sheet (line 11 minus line 18)

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0005

			7	o 12/31/2019	Date/Time Prep 7/21/2020 4:19	
	Cost Center Description		Inpati ent	Outpati ent	Total	) piii
	occi conten peron		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES		11.00	2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal		41, 462, 504	ļ	41, 462, 504	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		(		0	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)		41, 462, 504	ı İ	41, 462, 504	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT		9, 637, 177	7	9, 637, 177	11. 00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16.00	Total intensive care type inpatient hospital services (sum of I	i nes	9, 637, 177	'	9, 637, 177	16. 00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		51, 099, 681		51, 099, 681	17.00
18.00	Ancillary services		136, 115, 493	410, 491, 126	546, 606, 619	18.00
19.00	Outpati ent servi ces		21, 332, 777	136, 946, 194	158, 278, 971	19.00
20.00	RURAL HEALTH CLINIC		(	o o	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		(	0	0	21.00
22. 00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25. 00
26.00	HOSPI CE					26. 00
27. 00	PROFESSI ONAL FEES		1, 241, 624		97, 159, 091	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	209, 789, 575	643, 354, 787	853, 144, 362	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			371, 875, 993		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)			0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		371, 875, 993		43. 00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems HENDRICKS REGION	JAI HFAITH	In lie	u of Form CMS-2	2552-10
	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0005 Period:			Worksheet G-3	
			From 01/01/2019 To 12/31/2019	Date/Time Prep 7/21/2020 4:19	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			853, 144, 362	1. 00
2.00	Less contractual allowances and discounts on patients' accoun	ts		528, 891, 726	
3.00	Net patient revenues (line 1 minus line 2)			324, 252, 636	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		371, 875, 993	
5.00	Net income from service to patients (line 3 minus line 4)			-47, 623, 357	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			32, 568, 390	
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	
9.00	Revenue from television and radio service			0	
10. 00	Purchase di scounts			0	
	Rebates and refunds of expenses			0	
	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21.00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER REVENUE			11, 691, 125	24. 00
24. 01	ADJUSTING AMOUNTS			5	24. 01
25. 00	Total other income (sum of lines 6-24)			44, 259, 520	25. 00
	Total (line 5 plus line 25)			-3, 363, 837	
	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
	Net income (or loss) for the period (line 26 minus line 28)			-3, 363, 837	
			'	., ,	

0.41.00	u of Form CMS-2	2552-10			
CALCU	LATION OF CAPITAL PAYMENT	Provi der CCN: 15-0005	Peri od: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Pre 7/21/2020 4:19	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier				1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			77, 344 0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments				2. 01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)  Number of interns & residents (see instructions)			54. 31 0. 00	3. 00 4. 00
4. 00 5. 00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and				6.00
0.00	1.01) (see instructions)	y the sam of fines f and f. of	, corumns r and	0	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Part	1.04	7. 00		
	30) (see instructions)				
8. 00	Percentage of Medicaid patient days to total days (see instructions)				8.00
9.00	Sum of lines 7 and 8			17. 53	
10.00		tions)		3. 61	
11. 00 12. 00				58, 331 1, 751, 480	
12.00	Total prospective capital payments (see mistructions)			1, 751, 460	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instruction			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)	)		0	3.00
4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	4. 00 5. 00
3.00	Total impatient program capital cost (Time 3 x Time 4)			0	3.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2)	,		0	2. 00 3. 00
		)		0.00	
3.00	Annlicable excention nercentage (see instructions)				7.00
3. 00 4. 00	Applicable exception percentage (see instructions)  Capital cost for comparison to payments (line 3 x line 4)			0	5 00
3. 00 4. 00 5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
3. 00 4. 00 5. 00 6. 00		ee instructions)	(line 6)	0 0. 00 0	6.00
3. 00 4. 00 5. 00 6. 00 7. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se	ee instructions)	(line 6)	0.00	6. 00 7. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (so Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a	ee instructions) nary circumstances (line 2 > applicable)	ŕ	0. 00 0	6. 00 7. 00 8. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (so Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level	ee instructions) nary circumstances (line 2 > applicable) to capital payments (line 8	less line 9)	0. 00 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Capital cost for comparison to payments (line 3 x line 4). Percentage adjustment for extraordinary circumstances (so Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7). Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level or Worksheet L, Part III, line 14)	ee instructions) nary circumstances (line 2 > applicable) to capital payments (line 8 ver capital payment (from pri	less line 9) or year	0.00 0 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Capital cost for comparison to payments (line 3 x line 4). Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7). Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level or Worksheet L, Part III, line 14). Net comparison of capital minimum payment level to capital	ee instructions) nary circumstances (line 2 > applicable) to capital payments (line 8 ever capital payment (from pri al payments (line 10 plus lir	less line 9) or year ne 11)	0.00 0 0 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Capital cost for comparison to payments (line 3 x line 4). Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7). Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level or Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, etc.)	ee instructions) nary circumstances (line 2 > applicable) to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus lirenter the amount on this line	less line 9) or year ne 11)	0.00 0 0 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Capital cost for comparison to payments (line 3 x line 4). Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7). Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level or Worksheet L, Part III, line 14). Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, corryover of accumulated capital minimum payment level or carryover of accumulated capital minimum payment level or carryover of accumulated capital minimum payment level or carryover.	ee instructions) nary circumstances (line 2 > applicable) to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus lirenter the amount on this line	less line 9) or year ne 11)	0.00 0 0 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (so Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level ov (if line 12 is negative, enter the amount on this line)	pee instructions) nary circumstances (line 2 > applicable) to capital payments (line 8 per capital payment (from primal payments (line 10 plus line the the amount on this line per capital payment for the force in the force of	less line 9) or year ne 11)	0.00 0 0 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Capital cost for comparison to payments (line 3 x line 4). Percentage adjustment for extraordinary circumstances (set Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7). Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, carryover of accumulated capital minimum payment level of (if line 12 is negative, enter the amount on this line) current year allowable operating and capital payment (see	pee instructions) nary circumstances (line 2 > papplicable) to capital payments (line 8 yer capital payment (from primal payments (line 10 plus line payment the amount on this line yer capital payment for the fee instructions)	less line 9) or year ne 11)	0.00 0 0 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00