TART 1 0001			
Provi der	1. [X]Electronically filed cost report	Date: 5/30/2017	Time: 11:30 am
use only	2. []Manually submitted cost report		
	3. [0] If this is an amended report enter the number of times the provide 4. [F] Medicare Utilization. Enter "F" for full or "L" for low.	r resubmitted this cost	report
Contractor use only		O.NPR Date: 1.Contractor's Vendor Co 2.[0]If line 5, column number of times ro	1 is 4: Enter

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 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 01/01/2016 and ending 12/31/2016 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

(Signed)

Officer or Administrator of Provider(s)

OMB NO. 0938-0050 EXPIRES 05-31-2019

Date/Time Prepared:

5/30/2017 11: 30 am

Worksheet S

Parts I-III

Title

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	10, 149	-118, 295	0	152, 677	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	10, 149	-118, 295	0	152, 677	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. lf 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.

PLI	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENIIFICATION D	AIA	Provi de	er CCN:	15-0005	Period: From 01/0	01/2016		heet S- I	2
								31/2016	Date/	Time Pr	
	1.00	2.	00		3.00			4.00	5/30/	2017 11	: 29 a
	Hospital and Hospital Health Care Cor										
	Street: 1000 EAST MAIN STREET	PO Box:			4/400	1.100		01/0			1.
00	City: DANVILLE	State: I Component Na		CCN	CBSA	Provi de	nty: HENDRI er Date		ent Sve	stem (P,	2.
		component na		umber	Number		Certifie		Г, О, о		
								V	XVI I		
		1.00		2.00	3.00	4.00	5.00	6.0	0 7.00	0 8.00	
00	Hospital and Hospital-Based Component Hospital	ENDRICKS REGION		50005	26900	1	07/01/19	66 N	P	0	3.
.0		IEALTH			20,00				· · ·		0.
0	Subprovider - IPF										4.
0	Subprovider - IRF										5.
0 0	Subprovider - (Other) Swing Beds - SNF										6
0	Swing Beds - NF										8
0	Hospital-Based SNF										9.
00	Hospital-Based NF										10.
00 00	Hospital-Based OLTC Hospital-Based HHA										11.
	Separately Certified ASC										13
00	Hospi tal -Based Hospi ce										14
00	Hospital-Based Health Clinic - RHC										15
00 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16
00	Renal Dialysis										18
00	Other										19
							Fro			Го: 	_
00	Cost Reporting Period (mm/dd/yyyy)						1.			. 00 1/2016	20
	Type of Control (see instructions)							2010	12/3	172010	21
	Inpatient PPS Information							-			
00	Does this facility qualify and is it							(Ν	22
	share hospital adjustment, in accorda										
	for yes or "N" for no. Is this facili amendment hospital?) In column 2, ent				2.106(0	C) (2) (PI C	kre				
01	Did this hospital receive interim und	compensated care	payments f	for thi	s cost	reporting	a ,	(Y	22.
	period? Enter in column 1, "Y" for ye	es or "N" for no	for the po	ortion	of the	cost	-				
	reporting period occurring prior to (for no for the portion of the cost re										
	(see instructions)	porting period	occurring c			LUDEI I.					
02	Is this a newly merged hospital that	requires final	uncompensat	ted car	e payme	ents to b	e e	J		N	22
	determined at cost report settlement?										
	or "N" for no, for the portion of the in column 2, "Y" for yes or "N" for r										
	or after October 1.	io, foi the point	fon of the	COST	eportri	ig period	UII				
03	Did this hospital receive a geographi	c reclassificat	ion from ur	rban to	rural	as a res	ult I	J		Ν	22
	of the OMB standards for delineating						er				
	in column 1, "Y" for yes or "N" for r prior to October 1. Enter in column 2						the				
	cost reporting period occurring on or										
	hospital contain at least 100 but not			ounted	in acco	ordance w	th				
00	42 CFR 412.105)? Enter in column 3, "			d / am 25	bolow			-		N	1 22
00	Which method is used to determine Med 1, enter 1 if date of admission, 2 if	2						3		Ν	23.
	method of identifying the days in thi	s cost reportin	g period di	fferer	nt from	the meth					
	used in the prior cost reporting peri	od? In column						Mod		0+h	-
			In-State Medicaid	In-St Medic		Out-of State	Out-of State	Medica HMO da		Other edi cai d	
			paid days	eligi		edi cai d	Medi cai d			days	
				unpa	·	aid days	el i gi bl e				
			1 00	day 2.0		3.00	unpai d 4.00	5.00		6.00	-
00	If this provider is an IPPS hospital,	enter the	1.00 588		685	3.00	4.00	5.00	, 460		0 24
	in-state Medicaid paid days in column						0	2			
	Medicaid eligible unpaid days in colu										
	out-of-state Medicaid paid days in co										
	out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible but										
	column 5, and other Medicaid days in										
00	If this provider is an IRF, enter the	e in-state	0		0	0	0		o		25
	Medicaid paid days in column 1, the i										
		lill1 ∠,		1							
	Medicaid eligible unpaid days in colu out-of-state Medicaid days in column										
	out-of-state Medicaid days in column Medicaid eligible unpaid days in column	3, out-of-state									

	Financial Systems HENDRICK AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		ONAL HEALTH Provider CC	N: 15-0005		eriod: rom 01/01/	2016	u of For Workshe Part I Date/Ti	et S-2 me Pre	pared:
						Urban/Rur	al S	5/30/20 Date of		29 am
(00					6.11	1.00	1	2. ()0	
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	rural ge) st "2" f	atus at the en or rural. If a	d of the	cost		1			26.00 27.00
5.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status	in		0			35.00
						Begi nni r	ng:	Endi		
5. 00	Enter applicable beginning and ending dates of SCH st		Subscript line	36 for n	umber	1.00		2. (00	36.0
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the n					0			37.0
7.01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)									37.0
8. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.									38.0
						Y/N		Y/		
9.00	Does this facility qualify for the inpatient hospital	payme	nt adjustment	for low v	olume	1.00 N		2.0 N		39.00
0. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	uireme or "N" adjus er 1.	nts in accorda for no. (see tment? Enter " Enter "Y" for y	nce with nstructi (" for ye	42 ons) s or	N		N		40.00
	no in column 2, for discharges on or after October 1.	(see	instructions)				V	XVIII	XIX	
	Dreenestive Dowment System (DDC) Canital						1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	t for	di sproporti ona	te share	in ac	cordance	N	Y	N	45.0
6.00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.						Ν	N	N	46.0
	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals						N N	N N	N N	47.00 48.00
6.00	Is this a hospital involved in training residents in a or "N" for no.	approv	ed GME program	s? Enter	"Y"	for yes	Ν			56.0
	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes o h of t ", com	r "N" for no in his cost repor plete Workshee	n column ting peri	1. If od?	column 1 Enter "Y"				57.0
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	compl e	te Wkst. D-5.		i ces a	as	Ν			58.0
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health				s tho		N N			59.0 60.0
0.00	provider-operated criteria under §413.85? Enter "Y"	for ye								00.0
		Y/N	IME	Di rect	GME	IME		Di rect	GME	
		1.00	2.00	3.00)	4.00		5.0		
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)						0.00		0.00	61.0
1.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00		0.00					61.0
	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0. 00		0.00					61.0
	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00		0.00					61.0
1. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00		0.00					61.0
	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00		0.00					61.0

SPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION D	ATA	Provider CC		eriod: com 01/01/2016	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 5/30/2017 11:	pared
		Y/N	I ME	Direct GME	I ME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
.06 Enter the amount of ACA §5503 award used for cap relief and/or FTEs tha care or general surgery. (see instr	at are nonprimary		0.00	0.00			61.
		Pro	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
.10 Of the FTEs in line 61.05, specify	aaab naw neagean		1.00	2.00	3.00	4.00	(1
 special ty, if any, and the number of for each new program. (see instruct column 1, the program name, enter i program code, enter in column 3, th unweighted count and enter in colum FTE unweighted count. Of the FTEs in line 61.05, specify program special ty, if any, and the residents for each expanded program instructions) Enter in column 1, th 	of FTE residents ions) Enter in n column 2, the HME FTE nn 4, direct GME each expanded number of FTE n. (see				0.00		
enter in column 2, the program code 3, the IME FTE unweighted count and 4, direct GME FTE unweighted count.	l enter in column						
						1.00	
ACA Provisions Affecting the Health .00 Enter the number of FTE residents t	hat your hospital	trai nec			iod for which	0.00	62.
your hospital received HRSA PCRE fu .01 Enter the number of FTE residents t during in this cost reporting perio Togobing Uppritale, that Claim Deci	hat rotated from od of HRSA THC pro	a Teachi gram. (s	see instruction		your hospital	0.00	62.
Teaching Hospitals that Claim Resid .00 Has your facility trained residents "Y" for yes or "N" for no in column	s in nonprovider s	ettings	during this co		period? Enter	N	63.
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year F period that begins on or after July				This base year	is your cost	reporting	
.00 Enter in column 1, if line 63 is ye in the base year period, the number resident FTEs attributable to rotat settings. Enter in column 2 the nu resident FTEs that trained in your of (column 1 divided by (column 1 d	es, or your facili of unweighted no ions occurring in umber of unweighte hospital. Enter i	ty trair n-primar all nor d non-pr n columr	ed residents ry care provider imary care 3 the ratio	0.00	0.00	0. 000000	64.
	Program Name		gram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
.00 Enter in column 1, if line 63	1.00		2.00	3.00 0.00	4.00	5.00 0.000000	45
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care							

	Financial Systems		KS REGIONAL HEALTH		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provider C		eriod: rom 01/01/2016 o 12/31/2016	Worksheet S-2 Part I Date/Time Pre 5/30/2017 11:	pared:
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Settin	<u> </u>	2.00 For cost report	3.00 ing periods	
44 00	beginning on or after July 1, 20 Enter in column 1 the number of)10	ry care recident	0.00	0.00	0. 000000	66 00
00.00	FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	occurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0.00000	00.00
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
				FTEs Nonprovider	FTEs in Hospital	3/ (col . 3 + col . 4))	
				Site			
67.00	Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 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)						
			I				
	Inpatient Psychiatric Facility F				1.00	0 2.00 3.00	
70.00	Is this facility an Inpatient Ps	sychiatric Facility (IPF), or does it con	tain an IPF sub	provi der? N		70.00
71.00	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilia	ne facility have an a pefore November 15, 2 olumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	004? Enter "Y" for ility train resident)(D)? Enter "Y" for	yes or "N" for s in a new teac yes or "N" for	no. (see hi ng no.	0	71.00
75.00	Is this facility an Inpatient Re	habilitation Facilit	y (IRF), or does it	contain an IRF	N		75.00
76.00	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period enc no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	ne facility have an a ling on or before Nove train residents in a er "Y" for yes or "N"	ember 15, 2004? Ente new teaching progra for no. Column 3: I	r"Y" for yes o m in accordance f column 2 is Y	r "N" for with 42 ,	0	76.00
						1.00	
00.00	Long Term Care Hospital PPS		for you and INIL Co.	20		1	00.00
	Is this a long term care hospita Is this a LTCH co-located withir "Y" for yes and "N" for no. TEFRA Providers				period? Enter	N N	80.00 81.00
	Is this a new hospital under 42					N	85.00
86.00	Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo			r 42 CFR Sectio	n		86.00
87.00	Is this hospital a "subclause (I for yes or "N" for no.	I)" LTCH classified	under section 1886(d)(1)(B)(iv)(II)	? Enter "Y"	Ν	87.00
					V 1.00	XI X 2.00	
	Title V and XIX Services				1		
90. UU	Does this facility have title V yes or "N" for no in the applica		nospital services?	EITLEI Y TOP	N	Y	90.00
91.00	Ιs this hospital reimbursed for full or in part? Enter "Υ" for γ				N	Y	91.00
92.00	Are title XIX NF patients occupy	ving title XVIII SNF	beds (dual certifica			N	92.00
93.00	instructions) Enter "Y" for yes Does this facility operate an IC			nd XIX? Enter	N	N	93.00
	"Y" for yes or "N ["] for no in the Does title V or XIX reduce capit applicable column.	applicable column.			N	N	94.00

lealth Financial Systems HENDRICKS REGIONAL HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	r CCN: 15-0005	Peri od:	n Lieu	Workshe	
		From 01/01 To 12/31	/2016 /2016		me Prepare 17 11:29 a
		V		XLX	
	1	1.00		2.0	
P5.00 If line 94 is "Y", enter the reduction percentage in the applicable co Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" fo applicable column.		0. 00 N)	0. 0 N	0 95. 96.
07.00 If line 96 is "Y", enter the reduction percentage in the applicable co Rural Providers	olumn.	0.00)	0.0	0 97.
105.00 Does this hospital qualify as a critical access hospital (CAH)? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive for outpatient services? (see instructions)	method of paym	nent N			105. 106.
107.00 If this facility qualifies as a CAH, is it eligible for cost reimburse training programs? Enter "Y" for yes or "N" for no in column 1. (see i yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and th reimbursed. If yes complete Wkst. D-2, Pt. II.	nstructions) I				107.
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee s CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					108.
Physi cal				Respira	
1.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	2.00 N	3. 00 N	5	4. C N	
			ŀ	1.0	0
10.00 Did this hospital participate in the Rural Community Hospital Demonstr the current cost reporting period? Enter "Y" for yes or "N" for no.	ation project	(410A Demo)f	or	N	
Ni scal Langours Cost Donesting Laformation			1.00	2.00	3.00
Miscellaneous Cost Reporting Information 15.00(Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for n	no in column 1	lf column 1	N	1	0 115.
is yes, enter the method used (A, B, or E only) in column 2. If column 3 either "93" percent for short term hospital or "98" percent for long psychiatric, rehabilitation and long term hospitals providers) based o Pub. 15-1, chapter 22, §2208.1.	n 2 is "E", ent g term care (ir	er in column Icludes			0 113.
16.001s this facility classified as a referral center? Enter "Y" for yes or 17.001s this facility legally-required to carry malpractice insurance? Enter			N		116.
	er "Y" for yes	or "N" for	Y		117.
no. 18.00 is the mal practice insurance a claims-made or occurrence policy? Enter	3		Y 1		
no.	3	cy is	1	Insura	117.
no. 18.00 is the mal practice insurance a claims-made or occurrence policy? Enter	• 1 if the poli	cy is	1 es		117. 118. ance
no. 18.00 is the malpractice insurance a claims-made or occurrence policy? Enter claim-made. Enter 2 if the policy is occurrence.	Premiums	cy is s Losse 2.00	1 25 0	I nsura 3. 0	117. 118. ance 0
no. 18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter claim-made. Enter 2 if the policy is occurrence.	• 1 if the poli	cy is s Losse 2.00	1 es		117. 118. ance
no. 18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter claim-made. Enter 2 if the policy is occurrence. 18.01 List amounts of malpractice premiums and paid losses:	1 if the poli Premiums 1.00 888,	Cy is Losse 2.00 708 1.00	1 1 0 0		117. 118. ance 0 0 118. 0
no. 18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter claim-made. Enter 2 if the policy is occurrence. 18.01 List amounts of malpractice premiums and paid losses:	 1 if the poli Premiums 1.00 888, ner than the 	Cy is Losse 2.00 708 1.00 N	1 1 0 0	3.0	117. 118. ance 0 0 0118.
 no. 18.00 Is the mal practice insurance a claims-made or occurrence policy? Enter claim-made. Enter 2 if the policy is occurrence. 18.01 List amounts of mal practice premiums and paid losses: 18.02 Are mal practice premiums and paid losses reported in a cost center oth Administrative and General? If yes, submit supporting schedule listin and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter for the outpatient for the outpatient for the formation of the	Premiums 1 if the poli Premiums 1.00 888, ner than the ng cost centers provision in A "Y" for yes cor protipatie	cy is s Losse 2.00 708 1.00 5 N 6 N	1 1 0 0	3.0	117. 118. ance 0 0 118. 0
 no. 18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter claim-made. Enter 2 if the policy is occurrence. 18.01 List amounts of malpractice premiums and paid losses: 18.02 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. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless \$3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless [see instructions] that the set of the Hold Harmless provision in ACA \$3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 	1 if the poli Premiums 1.00 888, 1.00 888, 1.00 977 for yes corr the Outpatie nstructions)	cy is Losse 2.00 708 1.00 N Soca N Soca N	1 1 0 0	3.0	117. 118. 0 0 0 118. 0 118. 119.
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 no. 118.00 Is the mal practice insurance a claims-made or occurrence policy? Enter claim-made. Enter 2 if the policy is occurrence. 118.01 List amounts of mal practice premiums and paid losses: 118.02 Are mal practice premiums and paid losses reported in a cost center oth Administrative and General? If yes, submit supporting schedule listin and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? Enter "Y" for on in column 1. If column 1 is "Y", enter in column 2 the Workshee where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and yes, enter certification date(s) (mm/dd/yyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the cert in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified liver transplant center, enter the cert in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the cert in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified liver transplant center, enter the cert in column 1 and termination date, if applicable, in column 2. 	1 if the poli Premiums 1.00 888, 88, 97 than the ng cost centers provision in A "Y" for yes c or the Outpatie nstructions) vices charged t for yes or "N" et A line number "N" for no. If ertification dat tification date certification date certification date	cy is Losse 2.00 708 2.00 708 1.00 N S ACA N Pr S CO Y Y Pr N N N N N N N N N N N N N	1 1 0 0	3. 0 2. 0 N	117. 118. 0 0 0 118. 0 118. 119. 120. 121. 0 122. 125. 126. 127. 128.

Health Financial Systems	HENDRI CKS REGI			In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC		Period: From 01/01/2016	Worksheet S-2 Part I	
				To 12/31/2016	Date/Time Pre	pared:
					5/30/2017 11:	29 am
				1.00	2.00	
133.00 If this is a Medicare certified of			ication date			133.00
in column 1 and termination date, 134.00 If this is an organ procurement or	11		in column 1			134.00
and termination date, if applicabl						
All Providers 140.00 Are there any related organization	or home office costs as	defined in CMS	Pub 15-1	N		140.00
chapter 10? Enter "Y" for yes or '	'N" for no in column 1. If	yes, and home	office costs			140.00
are claimed, enter in column 2 the			tions)			
<u> </u>	n organization enter on		uah 143 the n	3.00 ame and address	of the home	
office and enter the home office of	contractor name and contra					
141.00Name: 142.00Street:	Contractor's Name: PO Box:		Contracto	r's Number:		141.00 142.00
142.00 Street: 143.00 Ci ty:	State:		Zip Code:			142.00
			I _ I			
144.00 Are provider based physicians' cos	ste included in Workshoot	12			1.00 Y	144.00
144. OOALE pLOVI del based physicialis cos		A?			T	144.00
				1.00	2.00	
145.00 If costs for renal services are cl inpatient services only? Enter "Y"				Y		145.00
no, does the dialysis facility in						
period? Enter "Y" for yes or "N"						
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in				N		146.00
yes, enter the approval date (mm/c			40, 34020) 11			
					1.00	-
147.00 Was there a change in the statisti	cal basis? Enter "Y" for	ves or "N" for	no.		1.00 N	147.00
148.00 Was there a change in the order of	f allocation? Enter "Y" fo	r yes or "N" f	or no.		N	148.00
149.00 Was there a change to the simplifi	ed cost finding method? E			no. Title V	N Title XIX	149.00
		Part A 1.00	Part B 2.00	3.00	4.00	-
Does this facility contain a provi		n exemption fro	m the applica	tion of the low	er of costs	
or charges? Enter "Y" for yes or ' 155.00Hospital	'N" for no for each compon	nent for Part A	and Part B. N	(See 42 CFR §41 N	3.13) N	155.00
156. 00 Subprovi der – TPF		N	N	N	N	156.00
157.00 Subprovi der – IRF		Ν	N	Ν	N	157.00
158. 00 SUBPROVI DER		N	N	N	N	158.00
159.00 SNF 160.00 HOME HEALTH AGENCY		N N	N N	N N	N N	159.00 160.00
161. 00 CMHC			N	N	N	161.00
					1.00	-
Multicampus					1.00	
165.00 Is this hospital part of a Multica	ampus hospital that has on	e or more camp	uses in diffe	rent CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.	Name	County	State Zip	Code CBSA	FTE/Campus	
	0	1.00		. 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	
Heal th Information Technology (HI 167.00 Is this provider a meaningful user				t Act	N	167.00
168.00 If this provider is a CAH (line 10				, enter the		168.00
reasonable cost incurred for the H						1.0.01
168.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?				a nardshi p		168.01
169.00 If this provider is a meaningful u	user (line 167 is "Y") and			"N"), enter the	0.00	169.00
transition factor. (see instruction	ons)					

Health Financial Systems	HENDRI CKS REGI O	NAL HEALTH	In Lie	u of Form CMS-	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DATA		Period:	Worksheet S-2	2	
			From 01/01/2016			
			To 12/31/2016	Date/Time Pre 5/30/2017 11:		
			Begi nni ng	Ending		
			1.00	2.00		
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	0.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/vyvy)					
			1.00	2.00		
171.00 If line 167 is "Y", does this pr	ovider have any days for ind	ividuals enrolled in	N	(0171.00	
section 1876 Medicare cost plans	reported on Wkst. S-3, Pt.	I, line 2, col. 6? Enter				
"Y" for yes and "N" for no in co	lumn 1. If column 1 is yes, (enter the number of section	on			
1876 Medicare days in column 2.	(see instructions)					

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Date/Time Pro 5/30/2017 11:	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO r	sponsos En	1.00	2.00	-
	mm/dd/yyyy format.		esponses. Lii		the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					_
. 00	Has the provider changed ownership immediately prior to the			N		1.00
	reporting period? If yes, enter the date of the change in co	nullin 2. (See	Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare Pr	ogram? If	N			2.00
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.					
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of	fices, drug	N			3.00
	or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other	the board				
	relationships? (see instructions)		N/ /N	Trues	Data	
			Y/N 1.00	Type 2.00	Date 3.00	
	Financial Data and Reports		1.00	2.00	5.00	
	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.00
00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco		N			5.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	-
	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is t	he provider	is N		6.00
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a		d during the	N N		7.00
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved g		cal education	n N		9.00
D. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or		the current	Ν		10.00
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.00
					Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po period? If yes, submit copy.			cost reporting	Y N	12.00
	If line 12 is yes, were patient deductibles and/or co-paymen Bed Complement	nts waived? I	fyes, see i	nstructions.	N	14.00
5.00	Did total beds available change from the prior cost reportin		yes, see in: t A	structions. Par	N t B	15.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	05/09/2017	Y Y	05/09/2017	16.00
7.00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for	Ν		N		17.00
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
8.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	Ν		N		18.00
	but are not included on the PS&R Report used to file this					

JSPITAL AND HUSPITA	AL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet S- Part II Date/Time Pr 5/30/2017 1	repared:		
			iption	Y/N	Y/N			
			0	1.00	3.00			
	17 is yes, were adjustments made to PS&R Tor Other? Describe the other adjustments:			N	N	20.0		
		Y/N	Date	Y/N	Date			
		1.00	2.00	3.00	4.00			
	report prepared only using the provider's es, see instructions.	N		N		21.0		
					1.00			
	COST REIMBURSED AND TEFRA HOSPITALS ONLY (EX	CEPT CHILDRENS	HOSPI TALS)			_		
Capital Relat	ed cost ween relifed for Medicare purposes? If yes, s	oo instructions			N	22.0		
3.00 Have changes								
	es and/or amendments to existing leases ente	red into during	this cost r	reporting period?	Ν	24.0		
	en new capitalized leases entered into durin	g the cost repo	orting period	1? If yes, see	N	25.0		
instructions.	ubject to Sec. 2314 of DEFRA acquired during		0.1	5	Ν	26.0		
7.00 Has the provi copy. Interest Expe	der's capitalization policy changed during t	he cost reporti	ng period? I	fyes, submit	N	27.0		
.00 Were new Loan	is, mortgage agreements or letters of credit s, see instructions.	entered into du	iring the cos	st reporting	N	28.0		
0.00 Did the provi	der have a funded depreciation account and/o funded depreciation account? If yes, see ins		ebt Service	Reserve Fund)	Ν	29.0		
	debt been replaced prior to its scheduled ma		≀debt?lfye	es, see	N	30.0		
I.00 Has debt been instructions. Purchased Ser	recalled before scheduled maturity without	issuance of new	/debt?lfye	es, see	N	31.0		
2.00 Have changes	or new agreements occurred in patient care s with suppliers of services? If yes, see inst		ed through c	contractual	N	32.0		
	yes, were the requirements of Sec. 2135.2 a		ng to compet	titive bidding? I	f N	33.0		
Provi der-Base								
lf yes, see i		0				34.0		
	; yes, were there new agreements or amended e ring the cost reporting period? If yes, see		ents with the	e provider-based	N	35. C		
				Y/N	Date			
				1.00	2.00			
Home Office C				N I	1			
	ice costs claimed on the cost report? yes, has a home office cost statement been	nrenared by the	home office	e? N		36. C		
lf yes, see i						38.0		
the provider?	Plf yes, enter in column 2 the fiscal year end of the holle of i yes, enter in column 2 the fiscal year end of the provider render services to ot	end of the home	offi ce.			39.0		
see instructi			5			40.0		
i nstructi ons.	yes, and the provider relider services to the					40.0		
		1.	00	2	. 00			
.00 Enter the fir	reparer Contact Information st name, last name and the title/position cost report preparer in columns 1, 2, and 3,	MI CHAEL		ALESSANDRI NI		41.0		
respecti vel y.		BLUE & CO., LI	_C			42.0		
	- · · ·	1		1		11		

Health Financial Systems HEND	RICKS REGIONAL HEA	ALTH	In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	INAI RE Provi		Period: From 01/01/2016	Worksheet S-2 Part II	
				Date/Time Pre 5/30/2017 11:	pared: 29 am
		3.00			
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the title/pos	ition DIRECTOR				41.00
held by the cost report preparer in columns 1, 2,	and 3,				
respecti vel y.					
42.00 Enter the employer/company name of the cost repor	t				42.00
preparer.					
43.00 Enter the telephone number and email address of t	he cost				43.00
report preparer in columns 1 and 2, respectively.					

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	HENDRICKS REGIO	Provi der CO	N. 15-0005	Peri od:	u of Form CMS-2 Worksheet S-3	
10351	AL AND HOSFITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	FIOVICEI CC	JN. 15-0005	From 01/01/2016	Part I	
					To 12/31/2016	Date/Time Pre	
						5/30/2017 11:	<u>29 am</u>
						I/P Days /	
						0/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Available 3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00	2.00	42.0		5.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	30.00	115	42,0	<i>•</i> 0 0.00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.0
3.00	HMO I PF Subprovi der						3.0
1.00	HMO I RF Subprovi der						4.0
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
b. 00	Hospital Adults & Peds. Swing Bed NF					0	6.0
. 00	Total Adults and Peds. (exclude observation		115	42, 0	90 0.00	0	
. 00	beds) (see instructions)		110	12,0		Ũ	,
. 00	I NTENSI VE CARE UNI T	31.00	12	4, 39	92 0.00	0	8.0
. 00	CORONARY CARE UNIT	01100		1,0		Ū	9.0
0.00	BURN I NTENSI VE CARE UNI T						10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY	43.00				0	
4.00	Total (see instructions)	101 00	127	46, 48	0.00	0	
5.00	CAH visits					0	
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER - IRF						17.0
8.00	SUBPROVIDER						18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPI CE						24.0
4.10	HOSPICE (non-distinct part)	30.00					24.
5.00	СМНС – СМНС						25.0
6.00	RURAL HEALTH CLINIC						26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.2
7.00	Total (sum of lines 14-26)		127				27.0
8.00	Observation Bed Days					0	28.0
9.00	Ambul ance Trips						29.0
0.00	Employee discount days (see instruction)						30.0
1.00	Employee discount days - IRF						31.0
2.00	Labor & delivery days (see instructions)		0		0		32.0
2.01	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions)						
3.00	LTCH non-covered days						33.0

iospi ta	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO		Period: From 01/01/2016 To 12/31/2016		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
8 	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6, 382	569	16, 01	3		1.00
3.00 H	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider	2, 525 0 0	2, 968 0 0				2.0 3.0 4.0
5.00 H	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	0	0		0		5. 00 6. 00
ł	Total Adults and Peds. (exclude observation beds) (see instructions)	6, 382	569	16, 01			7.00
0.00 0 0.00 1 1.00 2 2.00 0 3.00 1	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY	855	0	1, 85 3, 12	9		8.0 9.0 10.0 11.0 12.0 13.0
5.00 (6.00 5 7.00 5 8.00 5 9.00 5 0.00 1 1.00 (2.00 1 3.00 7 4.00 1	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE	7, 237 0	569 0 0		8 0.00 0	1, 325. 30	14. 0 15. 0 16. 0 17. 0 18. 0 20. 0 21. 0 22. 0 23. 0 24. 0 24. 1
5.00 (6.00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC ECORPALY QUALLELED HEALTH CENTER	0	0		0 0.00	0.00	25. 0 26. 0
7.00 ⁻ 8.00 (FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days		0	3, 43	0.00		27.0 28.0
0.00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	0			0		29.0 30.0 31.0
2.00 I 2.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room	0	196	46	2		32. C 32. C
	outpatient days (see instructions) LTCH non-covered days	0					33.0

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0005	Period: From 01/01/2016 To 12/31/2016		pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	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)		0	1, 99	94 114	5, 608	1.00
2.00 3.00 4.00 5.00 6.00 7.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)			65	59 737 0 0		2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00	I NTEŃSÌ VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						8.00 9.00 10.00 11.00 12.00 13.00
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	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0.00	0	1, 99	94 114	5, 608	14. 00 15. 00 16. 00 17. 00 18. 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) LTCH non-covered days	0. 00 0. 00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00

)SPI T	AL WAGE INDEX INFORMATION			Provider C	F	eriod: rom 01/01/2016 o 12/31/2016		pared
		Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	27 0
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
00	Total salaries (see	200.00	102, 226, 120	C	102, 226, 120	2, 714, 087. 00	37.67	1.0
00	instructions) Non-physician anesthetist Part		0	C	0	0.00	0.00	2.0
00	A Non-physician anesthetist Part		0	C	0	0.00	0.00	3.
00	B Physician-Part A -		15, 683	C	15, 683	111.00	141. 29	4.
01	Administrative Physicians - Part A - Teaching Dhugician and Nag		0	C	-		0.00	
00 00	Physician and Non Physician-Part B Non-physician-Part B for		7, 758, 463 0	C				
00	hospital-based RHC and FOHC services	21.00	0	C	0	0.00	0.00	7.
00	Interns & residents (in an approved program) Contracted interns and	21.00	0	C C		0. 00 0. 00		
01	residents (in an approved programs)		0			0.00	0.00	
00	Home office and/or related organization personnel		0	C	0	0.00	0.00	8.
00). 00	SNF Excluded area salaries (see instructions)	44.00	0 31, 599, 244	C C	0 31, 599, 244	0. 00 642, 060. 00		
. 00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		1, 946, 873	C	1, 946, 873	17, 806. 00	109. 34	11.
2. 00	Care Contract Labor: Top Level management and other management and administrative		0	C	o o	0.00	0.00	12.
. 00	services Contract Labor: Physician-Part		948, 114	C	948, 114	7, 343. 00	129. 12	13.
. 00	A - Administrative Home office and/or related orgainzation salaries and wage-related costs		0	C	0	0. 00	0. 00	14.
. 01	Home office salaries		0	C	0	0.00	0.00	
	Related organization salaries Home office: Physician Part A		0	C	0	0.00 0.00		
	- Administrative Home office and Contract		0	c				
. 00	Physicians Part A - Teaching WAGE-RELATED COSTS					0.00	0.00	
. 00	Wage-related costs (core) (see instructions)		20, 731, 282	C	20, 731, 282			17.
. 00	Wage-related costs (other) (see instructions)		0	C	0			18
. 00 . 00	Excluded areas Non-physician anesthetist Part		6, 994, 372 0	C	6, 994, 372 0			19 20
	A Non-physician anesthetist Part		0	C	0			21
. 00	B Physician Part A -		2, 085	C	2, 085			22
. 01	Administrative Physician Part A - Teaching		0	C	0			22.
. 00 . 00	Physician Part B Wage-related costs (RHC/FQHC)		974, 434 0	C	974, 434			23. 24.
00	Interns & residents (in an approved program)		0	C	0			25
. 50 . 51	Home office wage-related Related orgainzation		0 0	C				25 25
. 52	wage-related Home office: Physician Part A - Administrative -		0	C	0			25
. 53	wage-related Home office & Contract Physicians Part A - Teaching - wage-related		0	C	0			25.

Heal th	Financial Systems		HENDRICKS REG	IONAL HEALTH		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C	F	Period: From 01/01/2016 To 12/31/2016		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARI					1		
	Employee Benefits Department	4.00	1, 245, 317		1, 245, 317			26.00
	Administrative & General	5.00	11, 170, 498		11, 170, 498			27.00
28.00	Administrative & General under		4, 747, 785	0	4, 747, 785	17, 948. 00	264.53	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0	C	0.00		29.00
30.00	Operation of Plant	7.00	2, 481, 870	0	2, 481, 870	94, 483. 00	26.27	30.00
31.00	Laundry & Linen Service	8.00	325, 676	0	325, 676	21, 205. 00	15.36	31.00
32.00	Housekeepi ng	9.00	1, 953, 789	0	1, 953, 789	125, 041. 00	15.63	32.00
33.00	Housekeeping under contract (see instructions)		0	0	C	0.00	0.00	33.00
34.00	Dietary	10.00	1, 557, 124	-1, 093, 870	463, 254	26, 110. 00	17.74	34.00
35.00	Dietary under contract (see instructions)		0	C	C	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1, 093, 870	1, 093, 870	61, 654. 00	17.74	36.00
37.00	Maintenance of Personnel	12.00	0	0	C	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1, 919, 592	0	1, 919, 592	56, 737. 00	33.83	38.00
39.00	Central Services and Supply	14.00	757, 668	0	757, 668	33, 659. 00	22. 51	39.00
40.00	Pharmacy	15.00	1, 938, 321	0	1, 938, 321	49, 276. 00	39.34	40.00
	Medi cal Records & Medi cal Records Li brary	16.00	1, 292, 912	C	1, 292, 912			41.00
42.00	Soci al Servi ce	17.00	1, 697, 391	0	1, 697, 391	49, 724. 00	34.14	42.00
43.00	Other General Service	18.00	0		C		0.00	43.00

Heal th	Financial Systems		HENDRICKS REG	IONAL HEALTH		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2016 To 12/31/2016		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		99, 215, 442	0	99, 215, 44	2 2, 677, 319. 00	37.06	1.00
	instructions)							
2.00	Excluded area salaries (see		31, 599, 244	0	31, 599, 24	4 642, 060. 00	49.22	2.00
	instructions)							
3.00	Subtotal salaries (line 1		67, 616, 198	0	67, 616, 19	8 2, 035, 259. 00	33. 22	3.00
	minus line 2)							
4.00	Subtotal other wages & related		2, 894, 987	0	2, 894, 98	25, 149. 00	115. 11	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		20, 733, 367	0	20, 733, 36	0.00	30.66	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		91, 244, 552	0	91, 244, 55	2 2, 060, 408. 00	44.28	6.00
7.00	Total overhead cost (see		31, 087, 943	0	31, 087, 94	3 885, 648. 00	35.10	7.00
	instructions)							
	· · ·							-

Heal th	Financial Systems	HENDRI CKS REGI O	NAL HEALTH	In Lieu	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Pre 5/30/2017 11:	pared:
					Amount	
					Reported 1.00	
	PART IV - WAGE RELATED COSTS				1.00	
	Part A - Core List					
	RETIREMENT COST					
1.00	401K Employer Contributions				0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contri	buti on			3, 737, 556	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see	e instructions)			0	3.00
4.00	Qualified Defined Benefit Plan Cost (see in	nstructions)			1, 665, 581	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)				
5.00	401K/TSA Plan Administration fees				58, 642	5.00
6.00	Legal /Accounting/Management Fees-Pension Pl				0	6.00
7.00	Employee Managed Care Program Administratio	on Fees			0	7.00
	HEALTH AND INSURANCE COST					
8.00	Health Insurance (Purchased or Self Funded)				15, 430, 280	8.00
8.01	Health Insurance (Self Funded without a Thi				0	8.01
8.02	Health Insurance (Self Funded with a Third	Party Administrat	or)		0	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 ben				289, 860	
12.00	Accident Insurance (If employee is owner or				0	12.00
13.00	Disability Insurance (If employee is owner		`		2, 245	
14.00		ner or beneficiar	у)		0	14.00
15.00	'Workers' Compensation Insurance			ad by FACD 10/	727, 163	
16.00	Retirement Health Care Cost (Only current y Non cumulative portion)	lear, not the extr	aordinary accruai requir	ed by FASB 106.	0	16.00
	TAXES					
17 00	FICA-Employers Portion Only				6, 529, 809	17 00
18.00	Medicare Taxes - Employers Portion Only				0, 327, 007	18.00
19.00	Unemployment Insurance				22, 213	
	State or Federal Unemployment Taxes				0	
20.00	OTHER					20.00
21.00	Executive Deferred Compensation (Other Than instructions))	n Retirement Cost	Reported on lines 1 thro	ugh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances				0	22.00
23.00	Tuition Reimbursement				238, 824	
	Total Wage Related cost (Sum of lines 1 -23	3)			28, 702, 173	
	Part B - Other than Core Related Cost					
25.00	OTHER WAGE RELATED COSTS (SPECIFY)				0	25.00

Heal th	Financial Systems	HENDRICKS REGIONAL HEALTH	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016		pared:
	Cost Center Description		Contract Labor	Benefit Cost	
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identi				
1.00	Total facility's contract labor and benefit	cost	0	0	1.00
2.00	Hospi tal		0	0	2.00
3.00	Subprovider - IPF				3.00
4.00	Subprovider - IRF				4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00 9.00	Hospital -Based SNF				8.00 9.00
	Hospital -Based NF				10.00
10.00 11.00	Hospital-Based OLTC Hospital-Based HHA				10.00
12.00	Separately Certified ASC				12.00
12.00	Hospi tal -Based Hospi ce				12.00
	Hospi tal -Based Heal th Clinic RHC				14.00
	Hospital -Based Health Clinic FQHC				14.00
16.00	Hospi tal -Based-CMHC				16.00
	Renal Dialysis		0	0	
18.00	Other		0	0	18.00
	1			Ũ	1 . 0. 00

Heal th	Financial Systems	HENDRICKS REGIONA	L HEALTH		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CC	CN: 15-0005	Period:	Worksheet S-1	0
					From 01/01/2016 To 12/31/2016	Date/Time Pre	parad
					10 12/31/2010	5/30/2017 11:	
						1.00	
1 00	Uncompensated and indigent care cost compu		vided by Li	no 202 ool um	n ()	0 220027	1 00
1.00	Cost to charge ratio (Worksheet C, Part I Medicaid (see instructions for each line)	TThe 202 corumn 3 di	vided by ii	ne 202 corui	11 8)	0. 320037	1.00
2.00	Net revenue from Medicaid					11, 448, 496	2.00
3.00	Did you receive DSH or supplemental paymen	ts from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include al		l navments	from Medicai	d2	Y	4.00
5.00	If line 4 is "no", then enter DSH or suppl			in mean car	u.	0	5.00
6.00	Medi cai d charges	emeritar paymentes rice				57, 377, 886	
7.00	Medicaid cost (line 1 times line 6)					18, 363, 047	
8.00	Difference between net revenue and costs f	or Medicaid program	(line 7 mir	nus sum of li	nes 2 and 5: if	6, 914, 551	
	< zero then enter zero)		(
	Children's Health Insurance Program (CHIP)	(see instructions f	or each lin	ne)			
9.00	Net revenue from stand-alone CHIP					0	9.00
10.00	Stand-alone CHIP charges					0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 1	0)				0	11.00
12.00	Difference between net revenue and costs f	for stand-alone CHIP	(line 11 mi	nus line 9;	if < zero then	0	12.00
	enter zero)						
	Other state or local government indigent c					1	
13.00	Net revenue from state or local indigent of						13.00
14.00	Charges for patients covered under state of	or local indigent car	e program (Not included	in lines 6 or	0	14.00
15 00	10)	(line 1 times line 1				0	15.00
	State or local indigent care program cost Difference between net revenue and costs f			program (Li	no 15 minus ling	-	
10.00	13; if < zero then enter zero)	of state of focal fil	lui gent care	e program (ri		1 0	10.00
	Uncompensated care (see instructions for e	ach line)					
17.00	Private grants, donations, or endowment in		undi na char	ritv care		0	17.00
	Government grants, appropriations or trans					0	
19.00	Total unreimbursed cost for Medicaid, CHI	P and state and loca	i indigent	care program	s (sum of lines	6, 914, 551	19.00
	8, 12 and 16)		-		T		
				Uni nsured	Insured	Total (col. 1	
			-	patients	patients	+ col. 2)	
20,00			>	1.00	2.00	3.00	20.00
	Charity care charges for the entire facili			8, 726, 8			
	Cost of patients approved for charity care		20)	2, 792, 90			
	Partial payment by patients approved for c Cost of charity care (line 21 minus line 2			2, 792, 90	0 0)5 0		
23.00	Cost of charity care (The 21 minus The 2	.2)		2, 192, 90	0	2, 192, 905	23.00
						1.00	
24.00	Does the amount in line 20 column 2 includ	le charges for patien	it days beyc	ond a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or						
25.00	If line 24 is "yes," charges for patient	days beyond an indig	ent care pr	rogram's leng	th of stay limit	t O	25.00
	Total bad debt expense for the entire hosp	oital complex (see in	istructions)			23, 085, 494	
27.00	Medicare bad debts for the entire hospital					206, 551	
	Non-Medicare and non-reimbursable Medicare					22, 878, 943	
	Cost of non-Medicare and non-reimbursable		pense (line	e 1 times lin	e 28)	7, 322, 108	
	Cost of uncompensated care (line 23 column					10, 115, 013	
31.00	Total unreimbursed and uncompensated care	cost (line 19 plus l	ine 30)			17, 029, 564	31.00

Health Financial Systems	HENDRICKS REGIO				u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (JF EXPENSES	Provider CC		Period: From 01/01/2016	Worksheet A	
				To 12/31/2016	Date/Time Pre	
Cost Center Description	Sal ari es	Other	Total (col. 1	Reclassi fi cat	5/30/2017 11: Recl assi fi ed	29 аш
			+ col. 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		23, 121, 739	23, 121, 73	9 0	23, 121, 739	1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 245, 317	5, 304, 725	6, 550, 04			•
5. 00 00500 ADMI NI STRATI VE & GENERAL	11, 170, 498	30, 331, 823	41, 502, 32		41, 552, 642	5.00
7. 00 00700 OPERATION OF PLANT	2, 481, 870	7, 338, 644	9, 820, 51			7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE	325, 676	338, 620	664, 29			8.00
9. 00 00900 HOUSEKEEPI NG	1, 953, 789	1, 151, 548	3, 105, 33			9.00
10. 00 01000 DI ETARY	1, 557, 124	1, 702, 419	3, 259, 54	3 -2, 289, 888	969, 655	10.00
11. 00 01100 CAFETERI A	0	0		0 2, 289, 809	2, 289, 809	11.00
13.00 01300 NURSING ADMINISTRATION	1, 919, 592	797, 029	2, 716, 62			
14.00 01400 CENTRAL SERVICES & SUPPLY	757, 668	821, 781	1, 579, 44			
15.00 01500 PHARMACY	1, 938, 321	10, 037, 034	11, 975, 35			
16.00 01600 MEDI CAL RECORDS & LI BRARY	1, 292, 912	1, 604, 986	2, 897, 89			
17.00 01700 SOCIAL SERVICE	1, 697, 391	596, 279	2, 293, 67	0 13, 729	2, 307, 399	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	9, 823, 979	4, 441, 429	14, 265, 40	8 - 375, 043	13, 890, 365	30.00
31. 00 03100 INTENSIVE CARE UNIT	1, 645, 336	696, 204	2, 341, 54			31.00
43. 00 04300 NURSERY	629, 342	190, 785	820, 12			
ANCI LLARY SERVICE COST CENTERS	027, 342	170, 703	020,12	/ 07,733	130, 172	40.00
50. 00 05000 OPERATI NG ROOM	1, 483, 368	8, 856, 322	10, 339, 69	0 -2, 677, 204	7, 662, 486	50.00
50. 01 05001 ENDOSCOPY	968, 764	684, 393	1, 653, 15		1, 375, 556	
51.00 05100 RECOVERY ROOM	1, 181, 195	434, 136	1, 615, 33	1 -95, 993	1, 519, 338	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 709, 270	296, 323	2,005,59	3 -41, 910	1, 963, 683	52.00
53. 00 05300 ANESTHESI OLOGY	4, 879, 621	1, 037, 847	5, 917, 46	8 -197, 150	5, 720, 318	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 183, 237	2, 408, 483	6, 591, 72	0 -296, 366	6, 295, 354	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	1, 047, 020	14, 352, 180	15, 399, 20			•
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	143, 807	243, 951	387, 75			•
59.00 05900 CARDI AC CATHETERI ZATI ON	558, 767	985, 364	1, 544, 13			
60. 00 06000 LABORATORY	2, 491, 499	4, 899, 108	7, 390, 60			
64. 00 06400 I NTRAVENOUS THERAPY	877, 639	291, 424	1, 169, 06			1
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	1, 632, 433	849, 300	2, 481, 73			65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	4, 442, 301 358, 262	1, 919, 212 113, 452	6, 361, 51 471, 71			•
68. 00 06800 SPEECH PATHOLOGY	300, 538	95, 008	395, 54		395, 546	•
69. 00 06900 ELECTROCARDI OLOGY	506, 456	448, 590	955, 04			69.00
69. 01 06901 CARDI AC REHAB	394, 690	136, 582	531, 27			•
70. 00 07000 ELECTROENCEPHALOGRAPHY	101, 147	28, 074	129, 22		129, 221	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 6, 733, 614	6, 733, 614	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 11, 308, 025	11, 308, 025	73.00
73.01 07301 ULTRA SOUND	429, 827	252, 564	682, 39	1 -30, 709	651, 682	73.01
74.00 07400 RENAL DIALYSIS	0	157, 149	157, 14	9 -1,044	156, 105	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	1, 541, 158	4, 538, 729				•
91.00 09100 EMERGENCY	2, 957, 062	2, 131, 219	5, 088, 28	1 -319, 247	4, 769, 034	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117)	70, 626, 876	133, 634, 455	204, 261, 33	1 4, 245, 826	208, 507, 157	110 00
NONREIMBURSABLE COST CENTERS	10,020,010	133, 034, 433	204, 201, 33	4, 240, 620	200, 307, 157	110.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	25, 667, 448	16, 916, 287	42, 583, 73	5 -4, 028, 307	38, 555, 428	192 00
192. 01 19201 HEALTH TRACKS	2, 819, 924	1, 044, 368	3, 864, 29			•
194. 00 07950 PRI MARY CARE CLINIC	863, 130	1,005,938	1, 869, 06			
194. 01 07951 PARTNERS IN CARE	627, 693	298, 121	925, 81			
194. 02 07952 OCCUPATI ONAL MEDI CI NE	233, 599	606, 686	840, 28		788, 898	•
194. 03 07953 FOUNDATI ON	173, 600	60, 187	233, 78		233, 787	
194.0407954 SCHOOL & TOWN CLINICS	1, 213, 850	315, 221	1, 529, 07		1, 497, 479	
200.00 TOTAL (SUM OF LINES 118-199)	102, 226, 120	153, 881, 263	256, 107, 38		256, 107, 383	200.00

ECLASSI	FICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider C	CN: 15-0005	Period: From 01/01/2016	Worksheet A
					To 12/31/2016	
	Cost Center Description	Adjustments	Net Expenses			
		(See A-8)	For			
		6.00	Allocation 7.00	-		
CE	ENERAL SERVICE COST CENTERS	6.00	7.00			
	0100 NEW CAP REL COSTS-BLDG & FIXT	-975, 465	22, 146, 274	1		
	0400 EMPLOYEE BENEFITS DEPARTMENT	-69, 404				
	0500 ADMI NI STRATI VE & GENERAL	-8, 575, 405		1		
	0700 OPERATION OF PLANT	-568, 154		1		
	0800 LAUNDRY & LINEN SERVICE	-508, 154				
	0900 HOUSEKEEPING	0				
	1000 DI ETARY	-392, 858	-,			1
	1100 CAFETERI A	-782, 024				1
	1300 NURSI NG ADMI NI STRATI ON	-22, 352				1
	1400 CENTRAL SERVICES & SUPPLY	-22, 332				1
	1500 PHARMACY	- 48				1
	1600 MEDICAL RECORDS & LIBRARY	-1, 308				1
	1700 SOCIAL SERVICE					
		0	2, 307, 399	/		1
	NPATIENT ROUTINE SERVICE COST CENTERS	0.071.050	11 510 200	1		
	3000 ADULTS & PEDIATRICS	-2, 371, 059		1		3
	3100 INTENSIVE CARE UNIT	0		1		3
	4300 NURSERY	0	750, 172	<u>'</u>		4
	VCI LLARY SERVICE COST CENTERS	0	7 (() 40)	1		
	5000 OPERATING ROOM	0		1		5
	5001 ENDOSCOPY	0		1		5
	5100 RECOVERY ROOM	0				5
	5200 DELIVERY ROOM & LABOR ROOM	0	.,,	1		5
	5300 ANESTHESI OLOGY	-4, 879, 437	840, 88	1		5
	5400 RADI OLOGY-DI AGNOSTI C	-94, 353		1		5
	5401 RADI ATI ON-ONCOLOGY	0		1		5
	3450 NUCLEAR MEDICINE - DIAGNOSTIC	0		1		5
	5900 CARDI AC CATHETERI ZATI ON	0		1		5
	6000 LABORATORY	-31, 156				6
	6400 I NTRAVENOUS THERAPY	0				6
	6500 RESPI RATORY THERAPY	0	2, 420, 074			6
	6600 PHYSI CAL THERAPY	-556, 772		1		6
	6700 OCCUPATI ONAL THERAPY	-31, 363				6
	6800 SPEECH PATHOLOGY	-12, 545				6
	6900 ELECTROCARDI OLOGY	-132, 902				6
	6901 CARDI AC REHAB	0				6
	7000 ELECTROENCEPHALOGRAPHY	0				7
	7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	(7
	7200 IMPL. DEV. CHARGED TO PATIENT	0				7
	7300 DRUGS CHARGED TO PATIENTS	0		1		7
	7301 ULTRA SOUND	0		2		7
	7400 RENAL DI ALYSI S	0	156, 105	j		7
	JTPATIENT SERVICE COST CENTERS	_				
	9000 CLINIC	33, 513				9
	9100 EMERGENCY	-39, 484	4, 729, 550	0		9
	9200 OBSERVATION BEDS (NON-DISTINCT PART)					9
SF	PECIAL PURPOSE COST CENTERS					
8.00	SUBTOTALS (SUM OF LINES 1-117)	-19, 502, 626	189, 004, 531			11
	ONREIMBURSABLE COST CENTERS					
2.0019	9200 PHYSI CLANS' PRI VATE OFFI CES	0	38, 555, 428	3		19
2.01 19	9201 HEALTH TRACKS	0	3, 805, 835	5		19
	7950 PRIMARY CARE CLINIC	0	1, 855, 384	1		19
	7951 PARTNERS IN CARE	0	863, 415	1		19
	7952 OCCUPATI ONAL MEDI CI NE	0	788, 898			19
	7953 FOUNDATI ON	0	233, 787			19
	7954 SCHOOL & TOWN CLINICS	0	1, 497, 479			19
	TOTAL (SUM OF LINES 118-199)	-19, 502, 626		1		20

	Financial Systems SIFICATIONS		HENDRICKS REGI	ONAL HEALTH Provider CCN: 15-0005	5 Period:	u of Form CMS-2552-10 Worksheet A-6
					From 01/01/2016 To 12/31/2016	Date/Time Prepared: 5/30/2017 11:29 am
	Cost Center	I ncreases Li ne #	Sal ary	Other		
	2.00	3.00	4.00	5.00		
1.00 2.00 3.00	A - DRUG RECLASS DRUGS CHARGED TO PATIENTS INTRAVENOUS THERAPY	73.00 64.00 0.00	0 0 0	11, 308, 025 181, 924 0		1.00 2.00 3.00
4.00 5.00 6.00 7.00 8.00 9.00		0.00 0.00 0.00 0.00 0.00 0.00 0.00	0 0 0 0 0	0 0 0 0 0 0		4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00		0.00 0.00 0.00 0.00 0.00 0.00 0.00	0 0 0 0 0			10.00 11.00 12.00 13.00 14.00 15.00
16.00 17.00 18.00 19.00 20.00 21.00		0.00 0.00 0.00 0.00 0.00 0.00	0 0 0 0 0			16.00 17.00 18.00 19.00 20.00 21.00
22. 00 23. 00 24. 00	0	0. 00 0. 00 <u>0. 00</u>	0 0 0 0	0 0 		22. 00 23. 00 24. 00
1.00	B - MOB PLANT RECLASS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 751		1.00
2.00 3.00 4.00 5.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE MEDICAL RECORDS & LIBRARY	5.00 7.00 8.00 16.00	0 0 0 0	50, 362 11, 837 35, 591 2, 231		2.00 3.00 4.00 5.00
6.00 7.00 8.00	SOCI AL SERVI CE RADI OLOGY-DI AGNOSTI C RADI ATI ON-ONCOLOGY	17.00 54.00 54.01	0 0 0	13, 729 76, 457 121, 764		6.00 7.00 8.00
9.00 10.00 11.00 12.00 13.00	LABORATORY RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY CLINIC	60.00 65.00 66.00 67.00 <u>90.</u> 00		4, 330 2, 500 20, 142 20, 135 145, 104		9.00 10.00 11.00 12.00 13.00
1.00	0 C - CAFETERIA RECLASS CAFETERIA	<u>11.</u> 00	0 1, 09 <u>3, 8</u> 70	511, 933 <u>1, 195, 9</u> 39		1.00
1.00	O D - IMPLANTABLE DEVICES IMPL. DEV. CHARGED TO	72.00	1, 093, 870	<u>1, 195, 939</u> 6, 733, 614		1.00
2.00	PATI ENT	0.00		0000000		2.00
1 00	F - MEDI CAL SUPPLY RECLASS	50.00				1.00
1.00 2.00 3.00 4.00	OPERATI NG ROOM RADI ATI ON-ONCOLOGY	50.00 54.01 0.00 0.00	0 0 0 0	3, 700, 320 44, 401 0 0		1.00 2.00 3.00 4.00
5.00 6.00 7.00 8.00		0.00 0.00 0.00 0.00	0 0 0 0	0 0 0 0		5. 00 6. 00 7. 00 8. 00
9.00 10.00 11.00 12.00 13.00		0.00 0.00 0.00 0.00 0.00 0.00	0 0 0 0 0			9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00 18.00 19.00 20.00		0.00 0.00 0.00 0.00 0.00 0.00 0.00				14.00 15.00 16.00 17.00 18.00 19.00 20.00
21.00 22.00 23.00 24.00		0.00 0.00 0.00 0.00 0.00	0 0 0 0	0 0 0 0		21.00 22.00 23.00 24.00

Heal th I	Health Financial Systems			IONAL HEALTH		In Lieu of Form CMS-2552-10		
RECLASS	RECLASSI FI CATI ONS			Provider (CCN: 15-0005	Period: Worksheet A		6
						From 01/01/2016 To 12/31/2016	Date/Time Pr 5/30/2017 11	epared: :29 am
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
25.00		0.00	0	0				25.00
26.00		0.00	0	0				26.00
27.00		0.00	0	0				27.00
28.00		0.00	0	0				28.00
29.00		0.00	0	0				29.00
30.00		0.00	0	0				30.00
31.00		0.00	0	0				31.00
32.00		0.00	0	0				32.00
33.00		0.00	0	0				33.00
34.00		0.00	О	0				34.00
	0			3, 744, 721				
500.00	Grand Total: Increases		1, 093, 870	23, 676, 156				500.00

Health Financial Systems RECLASSIFICATIONS

HENDRICKS REGIONAL HEALTH

In Lieu of Form CMS-2552-10

Provider CCN: 15-0005

Period: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/30/2017 11:29 am

						5/30/2017 11	
		Decreases					
	Cost Center	Line #	Salary		Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - DRUG RECLASS PHARMACY	15.00	0	8, 367, 424	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	6, 307, 424 5, 293	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	227	0		3.00
4.00	NURSERY	43.00	0	804	0		4.00
5.00	OPERATI NG ROOM	50.00	0	9, 971	0		5.00
6.00	ENDOSCOPY	50.01	0	39	0		6.00
7.00	RECOVERY ROOM	51.00	0	874	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1, 281	0		8.00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	o	5, 759	0		9.00
10.00	CARDI AC CATHETERI ZATI ON	59.00	o	90	0		10.00
11.00	LABORATORY	60.00	o	81	0		11.00
12.00	RESPI RATORY THERAPY	65.00	0	438	0		12.00
13.00	PHYSI CAL THERAPY	66.00	0	67, 478	0		13.00
14.00	ELECTROCARDI OLOGY	69.00	0	157	0		14.00
15.00	CARDI AC REHAB	69.01	0	7	0		15.00
16.00	RENAL DIALYSIS	74.00	0	1, 044	0		16.00
17.00	CLINIC	90.00	0	4, 074	0		17.00
18.00	EMERGENCY	91.00	0	976	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2, 892, 914	0		19.00
20.00	HEALTH TRACKS	192.01	0	28, 129	0		20.00
21.00	PRIMARY CARE CLINIC	194.00	0	9, 715	0		21.00
22.00	PARTNERS IN CARE	194.01	0	21, 859	0		22.00
23.00	OCCUPATIONAL MEDICINE	194. 02	0	40, 814	0		23.00
24.00	SCHOOL & TOWN CLINICS	<u> </u>	0	3 <u>0, 5</u> 01	0		24.00
	0		0	11, 489, 949			
	B - MOB PLANT RECLASS		.1.				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	511, 933	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00 0.00	0	0	0		7.00
8.00			0	0	0		8.00
9.00 10.00		0.00 0.00	0	0	0		9.00 10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
12.00		0.00	0	0	0		13.00
13.00	<u> </u>		— — — d	511,933			13.00
	C - CAFETERIA RECLASS	<u> </u>		011, 700			1
1.00	DI ETARY	10.00	1,093,870	1, 195, 939	0		1.00
	0 — — — — — — —		1,093,870	1, 195, 939			1
	D - IMPLANTABLE DEVICES	· · · ·					1
1.00	OPERATING ROOM	50.00	0	6, 323, 152	0		1.00
2.00		90.00	0	410, 462	0		2.00
	0		0	6, 733, 614			
	F - MEDICAL SUPPLY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 133	0		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	41	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	406	0		3.00
4.00	DI ETARY	10.00	0	79	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	1, 540	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	4, 475	0		6.00
7.00	PHARMACY	15.00	0	17, 213	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	369, 750	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	111,039	0		9.00
10.00	NURSERY	43.00	0	69, 151	0		10.00
11.00	ENDOSCOPY	50.01	0	277, 562	0		11.00
12.00	RECOVERY ROOM	51.00	0	95, 119	0 0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	40, 629	0		13.00
14.00 15.00	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	53.00 54.00	0	197, 150 367, 064	0		14.00 15.00
15.00 16.00	OPERATING ROOM	50.00	0	44, 401	0		16.00
17.00	NUCLEAR MEDICINE -	56.00		1, 692	0		17.00
17.00	DI AGNOSTI C	50.00	0	1, 092	0		17.00
18.00	CARDI AC CATHETERI ZATI ON	59.00	0	754, 818	0		18.00
19.00	LABORATORY	60.00	0	1, 477	0		19.00
20.00	INTRAVENOUS THERAPY	64.00	0	56, 994	0		20.00
21.00	RESPI RATORY THERAPY	65.00	0	63, 721	0		21.00
22.00	PHYSI CAL THERAPY	66.00	0	197, 449	0		22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	4, 127	0		23.00
24.00	ELECTROCARDI OLOGY	69.00	0	3, 842	0		24.00
	•	. 1			-		•

Health Financial Systems		HENDRI CKS REG	IONAL HEALTH		In Lieu of Form CMS-2552-10		
RECLASSI FI CATI ONS	ECLASSI FI CATI ONS			Provider CCN: 15-0005			6
					From 01/01/2016 To 12/31/2016	Date/Time Pro 5/30/2017 11	
	Decreases						
Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref			
6.00	7.00	8.00	9.00	10.00			
25.00 CARDI AC REHAB	69.01	0	4, 581		0		25.00
26.00 ULTRA SOUND	73.01	0	30, 709		0		26.00
27.00 CLINIC	90.00	0	327		0		27.00
28.00 EMERGENCY	91.00	0	318, 271		0		28.00
29.00 PHYSICIANS' PRIVATE OFFICES	192.00	0	623, 460		0		29.00
30.00 HEALTH TRACKS	192.01	0	30, 328		0		30.00
31.00 PRIMARY CARE CLINIC	194.00	0	3, 969		0		31.00
32.00 PARTNERS IN CARE	194.01	0	40, 540		0		32.00
33.00 OCCUPATIONAL MEDICINE	194. 02	0	10, 573		0		33.00
34.00 SCHOOL & TOWN CLINICS	194.04	0	1, 091		0		34.00
0		0	3, 744, 721				
500.00 Grand Total: Decreases		1, 093, 870	23, 676, 156				500.00

Health Financial Systems	HENDRI CKS REGI					u of Form CMS-2552-	
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Fro To	iod: m 01/01/2016 12/31/2016		pared:
			Acquisition	IS			
	Begi nni ng Bal ances	Purchases	Donati on		Total	Disposals and Retirements	
	1.00	2.00	3.00		4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CA	PITAL ASSET BALANCES						
1.00 Land	16, 574, 202	4, 354, 009		0	4, 354, 009	0	1.00
2.00 Land Improvements	6, 174, 137	3, 838, 055		0	3, 838, 055	0	2.00
3.00 Buildings and Fixtures	246, 753, 868	9, 402, 078		0	9, 402, 078	0	3.00
4.00 Building Improvements	0	0		0	0	0	4.00
5.00 Fixed Equipment	0	0		0	0	0	5.00
6.00 Movable Equipment	82, 661, 937	26, 492, 431		0	26, 492, 431	9, 498, 239	6.00
7.00 HIT designated Assets	0	0		0	0	0	7.00
B.00 Subtotal (sum of lines 1-7)	352, 164, 144	44, 086, 573		0	44, 086, 573	9, 498, 239	8.00
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	352, 164, 144	44, 086, 573		0	44, 086, 573	9, 498, 239	10.00
	Endi ng	Fully					
	Bal ance	Depreciated					
		Assets					
	6. 00	7.00					
PART I - ANALYSIS OF CHANGES IN CA	PITAL ASSET BALANCES						
1.00 Land	20, 928, 211	0					1.00
2.00 Land Improvements	10, 012, 192	0					2.00
3.00 Buildings and Fixtures	256, 155, 946	0					3.00
4.00 Building Improvements	0	0					4.00
5.00 Fixed Equipment	0	0					5.00
5.00 Movable Equipment	99, 656, 129	0					6.00
7.00 HIT designated Assets	0	0					7.00
3.00 Subtotal (sum of lines 1-7)	386, 752, 478	0					8.00
9.00 Reconciling Items	0	0					9.00
10.00 Total (line 8 minus line 9)	386, 752, 478	0					10.00

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2016 Fo 12/31/2016			
				12/01/2010	5/30/2017 11:	29 am	
		SL	IMMARY OF CAPI	TAL			
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
				(see instructions)	instructions)		
	9.00	10.00	11.00	12.00	13.00		
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	<u>/N 2, LINES 1 a</u>	and 2				
1.00 NEW CAP REL COSTS-BLDG & FIXT	17, 994, 304	0	4, 864, 63	9 262, 796	0	1.00	
3.00 Total (sum of lines 1-2)	17, 994, 304	0	4, 864, 63	9 262, 796	0	3.00	
	SUMMARY O	F CAPITAL					
Cost Center Description	0ther	Total (1)					
	Capital-Relat	(sum of cols.					
	ed Costs (see	9 through 14)					
	instructions)						
	14.00	15.00					
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	/N 2, LINES 1 a	and 2				
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	23, 121, 739				1.00	
3.00 Total (sum of lines 1-2)	0	23, 121, 739				3.00	

Health Financial Systems	HENDRICKS REGI	ONAL HEALTH		In Lie	2552-10	
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2016 To 12/31/2016		pared:
	COMF	COMPUTATION OF RATIOS ALLOC			OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	23, 121, 739	0	23, 121, 73	9 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	23, 121, 739		23, 121, 73			3.00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C			1		I	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 17, 732, 386		1.00
3.00 Total (sum of lines 1-2)	0	0		0 17, 732, 386	0	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see instructions)	9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	4, 151, 092	262, 796		0 0	22, 146, 274	1.00
3.00 Total (sum of lines 1-2)	4, 151, 092	262, 796		0 0	22, 146, 274	3.00

Health Financial Systems

	Financial Systems		HENDRICKS REG		In Lie	u of Form CMS-2	
ADJUST	MENTS TO EXPENSES				eriod: rom 01/01/2016 p 12/31/2016		pared:
				Expense Classification on To/From Which the Amount is		5/30/2017 11:	29 am
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		<u>(2)</u> 1.00	2.00	3.00	4.00	Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	В		NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	2) Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	
7.00	Telephone services (pay stations excluded) (chapter 21)		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 -7, 979, 548		0.00	0 0	
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and Linen service		0		0.00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee	A	-767, 503 0	CAFETERI A	11. 00 0. 00	0 0	
16.00	and others Sale of medical and surgical supplies to other than		C		0.00	0	16.00
17.00	patients Sale of drugs to other than		C		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00	0	18.00
19. 00	abstracts Nursing school (tuition, fees,		C		0.00	0	19.00
20.00	books, etc.) Vendi ng machi nes		0		0.00		
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0. 00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	o	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) 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		o	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 30.00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3		OCCUPATIONAL THERAPY	0. 00 67. 00	0	29.00 30.00
30. 99	Hospice (non-distinct) (see instructions)		С	ADULTS & PEDIATRICS	30. 00		30. 99

Health Financial Systems

Heal th	Financial Systems		HENDRI CKS REG	IONAL HEALTH	In Lie	u of Form CMS-	2552-10
ADJUST	MENTS TO EXPENSES			F	eriod: rom 01/01/2016		
				T	o 12/31/2016	Date/Time Pre 5/30/2017 11:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)	2.00	2.00	4.00	Ref.	
31.00	Adjustment for speech	1.00 A-8-3	2.00	3.00 SPEECH PATHOLOGY	4.00	5.00	31.00
31.00	pathology costs in excess of	A-0-3			08.00		31.00
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		C		0.00	C	32.00
	Depreciation and Interest						
33.00	ADMITTING TELEPHONE	A	-6, 526	ADMI NI STRATI VE & GENERAL	5.00	C	33.00
22 01	(EQUIPMENT)	•	24.275		F 00		33.01
33. 01 33. 02	ADMITTING TELEPHONE (SALARY) MARKETING DEPARTMENT	A		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00 5.00		
34.00	STAFF EDUCATION ED DEPT	В		NURSING ADMINISTRATION	13.00		
01100	COURSES	5	22,002		101.00		
35.00	CBC - OB UNIT ED DEPT COURSES	В	-3, 100	ADULTS & PEDIATRICS	30.00	C	35.00
36.00	EMS PROGRAM ED DEPT COURSES	В	-39, 484	EMERGENCY	91.00	C	36.00
37.00	LABORATORY MISC. SERVICES	В		LABORATORY	60.00		
38.00	RADI OLOGY SALE OF X-RAYS	В		RADI OLOGY-DI AGNOSTI C	54.00		
39.00	PHYSICAL THERAPY SUPPLIES SOLD	В	-4,576	PHYSICAL THERAPY	66.00	C	39.00
40.00	SPORTS MEDICINE ED DEPT.	В	-31 262	PHYSI CAL THERAPY	66.00	C	40.00
40.00	COURSES	D	51,202		00.00		40.00
41.00	PLAINFIELD PT SUPPLIES SOLD TO	В	-8, 195	PHYSI CAL THERAPY	66.00	C	41.00
	OTHER						
43.00	DI ETARY CATERI NG	В		CAFETERIA	11.00		
44.00	REGISTRATION ANSWERING SERVICE			ADMI NI STRATI VE & GENERAL	5.00		
45.00	ACCOUNTING MISCELLANEOUS/OTHER			ADMI NI STRATI VE & GENERAL	5.00		
45.01	ACCOUNTING PURCHASE DI SCOUNTS	В	-36, 226	ADMI NI STRATI VE & GENERAL	5.00	C	45.01
45.02	GUEST ROOM RENTAL	В	-340	ADMI NI STRATI VE & GENERAL	5.00	C	45.02
45.03	HEALTH INFO MGMT MEDICAL	В		MEDI CAL RECORDS & LI BRARY	16.00		
	RECORDS TRA						
45.04	HUMAN RESOURCES JURY DUTY	В	-115	EMPLOYEE BENEFITS DEPARTMENT	4.00	C	45.04
45 05	RECEIPTS	5			14.00		45.05
45.05	MATERIALS MGMT. SUPPLIES SOLD	В	-98	CENTRAL SERVICES & SUPPLY	14.00	C	45.05
45.06	PLAINFIELD PT ED DEPT COURSES	В	-500	PHYSI CAL THERAPY	66.00	C	45.06
45.07	AVON ORTH/SPORT MISC. /OTHER	В		PHYSI CAL THERAPY	66.00		
45.08	OCC THERAPY REHAB SUPPLIES	В		OCCUPATIONAL THERAPY	67.00		
	SOLD TO O						
45.09	HRH WELLNESS ED DEPARTMENT	В	-69, 289	EMPLOYEE BENEFITS DEPARTMENT	4.00	C	45.09
45 10	COURSES	•	202.050		10.00		45 10
45.10 45.11	MEALS ON WHEELS 1993 CARRYFORWARD	A A	-392, 858	NEW CAP REL COSTS-BLDG &	10. 00 1. 00		45.10
т Ј. П		А	-14,017	FIXT	1.00	9	
45.12	1994 CARRYFORWARD	А	3, 288	NEW CAP REL COSTS-BLDG &	1.00	9	45.12
				FLXT			
	PHYSI CI AN RECRUI TMENT	А		ADMI NI STRATI VE & GENERAL	5.00		45.13
45.14		A		ADMI NI STRATI VE & GENERAL	5.00		
	AHA LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5.00 E.00		
45.16 45.17	HOSPITAL ASSESSMENT FEE WOUND OSTOMY LEASE REVENUE	A B		ADMI NI STRATI VE & GENERAL PHYSI CAL THERAPY	5. 00 66. 00		
	PHYSICAL THER ED EDPT COU	В		PHYSICAL THERAPY	66.00		1
45.21	B' BURG PT SUPPLIES SOLD T	В		PHYSI CAL THERAPY	66.00		
	AVON PHYS THRPY SUPPLIES	В		PHYSI CAL THERAPY	66.00		
45.24	OCC THER ED DEPT CO	В	-31, 307	OCCUPATI ONAL THERAPY	67.00	C	
	ACCOUNTING NON-OP REVENUE	В		ADMINISTRATIVE & GENERAL	5.00		
45.28	HI BBELN SUR CNT MI SCELLANEOUS	В			90.00		
45.29		В		SPEECH PATHOLOGY	68.00		
45.30	MAINTENANCE MISC REVENUE	B		OPERATION OF PLANT	7.00		
45.31 45.33	TRIMEDX MISC QUALITY ASSURANCE MISC	В		OPERATION OF PLANT ADMINISTRATIVE & GENERAL	7.00 5.00		
45.33	INTEREST EXPENSE LONG TERM	A		NEW CAP REL COSTS-BLDG &	1.00		
	CARE		201,107	FIXT	1.00	2	.0.00
50.00	TOTAL (sum of lines 1 thru 49)		-19, 502, 626				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) Do	scription - all chapter referen	cos in this c	olumn nortain t	OCMS Dub 15 1			

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

Health Financial Systems		HENDRICKS REG	IONAL HEALTH	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0005	Period:	Worksheet A-8	
				From 01/01/2016 To 12/31/2016	Date/Time Pre 5/30/2017 11:	pared: 29 am
			Expense Classification of	on Worksheet A		
			To/From Which the Amount i	s to be Adjusted		
				-		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2)				Ref.	
	1.00	2.00	3.00	4.00	5.00	

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

	Financial Syste		HENDRICKS REC	GIONAL HEALTH			eu of Form CMS-	
PROVI DE	ER BASED PHYSICI	AN ADJUSTMENT		Provider (Period: From 01/01/2016	Worksheet A-8	3-2
						To 12/31/2016	Date/Time Pre 5/30/2017 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	2, 367, 959	2, 367, 959	(179,000	0	1.00
2.00		EMERGENCY	501, 502	0	501, 502	179,000	5, 828	2.00
3.00	91.00	EMERGENCY	158, 170	0	158, 17	179,000	1, 838	3.00
4.00	60, 00	LABORATORY	73, 282	l o	73, 28	2 260, 300	586	4.00
5.00		PHYSICAL THERAPY	505, 227			179,000		1
6.00		ELECTROCARDI OLOGY	132, 902			179,000		
7.00		RADI OLOGY-DI AGNOSTI C	5, 840			179,000		
8.00		RADI OLOGY-DI AGNOSTI C	88, 183					8.00
8.00 9.00		ANESTHESI OLOGY						9.00
		ANESTHESTULUGY	4, 879, 437			2077 100		
10.00	0.00		0	0	700.05	۰ ۱	-	
200.00			8, 712, 502					200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0			0 0		1.00
2.00	91.00	EMERGENCY	501, 544	25, 077	(0 0	0	2.00
3.00	91.00	EMERGENCY	158, 174	7,909	(0 0	0	3.00
4.00	60.00	LABORATORY	73, 335	3, 667	(0 0	0	4.00
5.00	66, 00	PHYSICAL THERAPY	0	0	(0 0	0	5.00
6.00		ELECTROCARDI OLOGY	0	0		0	0	
7.00		RADI OLOGY-DI AGNOSTI C	0	0			0	
8.00		RADI OLOGY-DI AGNOSTI C	0	0			, v	
9.00		ANESTHESI OLOGY	0				0	
		ANESTHESTOLOGT	0	0			-	
10.00	0.00		722.052				-	
200.00			733, 053			°	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00		14	14.00	17.00	10.00	-	
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	0			2, 367, 959		1.00
2.00		EMERGENCY	0			0 0		2.00
3.00		EMERGENCY	0			0 0		3.00
4.00		LABORATORY	0	73, 335		0 0		4.00
5.00		PHYSICAL THERAPY	0	0	(505, 227		5.00
6.00	69.00	ELECTROCARDI OLOGY	0	0	(132, 902		6.00
7.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	(5,840		7.00
8.00		RADI OLOGY-DI AGNOSTI C	0	0		88, 183		8.00
9.00		ANESTHESI OLOGY	0	0		4, 879, 437		9.00
10.00	0.00			0		0 4,077,437	•	10.00
	0.00		0	, s		7, 979, 548		200.00
200.00								

Heal th	Financial Systems	HENDRICKS REG	IONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2016	Worksheet B Part I	
					To 12/31/2016		pared:
						5/30/2017 11:	29 am
			CAPI TAL RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
		for Cost	FIXT	BENEFITS	Gubtotui	E & GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		col. 7)	1.00	4.00	10	5.00	
	GENERAL SERVICE COST CENTERS	0	1.00	4.00	4A	5.00	
	00100 NEW CAP REL COSTS-BLDG & FIXT	22, 146, 274	22, 146, 274				1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 487, 256		6, 682, 45	7		4.00
5.00	00500 ADMINI STRATI VE & GENERAL	32, 977, 237	1, 485, 481	739, 21	9 35, 201, 937	35, 201, 937	5.00
	00700 OPERATION OF PLANT	9, 264, 197	2, 230, 148	164, 24	0 11, 658, 585	2, 037, 734	7.00
	00800 LAUNDRY & LINEN SERVICE	699, 481	277, 667	21, 55		174, 557	8.00
	00900 HOUSEKEEPI NG	3, 105, 337	124, 646	129, 29		587, 148	•
	01000 DI ETARY 01100 CAFETERI A	576, 797	489, 011	30, 65		191, 644	•
	01300 NURSI NG ADMI NI STRATI ON	1, 507, 785 2, 692, 729	86, 844 252, 766	72, 38 127, 03		291, 368 537, 028	
	01400 CENTRAL SERVICES & SUPPLY	1, 574, 876		50, 13		363, 074	•
	01500 PHARMACY	3, 590, 718		128, 27			•
	01600 MEDICAL RECORDS & LIBRARY	2, 898, 821	210, 118	85, 56		558, 347	16.00
	01700 SOCIAL SERVICE	2, 307, 399	91, 952	112, 32	2, 511, 678	439, 001	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	11, 519, 306		650, 11			•
	03100 I NTENSI VE CARE UNI T	2, 230, 274		108, 88			
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	750, 172	48, 691	41, 64	7 840, 510	146, 908	43.00
	05000 OPERATING ROOM	7, 662, 486	485, 858	98, 16	3 8, 246, 507	1, 441, 357	50.00
	05001 ENDOSCOPY	1, 375, 556		64, 10			
	05100 RECOVERY ROOM	1, 519, 338		78, 16		419,073	•
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 963, 683		113, 11		391, 854	
53.00	05300 ANESTHESI OLOGY	840, 881	0	322, 91	4 1, 163, 795	203, 413	53.00
	05400 RADI OLOGY-DI AGNOSTI C	6, 201, 001	939, 197	276, 83		1, 296, 378	
	05401 RADI ATI ON-ONCOLOGY	15, 565, 365	574, 745	69, 28		2, 833, 143	•
	03450 NUCLEAR MEDICINE - DIAGNOSTIC 05900 CARDIAC CATHETERIZATION	386,066	15, 384	9, 51		71,830	•
	06000 LABORATORY	789, 223 7, 362, 223		36, 97 164, 87		191, 377 1, 366, 664	•
	06400 I NTRAVENOUS THERAPY	1, 293, 993		58, 07			•
	06500 RESPI RATORY THERAPY	2, 420, 074		108, 02		490, 608	
66.00	06600 PHYSI CAL THERAPY	5, 559, 956	525, 266	293, 97	4 6, 379, 196	1, 114, 981	66.00
	06700 OCCUPATI ONAL THERAPY	456, 359	53, 712	23, 70	8 533, 779	93, 296	67.00
	06800 SPEECH PATHOLOGY	383, 001	69, 329	19, 88		82, 536	•
	06900 ELECTROCARDI OLOGY	818, 145		33, 51		170, 214	•
	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	526, 684		26, 11			•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	129, 221	78, 291 0	6, 69	4 214, 206 0 0	37, 440 0	•
	07200 IMPL. DEV. CHARGED TO PATIENT	6, 733, 614			0 6, 733, 614		
	07300 DRUGS CHARGED TO PATIENTS	11, 308, 025			0 11, 308, 025	1, 976, 462	
	07301 ULTRA SOUND	651, 682	19, 908	28, 44		122, 355	•
74.00	07400 RENAL DI ALYSI S	156, 105	0		0 156, 105	27, 285	74.00
	OUTPATIENT SERVICE COST CENTERS				_		
	09000 CLINIC	5, 843, 641	588, 611	101, 98			90.00
	09100 EMERGENCY	4, 729, 550	660, 130	195, 68		976, 233	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS				0		92.00
118.00		189,004,531	14, 733, 141	4, 591, 39	6 179, 500, 337	25, 221, 051	118 00
	NONREI MBURSABLE COST CENTERS	10,700,700	1177667111	11071107		20/221/001	
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	38, 555, 428	6, 401, 455	1, 698, 51	9 46, 655, 402	8, 154, 565	
192.01	19201 HEALTH TRACKS	3, 805, 835		186, 61		761, 210	192.01
	07950 PRIMARY CARE CLINIC	1, 855, 384		57, 11		391, 021	•
	07951 PARTNERS IN CARE	863, 415		41, 53		182, 386	
	07952 OCCUPATI ONAL MEDI CI NE	788, 898		15,45		164, 737	•
	07953 FOUNDATION 07954 SCHOOL & TOWN CLINICS	233, 787 1, 497, 479	14, 099 33, 511	11, 48 80, 32		45, 334 281, 633	
194.04 200.00	Cross Foot Adjustments	1,477,479	33, 511	80,32	8 1, 611, 318 0	201,033	200.00
200.00			0		0 0	0	200.00
202.00		236, 604, 757	-	6, 682, 45			
							-

Heal th Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS		HENDRICKS REGIONAL HEALTH Provider CCN: 15-0005			Period: From 01/01/2016	u of Form CMS-2552-10 Worksheet B Part I	
				Ţ		Date/Time Pre 5/30/2017 11:	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT			1			1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMI NI STRATI VE & GENERAL						5.00
	00700 OPERATION OF PLANT	13, 696, 319					7.00
	00800 LAUNDRY & LINEN SERVICE	0					8.00
	00900 HOUSEKEEPI NG	196, 154					9.00
10.00	01000 DI ETARY	769, 548	0	139, 720	2, 197, 376		10.00
11.00	01100 CAFETERI A	136, 665	0	0	0	2,095,050	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	397, 774	0	32, 443	0	84, 027	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	711, 712	362	79, 333	0	50, 760	14.00
	01500 PHARMACY	314, 076	1, 528	18, 471	0	73, 876	15.00
	01600 MEDICAL RECORDS & LIBRARY	249, 350				84, 133	
	01700 SOCI AL SERVI CE	0	0	3, 079	0	74, 350	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	T					
	03000 ADULTS & PEDIATRICS	3, 232, 772				412, 629	
	03100 I NTENSI VE CARE UNI T	404, 757				74, 484	
		76, 624	16, 707	13, 025	320, 391	23, 771	43.00
	ANCI LLARY SERVI CE COST CENTERS	764 507	70.462	200 (22	0	74.075	50.00
	05000 OPERATING ROOM 05001 ENDOSCOPY	764, 587 247, 328				74, 875 41, 159	
	05100 RECOVERY ROOM	1, 259, 198			-	48, 643	
	05200 DELIVERY ROOM & LABOR ROOM	259, 869			0	64, 509	
	05300 ANESTHESI OLOGY	237,007			0	49, 748	
	05400 RADI OLOGY-DI AGNOSTI C	878, 742	-		-	169, 181	
	05401 RADI ATI ON-ONCOLOGY	0				49, 138	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	24, 209			0	5, 269	
	05900 CARDI AC CATHETERI ZATI ON	422, 902			0	22, 136	
60.00	06000 LABORATORY	394, 375	141	113, 434	0	149, 691	60.00
	06400 I NTRAVENOUS THERAPY	62, 246	4, 745	8, 525	0	32, 046	64.00
65.00	06500 RESPI RATORY THERAPY	381, 558	0	14, 919	0	76, 304	65.00
	06600 PHYSI CAL THERAPY	322, 896				198, 777	
	06700 OCCUPATI ONAL THERAPY	19, 891	0			15, 199	
	06800 SPEECH PATHOLOGY	109, 102		.,		11, 688	
	06900 ELECTROCARDI OLOGY	192, 295				32, 190	
	06901 CARDI AC REHAB	135, 792				17, 933	
	07000 ELECTROENCEPHALOGRAPHY	123, 205			0	5, 139	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	
	07300 DRUGS CHARGED TO PATIENTS			0	0	0	
	07301 ULTRA SOUND	31, 329	-	-	-	13, 887	
	07400 RENAL DI ALYSI S	01,02				0	
	OUTPATIENT SERVICE COST CENTERS			1 11/100			
	09000 CLINIC	0	75, 888	164, 112	0	0	90.00
	09100 EMERGENCY	1, 038, 835				139, 508	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
Ī	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	13, 157, 791	1, 119, 594	3, 656, 638	2, 197, 376	2, 095, 050	118.00
	NONREI MBURSABLE COST CENTERS				. 1		1.05 -
	19200 PHYSI CLANS' PRI VATE OFFI CES	356, 109					192.00
	19201 HEALTH TRACKS	0	-,				192.01
	07950 PRIMARY CARE CLINIC 07951 PARTNERS IN CARE	102 410	587				194.00 194.01
		182, 419					194.02
	07952 OCCUPATI ONAL MEDI CI NE 07953 FOUNDATI ON		2, 065 0				194.02
	07953 FOUNDATION 07954 SCHOOL & TOWN CLINICS		432				194.03
194.04 200.00	Cross Foot Adjustments		432	2,131	0	0	200.00
	Negative Cost Centers		0	0	0	0	200.00
201.00	INEGATIVE COST CENTERS						

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	HENDRICKS REGI	Provider CC	CN: 15-0005	Peri od:	u of Form CMS-: Worksheet B	2002-10
					From 01/01/2016 To 12/31/2016	Part I Date/Time Pre 5/30/2017 11:	epared: 29 am
	Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		13.00	14.00	15.00	16.00	17.00	
1 00	GENERAL SERVICE COST CENTERS	<u>г</u> г					1 4 00
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATI ON OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 123, 798					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	3, 282, 515	5 011 1			14.00
15.00		0	0	5,011,42			15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0		0 4, 120, 904 0 0	3, 028, 108	16.00 17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0 0	3, 020, 100] 17.00
30.00	03000 ADULTS & PEDIATRICS	1, 364, 479	0		0 442, 795	2, 167, 491	30.00
31.00	03100 I NTENSI VE CARE UNI T	246, 302	0		0 91, 749	244, 240	
43.00	04300 NURSERY	78, 606	0		0 0	0	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	247, 596	3, 282, 515		0 0	0	
50.01	05001 ENDOSCOPY	136, 105	0		0 0	0	
51.00	05100 RECOVERY ROOM	160, 851	0		0 164, 192	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	213, 319	0		0 0	0	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	164, 505 559, 445	0		0 0 0 852,074	0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	559, 445	0		0 852,074	0	
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	73, 200	0		0 0	0	
60.00	06000 LABORATORY	0	0		0 870, 013	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	252, 320	0		0 66, 688	0	
66.00	06600 PHYSI CAL THERAPY	0	0		0 178, 705	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 28, 255	0	
68.00		0	0		0 0	0	
69.00 69.01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	106, 446 59, 300	0		0 220, 777 0 0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	37, 300	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	5, 011, 42	22 0	0	73.00
73.01	07301 ULTRA SOUND	0	0		0 0	0	
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
	OUTPATIENT SERVICE COST CENTERS	-	-				
90.00	09000 CLINIC	0	0		0 0	0	
91.00 92.00	09100 EMERGENCY	461, 324	0		0 1, 205, 656	616, 377	
92.00	09200 0BSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
118.00		4, 123, 798	3, 282, 515	5, 011, 42	22 4, 120, 904	3, 028, 108	118 00
	NONREI MBURSABLE COST CENTERS	1,120,170	0,202,010	0,011,1	1,120,701	0/020/100	
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
	19201 HEALTH TRACKS	0	0		0 0		192.01
	07950 PRIMARY CARE CLINIC	0	0		0 0		194.00
	07951 PARTNERS IN CARE	0	0		0 0		194.01
	07952 OCCUPATIONAL MEDICINE	0	0		0 0		194.02
		0	0		0 0		194.03
	07954 SCHOOL & TOWN CLINICS	0	0		0 0	0	194.04
200.00			0		0 0	0	200.00
201.00		4, 123, 798	3, 282, 515	5,011,4	-	3, 028, 108	
202.00		1 4, 123, 190	5, 202, 515	5, 011, 4,		5,020,100	1202.00

Heal th	Financial Systems	HENDRICKS REGI	ONAL HEALTH		In Lieu	of Form CMS-2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0005	Period: W From 01/01/2016 P	Jorksheet B Part I Date/Time Prepared: 5/30/2017 11:29 am
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS	1	[]		1	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINISTRATIVE & GENERAL					5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7.00
9.00	00900 HOUSEKEEPI NG					9.00
	01000 DI ETARY					10.00
	01100 CAFETERI A					11.00
	01300 NURSING ADMINISTRATION					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
	01500 PHARMACY					15.00
	01600 MEDI CAL RECORDS & LI BRARY					16.00
17.00	01700 SOCIAL SERVICE					17.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	27, 982, 477	0	27, 982, 4	77	30.00
	03100 I NTENSI VE CARE UNI T	4, 489, 741	0	4, 489, 7		31.00
	04300 NURSERY	1, 516, 542	0	1, 516, 5		43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	14, 425, 522	0	14, 425, 5		50.00
	05001 ENDOSCOPY	2, 350, 762	0	2, 350, 7		50.01
	05100 RECOVERY ROOM	4, 589, 735	0	4, 589, 7		51.00
	05200 DELIVERY ROOM & LABOR ROOM	3, 239, 260	0	3, 239, 20		52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	1, 588, 092 11, 466, 285	0	1, 588, 0º 11, 466, 28		53.00 54.00
	05400 RADI OLOGI PUT AGNOSTI C	19, 194, 022	0	19, 194, 02		54.00
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	519, 616	0	519, 6		56.00
	05900 CARDI AC CATHETERI ZATI ON	1, 861, 147	0	1, 861, 1,		59.00
60.00	06000 LABORATORY	10, 713, 476	0	10, 713, 4	76	60.00
	06400 I NTRAVENOUS THERAPY	1, 742, 422	0	1, 742, 42		64.00
65.00	06500 RESPI RATORY THERAPY	4,089,333	0	4,089,3		65.00
	06600 PHYSI CAL THERAPY	8, 386, 785	0	8, 386, 7		66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	708, 418 682, 648	0	708, 4 ⁻ 682, 64		67.00 68.00
	06900 ELECTROCARDI OLOGY	1, 757, 277	0	1, 757, 2		69.00
	06901 CARDI AC REHAB	1, 049, 841	0	1, 049, 8		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	420, 527	0	420, 52		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	7, 910, 542	0	7, 910, 5		72.00
	07300 DRUGS CHARGED TO PATIENTS	18, 295, 909	0	18, 295, 90		73.00
	07301 ULTRA SOUND 07400 RENAL DI ALYSI S	875, 657	0	875, 6		73.01
74.00	OTAGINENAL DIALISIS OUTPATIENT SERVICE COST CENTERS	194, 665	0	194, 6	00	74.00
90.00	09000 CLINIC	7, 916, 321	0	7, 916, 3	21	90.00
91.00	09100 EMERGENCY	10, 474, 297	0	10, 474, 29		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	SPECIAL PURPOSE COST CENTERS	1			1	
118.00		168, 441, 319	0	168, 441, 3	19	118.00
102 00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CLANS' PRI VATE OFFICES	55, 498, 581	0	55, 498, 58	81	192.00
	19200 HEALTH TRACKS	5, 223, 463	0	5, 223, 4		192.00
194.00	07950 PRI MARY CARE CLI NI C	2, 633, 747	0	2, 633, 7		194.00
	07951 PARTNERS IN CARE	1, 435, 822	Ő	1, 435, 82		194.01
194.02	07952 OCCUPATIONAL MEDICINE	1, 169, 945	0	1, 169, 9		194.02
	07953 FOUNDATI ON	306, 366	0	306, 30		194.03
	07954 SCHOOL & TOWN CLINICS	1, 895, 514	0	1, 895, 5		194.04
200.00		0	0		0	200.00
201.00 202.00		0 236, 604, 757	0	236, 604, 7	57	201.00 202.00
202.00	101AL (3011 11103 110-201)	200,004,707	u U	200,004,73		1202.00

Health Fina	ncial Systems	HENDRICKS REG	IONAL HEALTH		In Lie	u of Form CMS-2	2552-10
	OF CAPITAL RELATED COSTS		Provider CO		eriod:	Worksheet B	
					rom 01/01/2016 p 12/31/2016		pared:
			CAPI TAL			5/30/2017 11:	29 am
			RELATED COSTS				
	Cost Center Description	Directly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V	
		Assigned New Capital	FLXT		BENEFI TS DEPARTMENT	E & GENERAL	
		Related Costs			DELAKTMENT		
		0	1.00	2A	4.00	5.00	
	RAL SERVICE COST CENTERS						1.00
	EMPLOYEE BENEFITS DEPARTMENT	0	195, 201	195, 201	195, 201		4.00
	ADMINI STRATI VE & GENERAL	0	1, 485, 481	1, 485, 481	21, 593		5.00
	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	2, 230, 148	2, 230, 148	4, 797	87, 241	7.00
	HOUSEKEEPING	0	277, 667 124, 646	277, 667 124, 646	630 3, 777		8.00 9.00
	DIETARY	0	489, 011	489, 011	895		
	CAFETERIA	0	86, 844	86, 844	2, 114		
	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	252, 766 452, 259	252, 766 452, 259	3, 711 1, 465	22, 992 15, 544	
	PHARMACY	0	199, 580	199, 580	3, 747	29, 323	
16.00 01600	MEDICAL RECORDS & LIBRARY	0	210, 118	210, 118	2, 499		
	SOCIAL SERVICE	0	91, 952	91, 952	3, 281	18, 795	17.00
	I ENT ROUTI NE SERVI CE COST CENTERS	0	2,054,271	2,054,271	18, 990	106, 436	30.00
	INTENSIVE CARE UNIT	0		257, 204	3, 180		
	NURSERY	0	48, 691	48, 691	1, 217	6, 290	43.00
	LARY SERVICE COST CENTERS	0	485, 858	485, 858	2, 867	61 700	50.00
	ENDOSCOPY	0	465, 858	465, 656 157, 165	2,807	61, 709 11, 949	
	RECOVERY ROOM	0	800, 160	800, 160	2, 283		
	DELIVERY ROOM & LABOR ROOM	0	165, 135	165, 135	3, 304		
) ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	0 939, 197	0 939, 197	9, 432 8, 086		
	RADI ATI ON-ONCOLOGY	0	574, 745	574, 745	2, 024		
	NUCLEAR MEDICINE - DIAGNOSTIC	0	15, 384	15, 384	278		
	CARDIAC CATHETERIZATION	0	268, 734	268, 734	1, 080		
) LABORATORY I NTRAVENOUS THERAPY	0	292, 058 39, 554	292, 058 39, 554	4, 816 1, 696		60.00 64.00
	RESPIRATORY THERAPY	0	278, 834	278, 834	3, 155		
	PHYSI CAL THERAPY	0	525, 266	525, 266	8, 587		
	OCCUPATIONAL THERAPY	0	53, 712	53, 712	693		
	ELECTROCARDI OLOGY	0	69, 329 122, 194	69, 329 122, 194	581 979	3, 534 7, 287	68.00 69.00
	CARDI AC REHAB	0	143, 037	143, 037	763		
	ELECTROENCEPHALOGRAPHY	0	78, 291	78, 291	196		
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	EO 299	71.00 72.00
	DRUGS CHARGED TO PATIENTS	0	-	0	0		
73.01 0730	ULTRA SOUND	0		19, 908	831		73.01
	RENAL DI ALYSI S	0	0	0	0	1, 168	74.00
90.00 09000	ATLENT SERVICE COST CENTERS	0	588, 611	588, 611	2, 979	48, 896	90.00
91.00 09100		0			5, 716		
	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
	AL PURPOSE COST CENTERS	0	14 700 141	14 700 141	104 115	1 070 704	110.00
118.00 NONRE	SUBTOTALS (SUM OF LINES 1-117)	0	14, 733, 141	14, 733, 141	134, 115	1, 079, 786	118.00
	PHYSICIANS' PRIVATE OFFICES	0	6, 401, 455	6, 401, 455	49, 620	349, 098	192.00
	HEALTH TRACKS	0	362, 701	362, 701	5, 451	32, 590	
) PRIMARY CARE CLINIC PARTNERS IN CARE	0	324, 664 138, 541	324, 664 138, 541	1,668		194.00 194.01
	2 OCCUPATIONAL MEDICINE	0	138, 541	138, 541	1, 213 452		194.01 194.02
	FOUNDATI ON	0	14, 099	14, 099	336		194.03
	SCHOOL & TOWN CLINICS	0	33, 511	33, 511	2, 346		
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers		0	0	0		200. 00 201. 00
202.00	TOTAL (sum lines 118-201)	0		0	195, 201		
1					.,		

Heal th	Financial Systems	HENDRI CKS REG	IONAL HEALTH		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	F	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pre 5/30/2017 11:	epared: 29 am
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	2, 322, 186					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0					8.00
9.00	00900 HOUSEKEEPI NG	33, 258	0	186, 818	3		9.00
10.00	01000 DI ETARY	130, 475	0	6, 301	634, 887		10.00
11.00	01100 CAFETERI A	23, 171	0	(0 0	124, 603	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	67, 442		.,		4, 997	
14.00	01400 CENTRAL SERVICES & SUPPLY	120, 670				3, 019	
15.00	01500 PHARMACY	53, 251		1		4, 394	
16.00	01600 MEDICAL RECORDS & LIBRARY	42, 277	0			5,004	
17.00	01700 SOCIAL SERVICE	0	0	139	0	4, 422	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	548, 110	76, 787	74, 429	487, 408	24, 539	30.00
30.00	03100 I NTENSI VE CARE UNI T	68, 626				4, 430	
43.00	04300 NURSERY	12, 991	4, 069			1, 414	
10.00	ANCI LLARY SERVICE COST CENTERS	12,771	1,007		72,070	.,	10.00
50.00	05000 OPERATING ROOM	129, 634	19, 111	13, 061	0	4, 453	50.00
50.01	05001 ENDOSCOPY	41, 934				2, 448	
51.00	05100 RECOVERY ROOM	213, 495	21, 322	2, 371	0	2, 893	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	44,060	15, 009	278	3 0	3, 837	52.00
53.00	05300 ANESTHESI OLOGY	0	0	299	0	2, 959	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	148, 989	31, 557	7, 390	0 0	10, 062	54.00
54.01	05401 RADI ATI ON-ONCOLOGY	0		4, 250		2, 923	1
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	4, 105				313	
59.00	05900 CARDI AC CATHETERI ZATI ON	71, 702		_,		1, 317	
60.00	06000 LABORATORY	66, 866				8,903	
64.00	06400 I NTRAVENOUS THERAPY	10, 554				1, 906	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	64, 693 54, 746		673 5, 073		4, 538 11, 822	
67.00	06700 OCCUPATI ONAL THERAPY	3, 372				904	
68.00	06800 SPEECH PATHOLOGY	18, 498				695	
69.00	06900 ELECTROCARDI OLOGY	32, 603				1, 915	
69.01	06901 CARDI AC REHAB	23, 023				1,067	
70.00	07000 ELECTROENCEPHALOGRAPHY	20, 889		1		306	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0 0	0	73.00
73.01	07301 ULTRA SOUND	5, 312				826	
74.00	07400 RENAL DI ALYSI S	0	35	502	2 0	0	74.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS		10.404				
	09000 CLINIC	0				-	90.00
	09100 EMERGENCY	176, 133	37, 114	13, 467	0	8, 297	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
118.00		2, 230, 879	272, 699	164, 904	634, 887	124, 603	1118 00
110.00	NONREIMBURSABLE COST CENTERS	2,230,077	272,077	104, 90-	054,007	124,003	1110.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	60, 378	10, 445	13, 061	0	0	192.00
	19201 HEALTH TRACKS	0					192.01
	07950 PRIMARY CARE CLINIC	0				0	194.00
	07951 PARTNERS IN CARE	30, 929				0	194.01
	07952 OCCUPATI ONAL MEDI CI NE	0	503			0	194.02
	07953 FOUNDATI ON	0					194.03
	07954 SCHOOL & TOWN CLINICS	0	105	96	0	0	194.04
200.00							200.00
201.00		0					201.00
202.00	TOTAL (sum lines 118-201)	2, 322, 186	285, 770	186, 818	634, 887	124, 603	202.00

	Financial Systems	HENDRI CKS REGI				u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pre 5/30/2017 11:	epared: 29 am
	Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		13.00	14.00	15.00	16.00	17.00	
1 00	GENERAL SERVICE COST CENTERS	1					1 1 00
$\begin{array}{c} 1.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FLXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	353, 371 0 0 0	596, 623 0 0		0 285, 361		$\begin{array}{c} 1.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
17.00	01700 SOCIAL SERVICE	0	0		0 0	118, 589	17.00
30. 00 31. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS O3000 ADULTS & PEDI ATRI CS O3100 I NTENSI VE CARE UNI T O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	116, 923 21, 106 6, 736	0 0 0		0 30, 649 0 6, 351 0 0	84, 885 9, 565 0	31.00
50.00	05000 OPERATING ROOM	21, 217	596, 623		0 0	0	50.00
50.00	05001 ENDOSCOPY	11, 663	023		0 0	0	
51.00	05100 RECOVERY ROOM	13, 783	0		0 11, 365	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	18, 279	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	14, 097	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	47, 939	0		0 58, 978	0	
54.01	05401 RADI ATI ON-ONCOLOGY	0	0		0 0	0	
56.00 59.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC 05900 CARDIAC CATHETERIZATION	0	0		0 0	0	
60.00	06000 LABORATORY	6, 273	0		0 60, 220	0	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 00,220	0	
65.00	06500 RESPI RATORY THERAPY	21, 622	0		0 4, 616	0	
66.00	06600 PHYSI CAL THERAPY	0	0		0 12, 369	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 1, 956	0	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	9, 121	0		0 15, 282	0	69.00
69.01	06901 CARDI AC REHAB	5, 081	0		0 0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	
72.00	07300 DRUGS CHARGED TO PATIENTS	0	0	291, 50		0	
73.00	07301 ULTRA SOUND	0	0		0 0	0	
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS	· · · · · ·					
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	39, 531	0		0 83, 575	24, 139	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
440.00	SPECIAL PURPOSE COST CENTERS	050.074	50/ /00	001 50	0 005 0/4	110 500	110 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	353, 371	596, 623	291, 50	0 285, 361	118, 589	118.00
192 00	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192.00
	19201 HEALTH TRACKS	0	0		0 0		192.01
	07950 PRIMARY CARE CLINIC	0	0		0 0		194.00
	07951 PARTNERS IN CARE	0	0		0 0		194.01
	07952 OCCUPATI ONAL MEDI CI NE	0	0		0 0		194.02
	3 07953 FOUNDATI ON	0	0		0 0		194.03
	07954 SCHOOL & TOWN CLINICS	0	0		0 0		194.04
200.00			~				200.00
201.00 202.00		0 353, 371	0 596, 623	291, 50	0 0 0		201.00
202.00	I TOTAL (SUM TIMES TIO-201)	303, 371	590, 023	291, 50	200, 301	110, 389	1202.00

Heal th	Financial Systems	HENDRICKS REG	IONAL HEALTH		In Lieu o	of Form CMS-2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0005	From 01/01/2016 Pa To 12/31/2016 Da	orksheet B art II ate/Time Prepared: /30/2017 11:29 am
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS	1	[[1	1.00
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT					1.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
	01000 DI ETARY					10.00
	01100 CAFETERI A					11.00
	01300 NURSING ADMINISTRATION					13.00
	01400 CENTRAL SERVICES & SUPPLY					14.00
	01500 PHARMACY					15.00
	01600 MEDICAL RECORDS & LIBRARY					16.00
17.00	01700 SOCI AL SERVI CE					17.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	3, 623, 427	0	3, 623, 4	27	30.00
	03100 INTENSIVE CARE UNIT	462, 015				31.00
43.00	04300 NURSERY	174, 565	0	174, 5	65	43.00
	ANCILLARY SERVICE COST CENTERS		-			
	05000 OPERATING ROOM	1, 334, 533				50.00
	05001 ENDOSCOPY	237,859				50.01
	05100 RECOVERY ROOM	1,085,614	0			51.00
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	266, 678 35, 496		266, 6 35, 4		52.00 53.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 307, 700				54.00
	05400 RADI OLOGI - DI AGNOSTI C 05401 RADI ATI ON-ONCOLOGY	707, 208				54.00
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	23, 486		23, 4		56.00
	05900 CARDI AC CATHETERI ZATI ON	359, 851	0			59.00
	06000 LABORATORY	496, 524	0			60.00
	06400 I NTRAVENOUS THERAPY	65, 664	0	65,6		64.00
65.00	06500 RESPI RATORY THERAPY	399, 135	0	399, 1	35	65.00
66.00	06600 PHYSI CAL THERAPY	685, 022	0	685, 0	22	66.00
67.00	06700 OCCUPATI ONAL THERAPY	65, 443	0	65,4	43	67.00
	06800 SPEECH PATHOLOGY	92, 957	0		57	68.00
	06900 ELECTROCARDI OLOGY	195, 900				69.00
	06901 CARDI AC REHAB	179, 132				69.01
	07000 ELECTROENCEPHALOGRAPHY	103, 309		103, 3		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	FO 2	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	50, 388 376, 118		50, 3 376, 1		72.00 73.00
	07301 ULTRA SOUND	32, 478				73.00
	07400 RENAL DI ALYSI S	1, 705				74.00
	OUTPATIENT SERVICE COST CENTERS	1,703	0	1,7	00	74.00
	09000 CLINIC	666, 371	0	666, 3	71	90.00
	09100 EMERGENCY	1, 089, 897				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	SPECIAL PURPOSE COST CENTERS					
118.00		14, 118, 475	0	14, 118, 4	75	118.00
	NONREI MBURSABLE COST CENTERS				1	
	19200 PHYSI CLANS' PRI VATE OFFI CES	6, 884, 057				192.00
	19201 HEALTH TRACKS	406, 948				192.01
	07950 PRIMARY CARE CLINIC	343, 440		343, 4		194.00
	07951 PARTNERS IN CARE	179, 884		179,8		194.01
	07952 OCCUPATI ONAL MEDI CI NE 07953 FOUNDATI ON	148, 904	0	148, 9		194. 02 194. 03
	07953 FOUNDATION 07954 SCHOOL & TOWN CLINICS	16, 451 48, 115	-	16, 4 48, 1		194.03
200.00		48, 115	0	40, 1	0	200.00
200.00	5	0	0		0	200.00
201.00		22, 146, 274			-	201.00
00		,,/ 1		,, 2	- 1	1202.00

	ancial Systems ATION - STATISTICAL BASIS	HENDRI CKS REGI	ONAL HEALTH	CN: 15-0005 F	In Lie	u of Form CMS-: Worksheet B-1	
0001 /12200				F	rom 01/01/2016		
					o 12/31/2016	Date/Time Pre 5/30/2017 11:	
		CAPI TAL					
	Cost Center Description	RELATED COSTS NEW BLDG &	EMPLOYEE	Poconciliatio	ADMI NI STRATI V	OPERATION OF	
	cost center bescription	FLXT	BENEFITS	n	E & GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM. COST)	(SQUARE	
		FEET)	(GROSS			FEET)	
			SALARI ES)				
OFNE		1.00	4.00	5A	5.00	7.00	
	RAL SERVICE COST CENTERS	758, 663					1.00
	O EMPLOYEE BENEFITS DEPARTMENT	6, 687	100, 980, 803				4.00
	O ADMINI STRATI VE & GENERAL	50, 888	11, 170, 498		201, 402, 820		5.00
7.00 0070	O OPERATION OF PLANT	76, 398	2, 481, 870	C	11, 658, 585	298, 150	7.00
	O LAUNDRY & LINEN SERVICE	9, 512	325, 676			0	
	O HOUSEKEEPI NG	4, 270	1, 953, 789		0,007,277	4, 270	•
		16, 752	463, 254			16, 752	•
	O CAFETERI A O NURSI NG ADMI NI STRATI ON	2, 975 8, 659	1, 093, 870 1, 919, 592			2, 975 8, 659	•
	O CENTRAL SERVICES & SUPPLY	15, 493	757, 668			15, 493	•
	0 PHARMACY	6, 837	1, 938, 321			6, 837	•
	O MEDICAL RECORDS & LIBRARY	7, 198	1, 292, 912	C	3, 194, 499	5, 428	16.00
	0 SOCI AL SERVI CE	3, 150	1, 697, 391	(C	2, 511, 678	0	17.00
	TI ENT ROUTI NE SERVI CE COST CENTERS	70.070	9, 823, 979		14 222 (00)	70, 373	1 20 00
	0 ADULTS & PEDIATRICS 0 INTENSIVE CARE UNIT	70, 373 8, 811	9, 823, 979 1, 645, 336			70, 373 8, 811	30.00 31.00
	0 NURSERY	1, 668	629, 342			1, 668	
	LLARY SERVICE COST CENTERS	1,000	027,012		, 010, 010	1,000	10.00
	O OPERATING ROOM	16, 644	1, 483, 368	0	8, 246, 507	16, 644	50.00
	1 ENDOSCOPY	5, 384	968, 764			5, 384	•
	O RECOVERY ROOM	27, 411	1, 181, 195			27, 411	51.00
	0 DELI VERY ROOM & LABOR ROOM 0 ANESTHESI OLOGY	5, 657 0	1, 709, 270			5,657	52.00 53.00
	0 RADI OLOGY-DI AGNOSTI C	32, 174	4, 879, 621 4, 183, 237			0 19, 129	
	1 RADI ATI ON-ONCOLOGY	19, 689	1, 047, 020			19, 129	54.00
	O NUCLEAR MEDICINE - DIAGNOSTIC	527	143, 807			527	56.00
	O CARDI AC CATHETERI ZATI ON	9, 206	558, 767			9, 206	59.00
	0 LABORATORY	10, 005	2, 491, 499			8, 585	•
	O INTRAVENOUS THERAPY	1, 355	877, 639			1, 355	•
	0 RESPI RATORY THERAPY 0 PHYSI CAL THERAPY	9, 552 17, 994	1, 632, 433 4, 442, 301			8, 306 7, 029	
	0 OCCUPATIONAL THERAPY	1, 840	4, 442, 301 358, 262		-, -, -, -, -, -, -, -, -, -, -, -, -, -	433	
	O SPEECH PATHOLOGY	2, 375	300, 538			2, 375	•
	0 ELECTROCARDI OLOGY	4, 186	506, 456			4, 186	•
	1 CARDI AC REHAB	4, 900	394, 690			2, 956	
	0 ELECTROENCEPHALOGRAPHY	2, 682	101, 147			2, 682	
	O MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0			0	
	O I MPL. DEV. CHARGED TO PATIENT O DRUGS CHARGED TO PATIENTS	0	0			0	72.00 73.00
	1 ULTRA SOUND	682	429, 827			682	
	O RENAL DI ALYSI S	0	0			0	•
OUTP	ATIENT SERVICE COST CENTERS						
90.00 0900		20, 164	1, 541, 158			0	
	O EMERGENCY	22, 614	2, 957, 062	C	5, 585, 367	22, 614	
	O OBSERVATION BEDS (NON-DISTINCT PART)						92.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	504, 712	69, 381, 559	-35, 201, 937	144, 298, 400	286, 427	118.00
	EIMBURSABLE COST CENTERS					· · · · · · · · · · · · · · · · · · ·	
	0 PHYSICIANS' PRIVATE OFFICES	219, 294	25, 667, 448				192.00
	1 HEALTH TRACKS	12, 425	2, 819, 924				192.01
	O PRIMARY CARE CLINIC 1 PARTNERS IN CARE	11, 122	863, 130				194.00 194.01
	2 OCCUPATI ONAL MEDI CI NE	4, 746 4, 733	627, 693 233, 599				194.01
	3 FOUNDATI ON	4,733	173, 600				194.02
	4 SCHOOL & TOWN CLINICS	1, 148	1, 213, 850				194.04
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers				05 001 51	10 (0)	201.00
202.00	Cost to be allocated (per Wkst. B,	22, 146, 274	6, 682, 457		35, 201, 937	13, 696, 319	202.00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	29. 191188	0. 066176		0. 174784	45.937679	203 00
203.00	Cost to be allocated (per Wkst. B,	27.171100	195, 201		1, 507, 074	2, 322, 186	•
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part		0. 001933		0. 007483	7. 788650	205.00
	11)	I		I	1 I		I

Heal th Financial Systems	HENDRICKS REGI		01 45 0005 0		u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2016		
			ТТ	o 12/31/2016	Date/Time Pre 5/30/2017 11:	
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERIA (MANHOURS)	NURSI NG ADMI NI STRATI O N (DI RECT	
	8.00	9.00	10.00	11.00	NRSING HRS) 13.00	
GENERAL SERVICE COST CENTERS			1			
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY	891, 311 0 0 0 275 1, 161	17, 493 590 0 137 335 78	21, 460 0 0 0	1, 423, 905 57, 109 34, 499	847, 574 0	14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	146 13			0	
INPATIENT ROUTINE SERVICE COST CENTERS	0	13	0		0	17.00
30. 00 03000 ADULTS & PEDIATRICS	239, 493	6, 969				
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	33, 442 12, 692	608 55				1
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM 50. 01 05001 ENDOSCOPY	59, 607 32, 770	1, 223 30				1
51.00 05100 RECOVERY ROOM	66, 503	222	0	33, 060	33, 060	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESIOLOGY	46, 813 0	26 28			43, 844 33, 811	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	98, 427	692	0	114, 984	114, 984	54.00
54. 01 05401 RADIATION-ONCOLOGY 56. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	6, 147 0	398 31			0	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	239			15, 045	
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	107	479				1
65.00 06500 RESPIRATORY THERAPY	3, 605 0	36 63				1
66. 00 06600 PHYSI CAL THERAPY	60, 581	475				
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	76 30			0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	14, 339	180				
69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY	311 751	80 167				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0 0			0	
73.01 07301 ULTRA SOUND	0	34	0	9, 438	0	73.01
74. 00 07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	110	47	0	0	0	74.00
90. 00 09000 CLI NI C	57, 651	693			0	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	115, 758	1, 261	0	94, 817	94, 817	91.00 92.00
SPECIAL PURPOSE COST CENTERS						92.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	850, 543	15, 441	21, 460	1, 423, 905	847, 574	118.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	32, 577	1, 223	0	0	0	192.00
192. 01 19201 HEALTH TRACKS	5, 268	423				192.01
194. 00 07950 PRI MARY_CARE_CLI NI C 194. 01 07951 PARTNERS_I N_CARE	446 580	21 113		0		194.00 194.01
194. 02 07952 OCCUPATI ONAL MEDI CI NE	1, 569	256		0		194.02
194. 03 07953 FOUNDATI ON 194. 04 07954 SCHOOL & TOWN CLINICS	328	7		0		194.03 194.04
200.00 Cross Foot Adjustments						200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	1, 173, 257	4, 142, 579	2, 197, 376	2, 095, 050	4, 123, 798	201.00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	1. 316327	236. 813525	102. 394035	1. 471341	4. 865414	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	285, 770	186, 818	634, 887	124, 603	353, 371	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 320618	10. 679586	29. 584669	0. 087508	0. 416921	205.00

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2016	Worksheet B-1
				To 12/31/2016	Date/Time Prepared: 5/30/2017 11:29 am
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	575072017 11.29 am
	SERVI CES & SUPPLY	(100% ALLOCATION)	RECORDS & LI BRARY	SERVI CE (TI ME	
	(100%	ALLOCATION	(GROSS	SPENT)	
	ALLOCATION)	15.00	CHARGES)	17.00	
GENERAL SERVICE COST CENTERS	14.00	15.00	16.00	17.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINI STRATI VE & GENERAL					4.00 5.00
7. 00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE					8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY					9.00 10.00
11. 00 01100 CAFETERI A					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	100				13.00 14.00
15. 00 01500 PHARMACY	0	100			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	263, 618, 14		16.00
17. 00 01700 SOCI AL SERVI CE I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0		0 19,651	17.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	28, 326, 19	14, 066	30.00
31. 00 03100 INTENSIVE CARE UNIT	0	0	5, 869, 32		31.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	0		0 0	43.00
50. 00 05000 OPERATI NG ROOM	100	0		0 0	50.00
50. 01 05001 ENDOSCOPY 51. 00 05100 RECOVERY ROOM	0	0	10, 503, 56	0 0	50.01 51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	10, 503, 50	0 0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 RADI ATI ON-ONCOLOGY	0	0	54, 508, 34	2 0 0 0	54. 00 54. 01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		0 0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	59.00
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	0	0	55, 655, 87	1 0 0 0	60.00 64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	4, 266, 10	04 0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	0	0	11, 432, 00 1, 807, 51		66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0	14, 123, 41		69.00
69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0 0 0	69. 01 70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 73. 01 07301 ULTRA SOUND	0	100		0 0	73. 00 73. 01
74.00 07400 RENAL DIALYSIS	0	0		0 0	
OUTPATIENT SERVICE COST CENTERS	0	0		0 0	90.00
91. 00 09100 EMERGENCY	0	0	77, 125, 80		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117)	100	100	263, 618, 14	1 19,651	118.00
NONREI MBURSABLE COST CENTERS	100	100	203, 010, 14	17,031	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	192.00
192. 01 19201 HEALTH_TRACKS 194. 00 07950 PRI MARY_CARE_CLI NI C	0	0		0 0	192. 01 194. 00
194. 01 07951 PARTNERS IN CARE	0	0		0 0	194.01
194. 02 07952 OCCUPATI ONAL MEDI CI NE 194. 03 07953 FOUNDATI ON	0	0		0 0	194. 02 194. 03
194. 03 07953 FOUNDATION 194. 04 07954 SCHOOL & TOWN CLINICS	0	0		0 0	194.03
200.00 Cross Foot Adjustments					200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	3, 282, 515	5, 011, 422	4, 120, 90	3, 028, 108	201.00 202.00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part I)		50, 114. 220000	0.01563		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	596, 623	291, 500	285, 36	1 118, 589	204.00
205.00 Unit cost multiplier (Wkst. B, Part	5, 966. 230000	2, 915. 000000	0.00108	6. 034757	205.00
)				I	

	nancial Systems	HENDRICKS REGI	ONAL HEALTH		In Lie	u of Form CMS-	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016		epared:
			Title	XVIII	Hospi tal	PPS	27 um
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	PATIENT ROUTINE SERVICE COST CENTERS	07 000 477		27 002 47	7	27.002.477	1 20 00
	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT	27, 982, 477 4, 489, 741		27, 982, 47 4, 489, 74			
	300 NURSERY	1, 516, 542		1, 516, 54			
	CILLARY SERVICE COST CENTERS	1, 510, 542		1, 510, 54	2 0	1, 510, 542	45.00
	000 OPERATING ROOM	14, 425, 522		14, 425, 52	2 0	14, 425, 522	50.00
50.01 050	001 ENDOSCOPY	2, 350, 762		2, 350, 76	2 0	2, 350, 762	50.01
51.00 05	100 RECOVERY ROOM	4, 589, 735		4, 589, 73	5 0	4, 589, 735	51.00
	200 DELIVERY ROOM & LABOR ROOM	3, 239, 260		3, 239, 26		3, 239, 260	
	300 ANESTHESI OLOGY	1, 588, 092		1, 588, 09		1, 588, 092	
	400 RADI OLOGY-DI AGNOSTI C	11, 466, 285		11, 466, 28		11, 466, 285	
	401 RADI ATI ON-ONCOLOGY	19, 194, 022		19, 194, 02			
	450 NUCLEAR MEDICINE - DIAGNOSTIC	519, 616		519, 61		519, 616	1
	900 CARDI AC CATHETERI ZATI ON 000 LABORATORY	1, 861, 147 10, 713, 476		1, 861, 14 10, 713, 47		1, 861, 147 10, 713, 476	1
	400 I NTRAVENOUS THERAPY	1, 742, 422		1, 742, 42		1, 742, 422	1
	500 RESPI RATORY THERAPY	4, 089, 333	0			4, 089, 333	
	600 PHYSI CAL THERAPY	8, 386, 785	0			8, 386, 785	
	700 OCCUPATI ONAL THERAPY	708, 418	0			708, 418	
	800 SPEECH PATHOLOGY	682, 648	0	682,64		682, 648	1
69.00 069	900 ELECTROCARDI OLOGY	1, 757, 277		1, 757, 27	7 0	1, 757, 277	69.00
69.01 069	901 CARDI AC REHAB	1, 049, 841		1, 049, 84	1 0	1, 049, 841	69.01
70.00 070	000 ELECTROENCEPHALOGRAPHY	420, 527		420, 52	7 0	420, 527	70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	
	200 IMPL. DEV. CHARGED TO PATIENT	7, 910, 542		7, 910, 54		7, 910, 542	1
	300 DRUGS CHARGED TO PATIENTS	18, 295, 909		18, 295, 90			
	301 ULTRA SOUND	875, 657		875, 65			1
	400 RENAL DIALYSIS	194, 665		194, 66	5 0	194, 665	74.00
	TPATIENT SERVICE COST CENTERS	7 014 001		7 016 22	1 0	7 014 001	00.00
	000 CLINIC 100 EMERGENCY	7, 916, 321 10, 474, 297		7, 916, 32 10, 474, 29			
	200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 943, 579		4, 943, 57		4, 943, 579	
200.00	Subtotal (see instructions)	4, 943, 579 173, 384, 898	0				
200.00	Less Observation Beds	4, 943, 579		4, 943, 57		4, 943, 579	
201.00	Total (see instructions)	168, 441, 319		1 · · · · · · · · · · · · · · · · · · ·			
		,,,	0			,, 517	

Health Financial Systems	HENDRICKS REGI	ONAL HEALTH		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/30/2017 11:	epared: 29 am
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	,		r	- 1		-
30. 00 03000 ADULTS & PEDI ATRI CS	21, 496, 525		21, 496, 52			30.00
31.00 03100 INTENSIVE CARE UNIT	5, 318, 363		5, 318, 30			31.00
43. 00 04300 NURSERY	6, 162, 996		6, 162, 99	96		43.00
ANCILLARY SERVICE COST CENTERS	,					_
50.00 05000 OPERATING ROOM	17, 542, 784	26, 313, 306			0. 000000	
50. 01 05001 ENDOSCOPY	695, 404	11, 893, 971			0. 000000	
51.00 05100 RECOVERY ROOM	3, 467, 785	7,035,782			0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	10, 658, 775	170, 384	10, 829, 15	59 0. 299124	0.00000	
53. 00 05300 ANESTHESI OLOGY	4, 197, 855	5, 736, 210			0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	7, 413, 749	46, 655, 815	54,069,50	0. 212065	0.00000	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	391, 090	57, 591, 766	57, 982, 8	56 0. 331029	0.00000	54.01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	477, 758	4, 719, 553	5, 197, 3 ⁻	0. 099978	0.00000	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 517, 579	11, 431, 404	16, 948, 98	0. 109809	0. 000000	59.00
60. 00 06000 LABORATORY	10, 876, 690	45, 369, 056	56, 245, 74	0. 190476	0. 000000	60.00
64.00 06400 I NTRAVENOUS THERAPY	168, 214	7, 284, 203	7, 452, 41	0. 233806	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	2,974,083	1, 291, 531	4, 265, 6 ⁻	0. 958674	0.00000	65.00
66.00 06600 PHYSI CAL THERAPY	1, 629, 041	9, 751, 324	11, 380, 30	0. 736952	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	836, 031	869, 263	1, 705, 29	0. 415423	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	344, 932	1, 466, 526			0.00000	68.00
69.00 06900 ELECTROCARDI OLOGY	2, 475, 271	11, 468, 371	13, 943, 64		0. 000000	69.00
69. 01 06901 CARDI AC REHAB	27, 156	1, 815, 266	1, 842, 42	0. 569816	0. 000000	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	130, 611	707,064			0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0.000000	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	8, 940, 319	4, 355, 758	13, 296, 0		0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 680, 178	18, 071, 176			0.00000	
73.01 07301 ULTRA SOUND	1, 974, 236	9, 774, 725			0.00000	
74.00 07400 RENAL DI ALYSI S	241, 887	13, 345			0.000000	
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	30, 261	38, 091, 587	38, 121, 84	18 0. 207658	0.00000	90.00
91.00 09100 EMERGENCY	13, 977, 297	63,004,719			0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 789, 273			0, 000000	1
200.00 Subtotal (see instructions)	137, 646, 870	388, 671, 378				200.00
201.00 Less Observation Beds	,,,,	,,				201.00
202.00 Total (see instructions)	137, 646, 870	388, 671, 378	526, 318, 24	48		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCI: 15-0005 Period: From 01/01/2016 To 12/31/2016 Worksheet C Jate 1 Date	Health Financial Systems	HENDRICKS REGIO	NAL HEALTH	In Lieu of Form CMS-2552-10			
Cost Center Description PPS Inpatient Ratio 11.00 11.00 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 ARCILLARY SERVICE COST CENTERS 30.00 0.0000 OPERATING ROOM 0.328929 0.0100 RECOVERY ROOM 0.486769 10.00 OSCOD OPERATING ROOM 0.436969 50.00 OSCOD OPERATING ROOM 0.436969 51.00 OSCOD OPERATING ROOM 0.436969 52.00 OSCOD ANESTHERSILOLGY 0.1159663 53.00 OSCOD ANESTHERSILOLGY 0.1159663 53.00 OSCOD CARDIAC CATHETER IZATION 0.199978 50.00 OSCOD CARDIAC CATHETER IZATION 0.199674 50.00 OSCOR RESPIRATORY THERAPY 0.233806 60.00 OSCOR RESPIRATORY THERAPY 0.233806 61.00 OSCOR RESPIRATORY THERAPY 0.736552 62.00 OSCOR RESPIRATORY THERAPY 0.736557 63.00 OSCOR RESPIRATORY THERAPY 0.736552 63.00 OSCOR RESPIRATORY THERAPY 0.736552 63.00 OSCOR RESPIRATORY THERAPY 0.736552 64.00 OSCOR RESPIRATORY THERAPY 0.736552				From 01/01/2016	Part I Date/Time Pr 5/30/2017 11	epared: 29 am	
Ratio 11.00 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 43.00 04300 INTENSIVE CARE UNIT 31.00 43.00 04300 INTENSIVE CARE UNIT 31.00 50.00 05000 OPERATING ROOM 0.328929 50.01 50.00 05000 DELNOSCOPY 0.186726 50.01 51.00 05100 REOVERY ROOM 0.439699 51.00 52.00 05300 PADICTS REWORD & LABOR ROOM 0.299124 52.00 53.00 05300 ANSTHESI OLOGY 0.31029 54.01 54.00 05401 RADIATION-ONCOLOGY 0.31029 54.01 50.00 05400 CARDIAC CATHETERI ZATION 0.199809 54.00 59.00 05400 CARDIAC CATHETERI ZATION 0.199809 54.00 60.00 06000 LABORATORY 0.19807 0.331029 50.00 0500 OSCO CARDIAC CATHETERI ZATION 0.199809 59.00 60.00 06000 LABORATORY 0.19807 0.233806 64.00 60.00 06000 LABORATORY			Title XVIII	Hospi tal	PPS		
11.00 11.00 30.00 ADULTS & PEDLATRICS 30.00 31.00 03000 ADULTS & PEDLATRICS 30.00 31.00 03000 NUTRISI VE CARE UNIT 43.00 ANCILLARY SERVICE COST CENTERS 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 50.00 50.00 50.00 DS000 OPERATING ROM 0.328929 50.00 50.00 50.00 50.00 DS000 OPERATING ROM 0.436699 51.00 DS000 RADULTS & LABOR ROM 0.299124 52.00 DS200 DELIVERY ROM & LABOR ROM 0.299124 53.00 DS000 RADILOGV-DI AGNOSTI C 0.212065 54.00 DS400 RADILOGV-DI AGNOSTI C 0.212065 54.00 DS400 CADILAT CATHERI ZATION 0.199809 60.00 GO00 LABORATORY 0.190476 60.00 DO00 LABORATORY 0.233806 61.00 DG00 OPHY THERAPY 0.736850 63.00 OBG00 SPECH PATHOLOGY 0.736952 61.00 OG000 OPHYSICAL HERAPY <	Cost Center Description						
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 43.00 04300 MURSERY 43.00 ANOLLLARY SERVICE COST CENTERS 50.00 05000 (PENATING ROOM 0.328929 50.00 50.00 05000 (PENATING ROOM 0.43669 51.00 51.00 51.00 05100 RECOVERY ROOM 0.43669 52.00 52.00 52.00 05200 PELIVER ROOM 0.436649 51.00 52.00 05300 ANESTHESI OLOCY 0.159863 53.00 54.00 05401 RADICACY-DI AGNOSTI C 0.212065 54.01 55.00 05300 ANESTHESI OLOCY 0.331029 54.01 56.00 06300 CARDIA CATHEERA Y 0.199809 55.00 50.00 05300 CARDIA CATHERAPY 0.233806 64.00 60.00 06600 OLABIDACATHERAPY 0.7364552 66.00 60.00 06500 RESPIRATORY THERAPY 0.336650 67.00 60.00 06500 OLINTRACHAUS THERAPY 0.7364551							
30.00 00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 43.00 ANCILLARY SERVICE COST CENTERS 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 50.00 50.01 50.00 50.01 50.01 50.01 50.00 50.01 50.00 50.00 50.01 50.00 50.00 50.01 51.00 50.00 50.01 52.00 05200 FLIVER NOM & LABOR ROM 0.299124 53.00 05300 ASSO MARSTHESIOLOCY 0.331029 54.01 05400 RADIATION-ONCOLOGY 0.331029 54.01 05400 RADIATION-ONCOLOGY 0.331029 55.00 05900 CARDIAC CATHERERIZATION 0.199809 60.00 06500 RESPIRATORY THERAPY 0.2338064 61.00 06500 RESPIRATORY THERAPY 0.736952 62.00 06500 CEUPATION 0.599816 63.00 06600 SPECICHATORY THERAPY 0.376850 63.00 0		11.00					
31.00 03100 INTENSIVE CARE UNIT 31.00 43.00 04300 NURESERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 50.00 50.00 50.00 05000 PERATING ROOM 0.328929 50.00 50.10 50.00 50.00 50.00 50.00 51.00 05100 RECOVERY ROOM 0.436969 51.00 52.00 05300 ALEVEN ROOM & LABOR ROOM 0.299124 52.00 53.00 05300 ANDILLARY SERVICE COST CENTERS 53.00 54.00 05400 RADIOLOGY - DI AGNOSTI C 0.212065 54.01 54.01 05401 RADIOLOGY - DI AGNOSTI C 0.231029 54.00 54.00 05400 RADIOLOGY - DI AGNOSTI C 0.199609 59.00 50.00 03500 LEDRATINEY THERIZITI NON 0.199609 59.00 60.00 06000 LABORATORY 0.190476 60.00 61.00 06000 RESPIRATORY THERAPY 0.233806 64.00 62.00 06000 RESPIRATORY THERAPY 0.736952 66.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td>						-	
43. 00 04300 NURSERY 43. 00 ANCILLARY SERVICE COST CENTERS 50. 00 50. 01 05000 OPERATING ROM 0. 328929 50. 00 50. 01 05001 FINDSCOPY 0. 186726 50. 01 51. 00 DS100 RCDVERY ROM 0. 436769 51. 00 52. 00 DS200 DELIVERY ROM & LABOR ROM 0. 299124 52. 00 53. 00 DS300 ANSTRISTON 0. 199663 53. 00 54. 01 DS400 RADIOLOGY - DIAGNOSTIC 0. 212065 54. 01 56. 00 O3450 NUCLEAR MEDICINE - DIAGNOSTIC 0. 099978 56. 00 50. 00 DS900 CARDI AC CATHETERIZATION 0. 109809 64. 00 60. 00 OAd00 LARDARTORY THERAPY 0. 233806 64. 00 61. 00 O6000 DOBCOND CLABORATORY 0. 736952 66. 00 66. 00 O6000 OCUPATIONAL THERAPY 0. 736950 68. 00 60. 00 O6000 OCUPATIONAL THERAPY 0. 736950 68. 00 60. 00							
ANCILLARY SERVICE COST CENTERS 50.00 05000 0PERATING ROOM 0.328929 50.00 50.01 05001 ENDSCOPY 0.186726 50.01 51.00 05100 RECOVERY ROOM 0.436969 51.00 52.00 5200 DELVERY ROOM & LABOR ROOM 0.299124 52.00 52.00 53.00 05400 RADIOLOGY DI CONSTIC 0.212065 54.00 54.01 05401 RADI ATION-ONCOLOGY 0.331029 54.01 56.00 50.00 06500 ANTOLLEAR MEDI CINE - DI AGNOSTI C 0.099978 56.00 50.00 06500 CARDIAC CATHETERIZATI ON 0.190476 60.00 60.00 06600 INTRAVENUS THERAPY 0.233806 64.00 65.00 06500 RESPI RATORY THERAPY 0.736952 66.00 66.00 06600 PIYSI CAL THERAPY 0.376850 68.00 69.00 064000 LECTROBARDERAPHAUCRARPHY 0.502017 70.00 70.00 07000 ELECTROBARDERARED TO PATI ENTS 0.5069816 69.							
50. 00 05000 0PERATI NG ROOM 0.328929 50. 01 50. 01 05001 ENDOSCOPY 0.186726 50. 01 51. 00 05100 RECOVERY ROOM 0.436969 51. 00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.299124 53. 00 53. 00 05300 ANESTHESI OLOGY 0.159863 53. 00 54. 01 05401 RADIATI ON-ONCOLOGY 0.331029 54. 01 54. 01 05401 RADIATI ON-ONCOLOGY 0.331029 54. 01 50. 00 05900 CARDIAC CATHETERI ZATI ON 0.199899 59. 00 60. 00 06000 LABORATORY 0.233806 64. 00 61. 00 06400 INTRAVENUS THERAPY 0.233806 66. 00 62. 00 6600 PHYSI CAL THERAPY 0.376952 66. 00 63. 00 6600 OSPOIC CARDI AC REHAB 0.569816 67. 00 63. 00 6600 DOSPOIC CARDI AC REHAB 0.569816 67. 00 64. 00 6600 PHYSI CAL THERAPY 0.376850 68. 00 68. 00 06800						43.00	
50. 01 05001 ENDOSCOPY 0. 186726 50. 01 51. 00 05100 RECOVERY ROOM 0. 436649 51. 00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 299124 52. 00 53. 00 05300 ARESTHESI OLOCY 0. 15963 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 212065 54. 01 55. 00 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 0. 099798 56. 00 59. 00 05000 CARDIAC CATHETERI ZATI ON 0. 109809 56. 00 60. 00 06400 LABORATORY 0. 190476 60. 00 64. 00 06400 NUTRAVENOUS THERAPY 0. 233806 64. 00 65. 00 06500 RESPI RATORY THERAPY 0. 736952 66. 00 66. 00 06600 PHYSI CAL THERAPY 0. 126027 69. 01 69. 00 06900 CELCTROCARDI LOGY 0. 376850 68. 00 69. 01 06900 ELECTROCARDI OLOGY 0. 126027 70. 00 70. 00 07100 KEI CAL SUPPLIES CHARGED TO PATI ENTS 0. 502017 70. 00 71. 00 071000 K						-	
51.00 05100 RECOVERY ROOM 0.436969 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.299124 52.00 53.00 05300 ANESTHESI OLOGY 0.159863 53.00 54.01 05407 RADI TION-ONCOLOGY 0.331029 54.01 56.00 03450 NUCLEAR MEDICINE - DI AGNOSTI C 0.099978 56.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.109809 56.00 60.00 06000 LABORATORY 0.190476 60.00 61.00 06400 INTRAVENOUS THERAPY 0.233806 64.00 65.00 06500 RESPI RATORY THERAPY 0.736952 66.00 65.00 06600 PHESTI CAL THERAPY 0.415423 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0.126027 69.00 69.00 06900 ELECTROCARDI OLOGY 0.376850 69.01 71.00 07100 IELOTERNICEPHALOGRAPHY 0.502017 70.00 71.00 07100 IELOTROCKEPHALOGRAPHY 0.502017 70.00 72.00 072001 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
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53.00 05300 ANESTHESI OLOGY 0.159863 53.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 0.212065 54.01 54.01 05401 RADI ALT ON-ONCOLOGY 0.331029 54.01 56.00 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 0.099978 56.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.199809 59.00 60.00 D6000 LABRATORY 0.1990476 60.00 64.00 06400 INTRAVENOUS THERAPY 0.233806 64.00 65.00 06500 RESPI RATORY THERAPY 0.736952 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.316850 68.00 68.00 06400 SPECH PATHOLOGY 0.376952 66.00 69.00 06900 ELECTROCARDI OLOGY 0.126027 69.00 69.00 G6900 ELECTROCARDI OLOGY 0.569816 69.01 70.00 D6900 ELECTROENCEPHALOGRAPHY 0.502017 70.00 71.00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 72.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
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74.00 07400 RENAL DI ALYSI S 0.762698 74.00 OUTPATI ENT SERVI CE COST CENTERS 0.000 00000 CLI NI C 0.000 90.0							
OUTPATI ENT SERVICE COST CENTERS 90.00 00000 CLINIC 90.00 91.00 92.00							
90.00 09000 CLINIC 0.207658 90.00 91.00 09100 EMERGENCY 0.136062 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.304625 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00		0. 762698				74.00	
91.00 09100 EMERGENCY 0.136062 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.304625 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00							
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.304625 92.00 200.00 Subtotal (see instructions) 200.00 200.00 201.00							
200.00Subtotal (see instructions)200.00201.00Less Observation Beds201.00							
201.00 Less Observation Beds 201.00		1. 304625					
202.00 Total (see instructions) 202.00							
	202.00 Total (see instructions)					202.00	

Health Financial Systems	HENDRICKS REGI	ONAL HEALTH		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/30/2017 11:	epared: 29 am
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	(from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	07.000.177		07.000.47	-		
30. 00 03000 ADULTS & PEDI ATRI CS	27, 982, 477		27, 982, 47			
31.00 03100 INTENSIVE CARE UNIT	4, 489, 741		4, 489, 74		4, 489, 741	
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 516, 542		1, 516, 54	2 0	1, 516, 542	43.00
50. 00 05000 OPERATING ROOM	14, 425, 522		14, 425, 52	2 0	14, 425, 522	50.00
50. 01 05001 ENDOSCOPY	2, 350, 762		2, 350, 76		2, 350, 762	1
51. 00 05100 RECOVERY ROOM	4, 589, 735		4, 589, 73		4, 589, 735	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	3, 239, 260		3, 239, 26		3, 239, 260	1
53. 00 05300 ANESTHESI OLOGY	1, 588, 092		1, 588, 09		1, 588, 092	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 466, 285		11, 466, 28		11, 466, 285	
54.01 05401 RADI ATI ON-ONCOLOGY	19, 194, 022		19, 194, 02		19, 194, 022	
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	519, 616		519, 61		519, 616	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 861, 147		1, 861, 14	7 0	1, 861, 147	59.00
60. 00 06000 LABORATORY	10, 713, 476		10, 713, 47	6 0	10, 713, 476	60.00
64.00 06400 INTRAVENOUS THERAPY	1, 742, 422		1, 742, 42		1, 742, 422	
65. 00 06500 RESPI RATORY THERAPY	4, 089, 333	0	.,		4, 089, 333	
66. 00 06600 PHYSI CAL THERAPY	8, 386, 785	0	0/000//0		8, 386, 785	
67.00 06700 OCCUPATI ONAL THERAPY	708, 418	0	/ / / / / /		708, 418	1
68.00 06800 SPEECH PATHOLOGY	682, 648	0	682, 64		682, 648	
69. 00 06900 ELECTROCARDI OLOGY	1, 757, 277		1, 757, 27		1, 757, 277	
69. 01 06901 CARDI AC REHAB	1, 049, 841		1, 049, 84		1, 049, 841	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	420, 527		420, 52		420, 527	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	7, 910, 542		7, 910, 54		7, 910, 542	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	18, 295, 909		18, 295, 90		18, 295, 909	
73. 01 07301 ULTRA SOUND 74. 00 07400 RENAL DI ALYSI S	875, 657 194, 665		875, 65 194, 66		875, 657	1
OUTPATIENT SERVICE COST CENTERS	194, 005		194, 00		194, 665	74.00
90. 00 09000 CLINIC	7, 916, 321		7, 916, 32	1 0	7, 916, 321	90.00
91. 00 09100 EMERGENCY	10, 474, 297		10, 474, 29		10, 474, 297	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 943, 579		4, 943, 57		4, 943, 579	
200.00 Subtotal (see instructions)	173, 384, 898	0				
201.00 Less Observation Beds	4, 943, 579		4, 943, 57		4, 943, 579	
202.00 Total (see instructions)	168, 441, 319					

Health Financial Systems	HENDRICKS REGI	ONAL HEALTH		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/30/2017 11:	epared: 29 am
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	04 404 505		01 10/ 5/			0.00
30. 00 03000 ADULTS & PEDI ATRI CS	21, 496, 525		21, 496, 52			30.00
31. 00 03100 I NTENSI VE CARE UNI T	5, 318, 363		5, 318, 30			31.00
43. 00 04300 NURSERY	6, 162, 996		6, 162, 99	76		43.00
ANCI LLARY SERVICE COST CENTERS	17 540 704	2/ 212 20/	42.05/.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0,00000	50.00
	17, 542, 784	26, 313, 306			0.00000	
50. 01 05001 ENDOSCOPY	695, 404	11, 893, 971	12, 589, 3		0.00000	
51.00 05100 RECOVERY ROOM	3, 467, 785	7,035,782	10, 503, 50		0.00000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	10, 658, 775	170, 384	10, 829, 1		0.00000	
53. 00 05300 ANESTHESI OLOGY	4, 197, 855	5, 736, 210	9, 934, 00		0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 413, 749	46, 655, 815			0.00000	
54. 01 05401 RADI ATI ON-ONCOLOGY	391, 090	57, 591, 766	57, 982, 8		0. 000000	
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	477, 758	4, 719, 553	5, 197, 3		0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 517, 579	11, 431, 404	16, 948, 98		0.00000	
60. 00 06000 LABORATORY	10, 876, 690	45, 369, 056			0.00000	
64.00 06400 INTRAVENOUS THERAPY	168, 214	7, 284, 203	7, 452, 41		0.00000	
65. 00 06500 RESPI RATORY THERAPY	2, 974, 083	1, 291, 531	4, 265, 61		0.00000	
66.00 06600 PHYSI CAL THERAPY	1, 629, 041	9, 751, 324	11, 380, 30		0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	836, 031	869, 263			0.00000	
68.00 06800 SPEECH PATHOLOGY	344, 932	1, 466, 526	1, 811, 45		0.00000	
69. 00 06900 ELECTROCARDI OLOGY	2, 475, 271	11, 468, 371	13, 943, 64		0.00000	
69. 01 06901 CARDI AC REHAB	27, 156	1, 815, 266	1, 842, 42		0.00000	
70.00 07000 ELECTROENCEPHALOGRAPHY	130, 611	707, 064	837,6		0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	8, 940, 319	4, 355, 758	13, 296, 0		0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 680, 178	18, 071, 176	27, 751, 3		0.00000	
73.01 07301 ULTRA SOUND	1, 974, 236	9, 774, 725	11, 748, 90		0.00000	
74.00 07400 RENAL DI ALYSI S	241, 887	13, 345	255, 23	0. 762698	0.00000	74.00
OUTPATIENT SERVICE COST CENTERS	,					
90. 00 09000 CLINIC	30, 261	38, 091, 587	38, 121, 84		0. 000000	
91.00 09100 EMERGENCY	13, 977, 297	63, 004, 719			0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 789, 273	3, 789, 2		0.00000	
200.00 Subtotal (see instructions)	137, 646, 870	388, 671, 378	526, 318, 24	48		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	137, 646, 870	388, 671, 378	526, 318, 24	18		202.00

lealth Financial Systems	HENDRICKS REGIO	NAL HEALTH	In Lieu	ı of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/30/2017 11:	epared: 29 am
		Title XIX	Hospi tal	Cost	_
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 000000				50.00
50. 01 05001 ENDOSCOPY	0. 000000				50.01
51.00 05100 RECOVERY ROOM	0. 000000				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0. 000000				54.01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000				56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
50. 00 06000 LABORATORY	0. 000000				60.00
64. 00 06400 I NTRAVENOUS 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
58.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
59. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
69. 01 06901 CARDI AC REHAB	0. 000000				69.01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
73. 01 07301 ULTRA SOUND	0. 000000				73.01
74.00 07400 RENAL DIALYSIS	0. 000000				74.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	CN: 15-0005	Peri od:	Worksheet D	
				From 01/01/2016		
				To 12/31/2016		pared:
					5/30/2017 11:	<u>29 am</u>
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost	:	col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 623, 427	(3, 623, 42	19, 449	186.30	30.00
31.00 INTENSIVE CARE UNIT	462, 015		462, 01	5 1,856	248.93	31.00
43.00 NURSERY	174, 565		174, 56	5 3, 129	55.79	43.00
200.00 Total (lines 30-199)	4, 260, 007		4, 260, 00	24, 434		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30, 00 ADULTS & PEDIATRICS	6, 382	1, 188, 967	7			30.00
31. 00 I NTENSI VE CARE UNI T	855					31.00
43. 00 NURSERY	0	212,000				43.00
200.00 Total (lines 30-199)	7,237	1, 401, 802				200.00
200.00[10101 (11103 30 177)	1,237	1,401,002	-1			200.00

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0005	Peri od:	Worksheet D	
				From 01/01/2016	Part II	
				To 12/31/2016	Date/Time Pre 5/30/2017 11:	pared:
		Title	XVIII	Hospi tal	PPS	<u>27 alli</u>
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)		,	
	col. 26)		, , , , , , , , , , , , , , , , , , ,			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 334, 533	43, 856, 090	0. 03043	7, 206, 950	219, 307	50.00
50. 01 05001 ENDOSCOPY	237, 859	12, 589, 375			-	50.01
51.00 05100 RECOVERY ROOM	1, 085, 614					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	266, 678					
53. 00 05300 ANESTHESI OLOGY	35, 496					
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 307, 700	54, 069, 564	0. 02418	3, 747, 326	90, 633	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	707, 208	57, 982, 856			2,064	54.01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	23, 486	5, 197, 311	0.00451	9 253, 056	1, 144	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	359, 851			2, 421, 516	51, 411	59.00
60. 00 06000 LABORATORY	496, 524	56, 245, 746	0. 00882	28 5, 038, 874	44, 483	60.00
64.00 06400 INTRAVENOUS THERAPY	65, 664	7, 452, 417	0.00882	1 119, 854	1, 056	64.00
65. 00 06500 RESPI RATORY THERAPY	399, 135	4, 265, 614	0. 09357	70 1, 169, 765	109, 455	65.00
66. 00 06600 PHYSI CAL THERAPY	685, 022	11, 380, 365	0.06019	854, 029	51, 407	66.00
67.00 06700 OCCUPATI ONAL THERAPY	65, 443	1, 705, 294	0. 0383	424, 462	16, 289	67.00
68.00 06800 SPEECH PATHOLOGY	92, 957	1, 811, 458	0. 05131	6 188, 776	9, 687	68.00
69. 00 06900 ELECTROCARDI OLOGY	195, 900			1, 291, 172	18, 140	69.00
69. 01 06901 CARDI AC REHAB	179, 132	1, 842, 422	0. 09722	26 10, 146		69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	103, 309	837, 675	0. 12332	28 79, 273	9, 777	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-	0.00000	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	50, 388			3, 714, 593	14, 078	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	376, 118	27, 751, 354	0. 01355	4, 292, 293	58, 173	73.00
73.01 07301 ULTRA SOUND	32, 478	11, 748, 961	0.00276	633, 402	1, 751	73.01
74.00 07400 RENAL DI ALYSI S	1, 705	255, 232	0. 00668	30 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	666, 371					
91. 00 09100 EMERGENCY	1, 089, 897				103, 609	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	640, 139		0. 16893		0	92.00
200.00 Total (lines 50-199)	10, 498, 607	493, 340, 364		41, 637, 585	932, 171	200.00

Health Financial Systems	HENDRICKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider C		Period: From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/30/2017 11:	pared: 29 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Allied Health	All Other	Swi ng-Bed	Total Costs	
	School	Cost	Medi cal	Adjustment	(sum of cols.	
			Education	Amount (see	1 through 3,	
			Cost	instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem	I npati ent	I npati ent		
	Days	(col. 5 ÷	Program Days	Program		
	-	col. 6)		Pass-Through		
		ŕ		Cost (col. 7		
				x col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	19, 449	0.00	6, 38	2 0		30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 856	0.00	85	5 0	1	31.00
43.00 04300 NURSERY	3, 129	0.00		0 0	1	43.00
200.00 Total (lines 30-199)	24, 434		7, 23	7 0	1	200.00
· ·			•			•

Health Financial Systems	HENDRICKS REGION	VAL HEALTH			In Lieu	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS		CN: 15-0005			Worksheet D Part IV Date/Time Pre 5/30/2017 11:	pared: 29 am
		Titl€	XVIII		Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Allied Healt	th	All Other	Total Cost	
	Anesthetist	School			Medi cal	(sum of col 1	
	Cost				Educati on	through col.	
					Cost	4)	
	1.00	2.00	3.00		4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS							
50.00 05000 OPERATING ROOM	0	C)	0	0	0	50.00
50. 01 05001 ENDOSCOPY	0	C		0	0	0	50.01
51.00 05100 RECOVERY ROOM	0	C)	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0	0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	C		0	0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0	0	0	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0	C		0	0	0	54.01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	C		0	0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0	0	0	59.00
60. 00 06000 LABORATORY	0	C		0	0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0	C		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0	0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	C		0	0	0	69.00
69. 01 06901 CARDI AC REHAB	0	C		0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0	0	0	73.00
73.01 07301 ULTRA SOUND	0	C		0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	C		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					<u>_</u>		
90. 00 09000 CLINIC	0	C)	0	0	0	90.00
91.00 09100 EMERGENCY	0	C		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0	o	0	92.00
200.00 Total (lines 50-199)	0	C		0	0	0	200.00
					.1		

Health Financial Systems	HENDRICKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				rom 01/01/2016 0 12/31/2016	Part IV	norod.
				12/31/2010	Date/Time Pre 5/30/2017 11:	29 am
		Title	XVIII	Hospi tal	PPS	<u></u>
Cost Center Description	Total		Ratio of Cost		I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost		
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
	4)			col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS	r		1	1		
50.00 05000 OPERATI NG ROOM	0					
50. 01 05001 ENDOSCOPY	0					
51.00 05100 RECOVERY ROOM	0	10, 503, 567				1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	10, 829, 159				
53. 00 05300 ANESTHESI OLOGY	0	9, 934, 065			1, 501, 310	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	54, 069, 564			3, 747, 326	
54. 01 05401 RADI ATI ON-ONCOLOGY	0	57, 982, 856			169, 228	54.01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	5, 197, 311	0.00000	0. 000000	253, 056	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	16, 948, 983	0.00000	0. 000000	2, 421, 516	59.00
60. 00 06000 LABORATORY	0	56, 245, 746			5, 038, 874	
64.00 06400 INTRAVENOUS THERAPY	0	7, 452, 417	0.00000	0. 000000	119, 854	64.00
65. 00 06500 RESPI RATORY THERAPY	0	4, 265, 614	0.00000	0. 000000	1, 169, 765	65.00
66. 00 06600 PHYSI CAL THERAPY	0	11, 380, 365	0.00000	0. 000000	854, 029	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	1, 705, 294	0.00000	0. 000000	424, 462	67.00
68.00 06800 SPEECH PATHOLOGY	0	1, 811, 458			188, 776	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	13, 943, 642	0.00000	0. 000000	1, 291, 172	69.00
69. 01 06901 CARDI AC REHAB	0	1, 842, 422	0.00000	0. 000000	10, 146	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	837, 675	0.00000	0. 000000	79, 273	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000	0. 000000	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	13, 296, 077		0. 000000	3, 714, 593	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	27, 751, 354				73.00
73.01 07301 ULTRA SOUND	0	11, 748, 961	0.00000	0. 000000	633, 402	73.01
74.00 07400 RENAL DI ALYSI S	0	255, 232	0.00000	0. 000000	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0					
91. 00 09100 EMERGENCY	0	,				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 789, 273		0. 000000		
200.00 Total (lines 50-199)	0	493, 340, 364			41, 637, 585	200.00

Health Financial Systems	HENDRICKS REGIO	ONAL HEALTH		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Pre 5/30/2017 11:	epared: 29 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Inpatient	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS	1 1		T			
50.00 05000 OPERATING ROOM	0	18, 088, 277		0		50.00
50. 01 05001 ENDOSCOPY	0	0		0		50.01
51.00 05100 RECOVERY ROOM	0	944, 222		0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
53.00 05300 ANESTHESI OLOGY	0	696, 972		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	11, 041, 386		0		54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0	17, 718, 851		0		54.01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	1, 399, 331		0		56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	3, 348, 959		0		59.00
60. 00 06000 LABORATORY	0	3, 740, 841		0		60.00
64.00 06400 I NTRAVENOUS THERAPY	0	3, 283, 261		0		64.00
65. 00 06500 RESPI RATORY THERAPY	0	420, 108		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	308, 999		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	15, 462		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	26, 972		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 876, 646		0		69.00
69. 01 06901 CARDI AC REHAB	0	807,464		0		69.01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	508, 892		0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 433, 073		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4, 046, 926		0		73.00
73.01 07301 ULTRA SOUND	0	1, 904, 957		0		73.01
74.00 07400 RENAL DIALYSIS	0	6, 172		0		74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0		90.00
91.00 09100 EMERGENCY	0	12, 207, 988		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	704, 671		0		92.00
200.00 Total (lines 50-199)	0	84, 530, 430		0		200.00

Health Financial Systems	HENDRICKS REG	IONAL HEALTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C	CN: 15-0005	Period: From 01/01/2016 To 12/31/2016		pared:
		Title	e XVIII	Hospi tal	PPS	27 am
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not	. ,	
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.	í í	Ded. & Coins	. Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 328929	18, 088, 277	1	0 0	5, 949, 759	50.00
50. 01 05001 ENDOSCOPY	0. 186726	0		0 0	0	50.01
51.00 05100 RECOVERY ROOM	0. 436969	944, 222		0 0	412, 596	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 299124	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 159863	696, 972		0 0	111, 420	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 212065	11,041,386		0 634	2, 341, 492	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0. 331029	17, 718, 851		0 13,644	5, 865, 454	54.01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 099978			0 0	139, 902	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0, 109809			0 0	367, 746	59.00
60. 00 06000 LABORATORY	0. 190476	3, 740, 841	1, 01	5 0	712, 540	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 233806	3, 283, 261		0 0	767, 646	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 958674			0 0	402, 747	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 736952	308, 999		0 0	227, 717	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 415423			0 0	6, 423	67.00
68.00 06800 SPEECH PATHOLOGY	0. 376850			0 0	10, 164	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 126027			0 0	236, 508	69.00
69. 01 06901 CARDI AC REHAB	0. 569816			0 0	460, 106	1
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 502017			0 0	255, 472	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 594953			0 0	852, 611	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.659280			0 5, 375	2,668,057	73.00
73. 01 07301 ULTRA SOUND	0. 074531			0 0	141, 978	
74.00 07400 RENAL DI ALYSI S	0. 762698			0 0	4, 707	74.00
OUTPATIENT SERVICE COST CENTERS			1		.,	
90. 00 09000 CLINIC	0. 207658	0)	0 0	0	90.00
91.00 09100 EMERGENCY	0. 136062			0 0	1,661,043	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 304625			0 0	919, 331	
200.00 Subtotal (see instructions)		84, 530, 430		5 19,653		
201.00 Less PBP Clinic Lab. Services-Program			.,	0 0	, , ,	201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		84, 530, 430	1, 01	5 19, 653	24, 515, 419	202.00

Health Financial Systems	HENDRI CKS REGI			In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period: From 01/01/2016 To 12/31/2016	5/30/2017 11:	epared: 29 am
			XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
50. 01 05001 ENDOSCOPY	0	0				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	134				54.00
54. 01 05401 RADI ATI ON-ONCOLOGY	0	4, 517				54.01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0				56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	193	0				60.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
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	3, 544				73.00
73.01 07301 ULTRA SOUND	0	0				73.01
74.00 07400 RENAL DIALYSIS	0	0				74.00
OUTPATIENT SERVICE COST CENTERS	<u>.</u>					
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	193	8, 195				200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00 Net Charges (line 200 +/- line 201)	193	8, 195				202.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0005	Period:	Worksheet D-1	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	
		Title XVIII	Hospi tal	5/30/2017 11: PPS	29 a
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs. excluding newborn)		19, 449	1 1
00	Inpatient days (including private room days, excluding swing-	-bed and newborn days)		19, 449	
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ped days)		16, 013	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	Som days) arter becomber		0	
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	om davs) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable 1 newborn days)	to the Program (excludin	g swing-bed and	6, 382	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10
. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, e		room days) arter	0	' '
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13
	after December 31 of the cost reporting period (if calendar y	year, enter 0 on this li	ne)	0	
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		1		
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
00	reporting period			0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es arter becember 31 or	the cost	0.00	20
	Total general inpatient routine service cost (see instruction			27, 982, 477	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	per 31 of the cost repor	ting period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	- 31 of the cost reporti	ng period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost report	ing period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		27, 982, 477	
00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		•••••		
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed c	narges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	nus lino 22) (coo instru	ctions)	0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li			0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	-	
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
	Provide the second seco				1
. 00	Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 438. 76	38
0. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	e 38)		1, 438. 76 9, 182, 166 0	39

COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 15-0005 Period: From 01/01/2016 Worksheet D-1 Description Total Total Number of the program of th
Title XVIII Hospital PPS Cost Center Description Total Inpatient Cost Total Inpatient Cost Total Days Average Per Diem (col. 1 + col. 2) Program Days Cost Program Cost (col. 3 x col. 4) 42.00 NURSERY (title V & XIX only) 0<
Inpatient CostInpatient DaysDiem (col. 1 + col. 2)(col. 3 x col. 4)42.00NURSERY (title V & XIX only)00.004.0042.00NURSERY (title V & XIX only)00001.002.003.004.005.0043.00INTENSIVE CARE UNIT4,489,7411,8562,419.0445.00BURN INTENSIVE CARE UNIT4,489,7411,8562,419.0445.00SURGI CAL INTENSIVE CARE UNIT4,489,7411,8562,419.0446.00SURGI CAL INTENSIVE CARE UNIT4,489,7411,8562,419.0447.00OTHER SPECIAL CARE (SPECIFY)11148.00Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)13,553,69649.00Total Program inpatient costs (sum of lines 41 through 48) (see instructions)24,804,141PASS THROUGH COST ADJUSTMENTS11,401,80250.00Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts I and 1,401,802111)1102,333,97352.00Total Program excludable cost (sum of lines 50 and 51)2,333,97353.00Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and22,470,168
1.00 2.00 3.00 4.00 5.00 42.00 NURSERY (title V & XIX only) 0 0 0 0.00 0 <t< td=""></t<>
Intensive Care Type Inpatient Hospital Units 43.00 INTENSI VE CARE UNIT 44.00 CORONARY CARE UNIT 45.00 BURN INTENSI VE CARE UNIT 45.00 BURN INTENSI VE CARE UNIT 46.00 SURGICAL INTENSI VE CARE UNIT 46.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description 48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48) (see instructions) PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts I and III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and III) 52.00 Total Program excludable cost (sum of lines 50 and 51) 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 22, 470, 168
43.00INTENSI VE CARE UNIT4,489,7411,8562,419.048552,068,27944.00CORONARY CARE UNITBURN INTENSI VE CARE UNIT4,489,7411,8562,419.048552,068,27945.00BURN INTENSI VE CARE UNITaaaaaaaa46.00SURGI CAL INTENSI VE CARE UNITaaa
44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description 1.00 48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 1.00 48.00 Program inpatient costs (sum of lines 41 through 48) (see instructions) 24, 804, 141 PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts I and III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 932, 171 and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 2, 333, 973 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 2, 470, 168
46.00 SURGICAL INTENSIVE CARE UNIT
47.00 OTHER SPECIAL CARE (SPECIFY) 1.00 Cost Center Description 1.00 48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 13, 553, 696 49.00 Total Program inpatient costs (sum of lines 41 through 48) (see instructions) 24, 804, 141 PASS THROUGH COST ADJUSTMENTS 1, 401, 802 50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III) 1, 401, 802 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 932, 171 and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 2, 333, 973 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 22, 470, 168
Cost Center Description 48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 1.00 48.00 Total Program inpatient costs (sum of lines 41 through 48) (see instructions) 24, 804, 141 PASS THROUGH COST ADJUSTMENTS 24, 804, 141 50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III) 1, 401, 802 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV) 932, 171 52.00 Total Program excludable cost (sum of lines 50 and 51) 2, 333, 973 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 22, 470, 168
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 1.00 48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 13,553,696 49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions) 24,804,141 PASS THROUGH COST ADJUSTMENTS 24,804,141 50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III) 1,401,802 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 932,171 and IV) 932,171 52.00 Total Program excludable cost (sum of lines 50 and 51) 2,333,973 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 22,470,168
49.00 Total Program inpatient costs (sum of Lines 41 through 48) (see instructions) 24,804,141 PASS THROUGH COST ADJUSTMENTS 20,804,141 50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III) 1,401,802 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 932,171 and IV) 52.00 Total Program excludable cost (sum of Lines 50 and 51) 2,333,973 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 22,470,168
PASS_THROUGH_COST_ADJUSTMENTS 50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and I, 401, 802 III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 932, 171 and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 22, 470, 168
50.00Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)1,401,80251.00Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)932,17152.00Total Program excludable cost (sum of lines 50 and 51)2,333,97353.00Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and22,470,168
51.00Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)932,17152.00Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 22,470,1682,333,973
and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 22,470,168
52.00TotalProgram excludable cost (sum of lines 50 and 51)2,333,97353.00TotalProgram inpatient operating cost excluding capital related, non-physician anesthetist, and22,470,168
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 22,470,168
medical education costs (line 10 minus line 52)
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program di scharges 0
55.00 Target amount per discharge 0.00
56.00 Target amount (line 54 x line 55) 0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 58.00 Bonus payment (see instructions) 0
58.00 Bonus payment (see instructions) 0 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the 0.00
market basket
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target
amount (line 56), otherwise enter zero (see instructions)
62.00 Relief payment (see instructions)
63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 PROGRAM INPATIENT ROUTINE SWING BED COST
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 0
instructions)(title XVIII only)
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See 0 instructions)(title XVIII only)
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For 0
CAH (see instructions)
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 0 (line 12 x line 19)
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 0
(line 13 x line 20)
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)
74.00 Total Program general inpatient routine service costs (line 72 + line 73)
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column
26, line 45)
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76)
78.00 Inpatient routine service cost (line 74 minus line 77)
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service 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
87.00 Total observation bed days (see instructions) 3,436
88.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,438.7689.00Observation bed cost (line 87 x line 88) (see instructions)4,943,579

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016		pared: 29 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	3, 623, 427	27, 982, 477	0. 12948	9 4, 943, 579	640, 139	90.00
91.00 Nursing School cost	0	27, 982, 477	0.00000	0 4, 943, 579	0	91.00
92.00 Allied health cost	0	27, 982, 477	0.00000	0 4, 943, 579	0	92.00
93.00 All other Medical Education	0	27, 982, 477	0.00000	0 4, 943, 579	0	93.00

INPUT	Financial Systems HENDRICKS REGION ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0005	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	par
				5/30/2017 11:	
	Cost Center Description	Title XIX	Hospi tal	Cost	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		19, 449	1 1
00	Inpatient days (including private room days, excluding swing			19, 449	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only p	rivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation b	bed days)		16, 013	4
00	Total swing-bed SNF type inpatient days (including private re	oom days) through Decemb	er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private re	oom davs) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	om davs) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable - newborn days)	to the Program (excludin	g swing-bed and	569	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII (only (including private	room days)	0	10
~ ~	through December 31 of the cost reporting period (see instruc				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
00	through December 31 of the cost reporting period		t		1.
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendary			0	13
	Medically necessary private room days applicable to the Prog			0	1
	Total nursery days (title V or XIX only)			3, 129	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	19
. 00	reporting period	ces arter becember 51 01	the cost	0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting poriod (lind	27, 982, 477	
. 00	5 x line 17)	ber 31 of the cost repor	ting period (ine	0	22
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	or 21 of the cost report	ing pariod (line	0	24
. 00	7 x line 19)	el 31 ul the cust report	ring period (inne	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		27, 982, 477	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed c	harges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li	ine 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	0 27, 982, 477	
	27 minus line 36)			27, 702, 477] "
	PART II – HOSPITAL AND SUBPROVIDERS ONLY				
	DDOODAM INDATIENT ODEDATING COST REFORE DACE TURQUOU COST AR				
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see			1, 438, 76	38
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	e instructions) e 38)		1, 438. 76 818, 654	

	TATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	1
					rom 01/01/2016 o 12/31/2016	Date/Time Pre	
			Titl	e XIX	Hospi tal	5/30/2017 11: Cost	29 a
	Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00		1, 516, 542	3, 129	484.67	0	0	42.
~ ~	Intensive Care Type Inpatient Hospital Units		4.057	0.440.0			
. 00		4, 489, 741	1, 856	2, 419. 04	0	0	43
. 00						1	44
	SURGI CAL I NTENSI VE CARE UNI T					1	46
	OTHER SPECIAL CARE (SPECIFY)					1	47
	Cost Center Description						
00	Dragram innationt anaillany compiles east (W	at D 2 and 2	Line 200)			1.00	40
. 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines			anc)		638, 772 1, 457, 426	
. 00	PASS THROUGH COST ADJUSTMENTS	41 (1100g)1 48) (see mistructio	51157		1, 437, 420	47
. 00		atient routine	services (fro	n Wkst. D, sum	of Parts I and	0	50
	111)						
. 00	Pass through costs applicable to Program inpa	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	0	51
. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				0	52
3.00	5		lated, non-ph	vsician anesth	etist, and	0	
	medical education costs (line 49 minus line !			, 			
	TARGET AMOUNT AND LIMIT COMPUTATION						
. 00	5 5					0	
. 00	5 1 5					0.00	
. 00	5	ing cost and ta	urget amount (ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	ing cost and ta		The 50 minus	The 55)	0	
. 00		porting period	endina 1996. u	updated and co	mpounded by the		
	market basket	511	5		,		
. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	
. 00	If line 53/54 is less than the lower of line					0	61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% or	the target	1	
> 00	Relief payment (see instructions)					0	62
	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64
5.00		ts after Decemb	er 31 of the	rost reporting	period (See	0	65
	instructions)(title XVIII only)			boot i opoi ting	po ou (000	, U	
5.00	5 1	ne costs (line	64 plus line	55)(title XVII	l only). For	0	66
	CAH (see instructions)		D	C 11			
7.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31	or the cost re	porting period	0	67
3. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	rting period	0	68
	(line 13 x line 20)					-	
9.00	<u>y</u>					0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU						
. 00	3					1	70
. 00	5 5		The 70 ÷ The	2)		1	72
. 00	5	,	ı (line 14 x li	ne 35)		1	73
. 00	Total Program general inpatient routine servi	ice costs (line	72 + line 73)		1	74
. 00	Capital-related cost allocated to inpatient	routine service	e costs (from)	Vorksheet B, P	art II, column	1	75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)				1	76
. 00							77
. 00							78
. 00			rovi der recor	ds)		1	79
00			ost limitation	n (line 78 min	us line 79)	1	80
00	Inpatient routine service cost per diem limi		`				81
. 00							82
. 00	Reasonable inpatient routine service costs (is)				83
. 00 . 00			(and				84
. 00							86
	PART IV - COMPUTATION OF OBSERVATION BED PASS						1 3
. 00	Total observation bed days (see instructions))				3, 436	
	Adjusted general inpatient routing cost per	diem (line 27 ∸	ling 2)			1, 438. 76	88
	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	•				4, 943, 579	

Health Financial Systems	HENDRI CKS REGI	ONAL HEALTH		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		pared: 29 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	3, 623, 427	27, 982, 477	0. 12948	9 4, 943, 579	640, 139	90.00
91.00 Nursing School cost	0	27, 982, 477	0.00000	0 4, 943, 579	0	91.00
92.00 Allied health cost	0	27, 982, 477	0.00000	0 4, 943, 579	0	92.00
93.00 All other Medical Education	0	27, 982, 477	0.00000	0 4, 943, 579	0	93.00

Health Financial Systems HENDRICKS REGIONAL HEALTH		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider	CCN: 15-0005	Peri od:	Worksheet D-3	
		From 01/01/2016		
		To 12/31/2016	Date/Time Pre 5/30/2017 11:	
	le XVIII	Hospi tal	PPS	29 dili
Cost Center Description	Ratio of Co		Inpati ent	
	To Charges		Program Costs	
	TO Charges	Charges	(col. 1 x	
		charges	col. 2)	
	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS		7, 021, 626		30.00
31. 00 03100 I NTENSI VE CARE UNI T		2, 413, 622		31.00
43. 00 04300 NURSERY		2, 110, 022		43.00
ANCI LLARY SERVI CE COST CENTERS				45.00
50. 00 05000 OPERATI NG ROOM	0. 3289	29 7, 206, 950	2, 370, 575	50.00
50. 01 05001 ENDOSCOPY	0. 1867		2,070,070	50.01
51. 00 05100 RECOVERY ROOM	0. 4369		520, 154	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 2991		3, 939	52.00
53. 00 05300 ANESTHESI OLOGY	0. 1598		240,004	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 2120		794, 677	54.00
54. 01 05401 RADIALION-ONCOLOGY	0. 3310		56, 019	
56. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 0999		25, 300	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 1098		265, 904	59.00
60. 00 06000 LABORATORY	0. 1098		959, 785	
64. 00 06400 I NTRAVENOUS THERAPY	0. 2338		28, 023	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 2336		1, 121, 423	•
66. 00 06600 PHYSI CAL THERAPY	0. 7369		629, 378	
67. 00 06700 OCCUPATI ONAL THERAPY				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 4154		176, 331	
69. 00 06900 ELECTROCARDI OLOGY	0. 3768		71, 140	
			162, 723	
69. 01 06901 CARDI AC REHAB	0. 5698		5, 781	69.01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 5020		39, 796	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0.0000		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 5949		2, 210, 008	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 6592		2, 829, 823	
73.01 07301 ULTRA SOUND	0.0745		47, 208	73.01
74.00 07400 RENAL DI ALYSI S	0. 7626	98 0	0	74.00
OUTPATIENT SERVICE COST CENTERS			-	
90. 00 09000 CLINIC	0.2076		0	90.00
91.00 09100 EMERGENCY	0. 1360		995, 705	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.3046		0	92.00
200.00 Total (sum of lines 50-94 and 96-98)	.	41, 637, 585	13, 553, 696	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)	0		201.00
202.00 Net Charges (line 200 minus line 201)	I	41, 637, 585		202.00

Health Financial Systems HENDRI	CKS REGIONAL HEALTH		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0005	Peri od:	Worksheet D-3	
			From 01/01/2016		
			To 12/31/2016	Date/Time Pre 5/30/2017 11:	
	Ti +1	e XIX	Hospi tal	Cost	29 alli
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
		TO charges	U		
			Charges	(col. 1 x	
		1.00	2.00	<u>col.2)</u> 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			500, 591		30.00
31. 00 03100 INTENSIVE CARE UNIT			77, 206		31.00
43. 00 04300 NURSERY			271, 268		43.00
ANCI LLARY SERVICE COST CENTERS				(7, 100	
50. 00 05000 OPERATING ROOM		0. 32892		67, 429	50.00
50. 01 05001 ENDOSCOPY		0. 18672		1, 169	50.01
51.00 05100 RECOVERY ROOM		0. 43696		14, 831	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 29912		203, 657	52.00
53. 00 05300 ANESTHESI OLOGY		0. 15986		8, 415	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 21200	55 132, 818	28, 166	54.00
54. 01 05401 RADI ATI ON-ONCOLOGY		0. 33102		231	54.01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0.0999	78 5, 036	503	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 10980	0 0	0	59.00
60. 00 06000 LABORATORY		0. 1904	76 346, 547	66, 009	60.00
64.00 06400 INTRAVENOUS THERAPY		0. 23380	3, 520	823	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 9586	74 57,734	55, 348	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 7369	52 11, 808	8, 702	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 41542		2, 721	67.00
68.00 06800 SPEECH PATHOLOGY		0. 3768	50 3, 769	1, 420	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 12602		13, 639	69.00
69. 01 06901 CARDI AC REHAB		0. 5698		247	69.01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 5020		772	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 5949		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 65928		124, 389	
73. 01 07301 ULTRA SOUND		0. 03 920		2, 710	
74. 00 07400 RENAL DI ALYSI S		0. 76269		3,672	74.00
OUTPATIENT SERVICE COST CENTERS		0.7020	4,014	5,072	74.00
		0. 2076	- 0	0	00.00
				0	90.00
		0. 1360		33, 919	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 30462		0	92.00
200.00 Total (sum of lines 50-94 and 96-98)			2, 136, 495	638, 772	
201.00 Less PBP Clinic Laboratory Services-Program c	oniy charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)		1	2, 136, 495		202.00

	Financial Systems HENDRICKS REGION ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0005	Peri od: From 01/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/30/2017 11:	pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00
1.00	DRG amounts other than outlier payments for discharges occurr instructions)	ring prior to October 1	(see	0	1.00
1. 02	DRG amounts other than outlier payments for discharges occurr instructions)	ring on or after October	1 (see	15, 913, 743	1.02
1. 03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	for discharges occurring	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	for discharges occurring	on or after	0	1.04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			323, 821 0	2.00 2.01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruct	tions)		0	2.01
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	orting period (see instr	uctions)	0 117. 61	3.00 4.00
4.00	Indirect Medical Education Adjustment				4.00
5.00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	st recent cost reporting	period ending on	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e)	the criteria for an add	l-on to the cap	0.00	6.00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified ACA Section 5503 reduction amount to the IME cap as specified	under 42 CFR §412.105(0.00 0.00	7.00 7.01
8. 00	If the cost report straddles July 1, 2011 then see instruction Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1000) and (7.75, 500(c) (August 1, 2002)	athic and osteopathic pr	5	0.00	8.00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sl the cost report straddles July 1, 2011, see instructions.	ots under section 5503	of the ACA. If	0.00	8.01
8. 02	The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teach	ing hospital	0.00	8.02
9. 00	under section 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	nes (8, 8,01 and 8,02)	(see	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the curr	rent year from your reco	ords		10.00
11.00 12.00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)				11.00 12.00
13.00	Total allowable FTE count for the prior year.				13.00
14.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Se	ptember 30, 1997,		14.00
15.00 16.00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program				15.00 16.00
17.00	Adjustment for residents displaced by program or hospital clo	osure			17.00
	Adjusted rolling average FTE count				18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4 Prior year resident to bed ratio (see instructions)	•).		0. 000000 0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22.00	IME payment adjustment (see instructions)			0	
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Sect	ion 122 of the MMA		0	22.01
23.00	Number of additional allopathic and osteopathic IME FTE resid		Sec. 412.105	0.00	23.00
24.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -O-, then enter the instructions) $% \left({{\left[{{{\left[{{\left[{{\left[{{\left[{{\left[{{\left[$	lower of line 23 or lin	e 24 (see	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.00000	
27.00 28.00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0. 000000 0	
28.01	IME add on adjustment amount - Managed Care (see instructions)	5)		0	
	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0			0	1
~~	Disproportionate Share Adjustment				
	Percentage of SSI recipient patient days to Medicare Part A p	batient days (see instru	ictions)	2.29	
	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			17.40 19.69	31.00 32.00
	Allowable disproportionate share percentage (see instructions	5)		5.55	
	Disproportionate share adjustment (see instructions)			220, 803	

GAL CLIANTON OF RETINUES STITUTION TO THE ADDR STATUS OF ADDR STATUS OF RETINUES ADDR STATUS OF ADDR ST	Heal th	Financial Systems H	ENDRICKS REGIONAL HEALTH		In Lie	u of Form CMS-2	552-10
Total Total Table 2012 Description Export Time Pregards 11:02:0:00 Title XVIII Prior to 10/1 Description 2002 2002 10:00 Prior to 10/1 Description 2002 2002 2002 10:00 Factor 3 (see instructions) 6.406.145.54 5.977.483.147 36.00 30:01 Factor 3 (see instructions) 6.406.145.54 5.977.483.147 36.00 10:00 Concerning source (sum of columns 1 and 2 on line 35.03) 0.00004224 0.00002200 36.01 10:01 Incomposed columns 1 and 2 on line 35.03 199.42.00 36.00 153.126 36.00 20:01 Total ender on discharges on Worksheer 5.3. Pert 1 excluding discharges (ines 40 through 46) 0.00 41.00 10:01 Total ESD Medicare discharges excluding MS-DRGs 652.62.62.63.64 664.06 41.00 10:01 Total ESD Medicare discharges excluding MS-DRGs 622.62.63.64 664.00 41.00 10:01 Concerning Length of stay to one week (line 43 divided by line 41 divided by 7 0.000000 44.00 10:00 Concerning Length of stay to one wee			Provi der				
Ittle XVIII Isognam 5/30/2017 ft:29, an Prive to 1071 privation of the second							pared:
Prior 100 Prior 100 2.00 35.00 Total uncompensated care mount (see instructions) 6.406.145.534 5.977.463.147 35.00 35.01 Total uncompensated care payment (if line 34 is zero, enter zero on this line) 6.406.145.534 5.977.463.147 35.00 35.02 Hogglial uncompensated care payment for high parzentage of 1580 benefic any discharges (lines 40 through 46) 405.21 35.03 36.00 Total uncompensated and bis (see instructions) 45.21 35.03 60 40.01 Total uncompensated and bis (see instructions) 40.00 45.21 40.00 41.00 Total Staff and bis (see instructions) 40.00 41.00 41.00 10.11 Total Staff and bis (see instructions) 0.00 42.00 43.00 41.00 Total Staff and bis (see instructions) 0.00 42.00 43.00 41.00 Total Staff and bis (see instructions) 0.00 42.00 43.00 41.01 Total staff and bis (see instructions) 0.00 42.00 43.00 41.01 Total staff and bis (see instructions) 0.00<						5/30/2017 11:2	
1.00 2.00 bicompensated Care Adjustment 6,406,145,534 5,977,483,147 35.00 factor 1 (accompensated care payment (if line 34 is zero, enter zero on this line) 0,406,145,534 5,977,483,147 35.01 factor 1 (accompensated care payment (if line 34 is zero, enter zero on this line) 0,60,04724 0,0002/2003 35,01 35.02 factor 1 (accompensated care (sum of columes 1 and 2 on line 35,03) 0,00 455,241 139,063 36,00 36.00 factor 1 ked care discharges on Worksheet 5-3, Part I excluding discharges for WS-0K68 0 40,00 40.01 factor 1 ked care discharges calculang WS-0K68 oS2, 682, 683, 684 an 685. (see 0 41,00 1.01 tait SRD Molicare Covered and public-DK68 oS2, 682, 682, 683, 684 an 685. (see 0 41,00 1.01 tait SRD Molicare CSM ord care see (line 43 divided by line 41 divided by 7 0,00000 44.00 43:00 tait diditional payment (line 45 times line 44 times line 41 ural hospitals 0 0 0.00 tait additional payment (line 45 times line 44 times line 41.01) 0 0 45.00 0.00 tait discharges care discharges care discharges care discharges care discharges care discharges care discharge			lit	le XVIII			
35.00 Total uncompensated care amount (see instructions) 6.406,145,534 5.977,482,147 35.00 35.01 Factor 3 (see instructions) 0.000092300 35.01 35.01 Factor 3 (see instructions) 0.00092300 35.01 35.01 Factor 3 (see instructions) 0.00092300 35.01 35.01 Factor 40 0.00092300 35.01 35.02 Hospital uncompensated care payment amount (see instructions) 455,241 35.03 35.03 Factor 40 0.00 455,241 35.03 35.04 Total indepensated care instructions) 0.00 40.00 0.00 62,62,63,641 0.00 62,62,63,644 0.00 41.00 11.01 Total ESR0 Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see 0 0.00 44.00 41.01 40.00 Fatter 10 scharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see 0 0.00 44.00 41.01 Instructions) 0.00 45.00 45.00 45.00 45.00 Newrage exclusing MS-DRGs 652, 682, 683, 684 an 685. (see 0 0.00 44.00 45.00 45.00 45.00 45.00 45.00 45.00							
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44.00Total payment for inpatient operating costs (see instructions)17,052,67349,0050.00Payment for inpatient program capital (from Wkst. L, Pt. III, and Pt. II, as applicable)1,388,47450.0051.00Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)1,388,47450.0052.00Direct graduate medical education payment (from Wkst. E, 4, line 49 see instructions).052.0053.00Nursing and Allied Health Managed Care payment053.0054.01Islet Isolation add-on payment054.0155.00Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)054.0156.00Cost of physicians' services in a teaching hospital (see intructions)055.0057.00Routine service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)058.0059.00Total (sum of amounts on lines 49 through 58)018,441,14761.00Total amount payable for program beneficiaries (line 59 minus line 60)18,434,32661.0063.00Colonsurance billed to program beneficiaries (see instructions)16,69,91267.0064.00Allowable bad debts for dual eligible beneficiaries (see instructions)16,69,91267.0065.00Outlier services from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)16,69,91267.0065.00Allowable bad debts for dual eligible beneficiaries (see instructions)16,69,91267.0066.00Outlier serceived from manufacturers for replaced devices for applicable to MS							
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53.00Nursing and Allied Health Managed Care payment053.0054.00Special add-on payments for new technologies054.0054.01Islet isolation add-on payment054.0055.00Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)054.0056.00Cost of physicians' services in a teaching hospital (see intructions)055.0057.00Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).056.0059.00Total (sum of amounts on lines 49 through 58)18,441,4759.0056.0060.00Primary payer payments6.91160.0018,441,4759.0061.00Total (sum of program beneficiaries (line 59 minus line 60)18,441,4759.0062.00Deductibles billed to program beneficiaries19,940,09362.0063.00Coinsurance billed to program beneficiaries19,943,64.0064.00Allowable bad debts (see instructions)84,46365.0065.00Adjusted reimbursable bad debts (see instructions)84,46365.0066.00Allowable bad debts for dual eligible beneficiaries (see instructions)16,569,91267.0067.00Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)068.0069.00Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)070.9070.88SCH or MDH volume decrease adjustment070.9070.9070.90HSP bonus payment HWBP adjus						-	
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70. 95 Recovery of accelerated depreciation 0 70.95							
	70.95	Recovery of accelerated depreciation			I	0	70.95

Heal th	Financial Systems HENDRICKS REGION	NAL HEALTH		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/30/2017 11:	
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period prior to 10/1)	in column O		0	0	70.96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or at			0	0	70.97
70. 98	Low Volume Payment-3				0	70.98
70.99	HAC adjustment amount (see instructions)				0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			16, 621, 972	71.00
71.01	Sequestration adjustment (see instructions)				332, 439	71.01
72.00	Interim payments				16, 279, 384	72.00
73.00	Tentative settlement (for contractor use only)				0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72	2, and 73)			10, 149	74.00
75.00	Protested amounts (nonallowable cost report items) in accorda	ance with			344, 327	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 (see ins	structions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instr				0	92.00
	Capital outlier reconciliation adjustment amount (see instruct				0	93.00
	The rate used to calculate the time value of money (see instr				0.00	
	Time value of money for operating expenses (see instructions)				0	95.00
96.00	Time value of money for capital related expenses (see instruct	ctions)			0	96.00
				Prior to 10/1		
				1.00	2.00	
	HSP Bonus Payment Amount				-	
	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)	>		0. 000000000	0. 000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instruction	15)		0	0	102.00
102 00	HRR Adjustment for HSP Bonus Payment			0.0000	0,0000	102 00
	HRR adjustment factor (see instructions)	-)		0. 0000	0.0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions	>)		0	0	104.00

DW VC	Financial Systems DLUME CALCULATION EXHIBIT 4		HENDRICKS REGI	Provider Co		Period: From 01/01/2016	u of Form CMS-2 Worksheet E Part A Exhibi	
						To 12/31/2016	Date/Time Pre 5/30/2017 11:	pare
				Title	XVIII	Hospi tal	PPS	_ / u
		line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	0n/After 10/01	Total (Col 2 through 4)	
00	DRG amounts other than outlier	0	1.00	2.00	3.00	4.00	5.00	1.
00	payments	1.00	0	0		0		'.
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	0	1.
02	DRG amounts other than outlier payments for discharges occurring on or after October	1.02	15, 913, 743	0		15, 913, 743	15, 913, 743	1.
03	I DRG for Federal specific operating payment for Model 4 BPCL occurring prior to	1.03	0	0		0	0	1
04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1
00	Outlier payments for	2.00	323, 821	0		0 323, 821	323, 821	2
01	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2.02	0	0		о о	0	2
00	Operating outlier reconciliation	2. 01	0	0		0 0	0	3
00	Managed care simulated payments	3.00	0	0		0 0	0	4
00	Indirect Medical Education Adju Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0.00000	0 0. 000000		5
0	A, line 21 (see instructions)		0.000000	0.000000	0.00000	0.000000		
00	IME payment adjustment (see instructions)	22.00	0	0		0 0	0	6
)1	IME payment adjustment for managed care (see instructions)	22.01	0	0		0 0	0	6
	Indirect Medical Education Adju	ustment for th	e Add-on for Se	ection 422 of t	the MMA			1
00	IME payment adjustment factor	27.00	0. 000000	0. 000000	0.00000	0 0. 000000		7
0	(see instructions) IME adjustment (see	28.00	0	0		o o	0	8
)1	instructions) IME payment adjustment add on for managed care (see	28.01	0	0		o o	0	8
00	instructions) Total IME payment (sum of	29.00	0	0		0 0	0	9
)1	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29.01	О	0		o o	0	9
	8.01) Disproportionate Share Adjustme	nt						
00	Allowable disproportionate share percentage (see	33.00	0. 0555	0. 0555	0. 055	5 0. 0555		10
00	instructions) Disproportionate share adjustment (see instructions)	34.00	220, 803	0		0 220, 803	220, 803	11
01	adjustment (see instructions) Uncompensated care payments	36.00	594, 306	0	455, 24	1 139, 065	594, 306	11
00	Additional payment for high per Total ESRD additional payment			di scharges 0		0 0		
00 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47.00 48.00	17, 052, 673 0	0 0	455, 24	1 16, 597, 432 0 0	17, 052, 673 0	
00	small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see	49.00	17, 052, 673	0	455, 24	1 16, 597, 432	17, 052, 673	15
00	instructions) Payment for inpatient program capital	50.00	1, 388, 474	0		0 1, 388, 474	1, 388, 474	16
00	Special add-on payments for new technologies	54.00	0	0		0 0	0	17
01 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		o o	0	17 17

	Financial Systems		HENDRI CKS REGI				u of Form CMS-	2552-10
LOW VO	ULUME CALCULATION EXHIBIT 4				CN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/30/2017 11:	pared:
					× XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prion to 10/01	r Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	C		0 0		
19.00	SUBTOTAL		(1)	C	455, 24	17, 985, 906	18, 441, 147	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, 279, 423	C)	0 1, 279, 423	1, 279, 423	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0	C		0 0	C	20. 01
21.00	Capital DRG outlier payments	2.00	56, 978	C		0 56, 978	56, 978	21.00
	Model 4 BPCI Capital DRG outlier payments	2. 01	0	C		0 0	O	21.01
	Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000				22.00
	Indirect medical education adjustment (see instructions)	6.00	0	C		0 0	C	
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0407	0. 0407	0. 040	0. 0407		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	52, 073	C		0 52, 073	52, 073	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 388, 474	C		0 1, 388, 474	1, 388, 474	26.00
		W/S E, Part A	(Amounts to					
		line	E, Part A)	0.00	2.00	1.00	5.00	
27.00	I an interest address to the second	0	1.00	2.00	3.00	4.00	5.00	07.00
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 00000	0.000000	O	27.00 28.00
29.00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	C	29.00
100. 00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	6 Provider CC	CN: 15-0005	Period:	Worksheet E	
					From 01/01/2016 To 12/31/2016		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	
. 00	DRG amounts other than outlier payments	1.00					1.0
. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0		0	0	1.0
. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	15, 913, 743		15, 913, 743		1. (
. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.0
. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.0
. 00	Outlier payments for discharges (see instructions)	2.00	323, 821		0 323, 821	323, 821	2.0
. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2.0
. 00	Operating outlier reconciliation	2. 01	0		0 0	0	3.0
. 00	Managed care simulated payments Indirect Medical Education Adjustment	3.00	0		0 0	0	4.0
. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 00000	0. 000000		5.
. 00 . 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)		0		0 0 0 0	0	6. (6. (
	Indirect Medical Education Adjustment for the						
. 00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000			7.0
00	IME adjustment (see instructions)	28.00	0		0 0	0	8.
01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8.
00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0		0 0	0	9.
	Disproportionate Share Adjustment	22.00	0.0555	0.055			10
	Allowable disproportionate share percentage (see instructions)	33.00	0. 0555	0. 055			10.
. 00	Disproportionate share adjustment (see instructions)	34.00	220, 803		0 220, 803	220, 803	
	Uncompensated care payments Additional payment for high percentage of ESI	36.00 20. beneficiary	594, 306	455, 24	139,065	594, 306	11.
. 01							
. 01 2. 00	Total ESRD additional payment (see	46.00	0		0 0	0	12.
. 00	Total ESRD additional payment (see instructions)		0	455, 24			
. 00	Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	46.00 47.00		455, 24			
. 00 . 00 . 00	Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs	46.00 47.00	0		11 16, 597, 432 0 0	17, 052, 673 0	13. 14.
. 00 . 00 . 00	Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)	46. 00 47. 00 48. 00	0 17, 052, 673 0 17, 052, 673		11 16, 597, 432 0 0 11 16, 597, 432	17, 052, 673 0 17, 052, 673	13. 14. 15.
. 00 . 00 . 00 . 00	Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital	46.00 47.00 48.00 49.00 50.00	0 17, 052, 673 0		11 16, 597, 432 0 0 11 16, 597, 432	17, 052, 673 0 17, 052, 673 1, 388, 474	13. 14. 15. 16.
. 00 . 00 . 00 . 00 . 00 . 00	Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital Special add-on payments for new technologies	46.00 47.00 48.00 49.00 50.00	0 17, 052, 673 0 17, 052, 673		11 16, 597, 432 0 0 11 16, 597, 432	17, 052, 673 0 17, 052, 673	13. 14. 15. 16. 17.
. 00 . 00 . 00 . 00 . 00 . 00 . 01	Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital Special add-on payments for new technologies Net organ acquisition cost Credits received from manufacturers for	46.00 47.00 48.00 49.00 50.00	0 17, 052, 673 0 17, 052, 673		11 16, 597, 432 0 0 11 16, 597, 432	17, 052, 673 0 17, 052, 673 1, 388, 474 0	13. 14. 15. 16.
2.00	Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital Special add-on payments for new technologies Net organ acquisition cost	46.00 47.00 48.00 49.00 50.00 54.00	0 17, 052, 673 0 17, 052, 673 1, 388, 474 0		11 16, 597, 432 0 0 11 16, 597, 432	17, 052, 673 0 17, 052, 673 1, 388, 474 0	 13. 14. 15. 16. 17. 17. 17. 17.

	Financial Systems	HENDRICKS REG				u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2016 To 12/31/2016		pared:
				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, 279, 423		0 1, 279, 423	1, 279, 423	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20.01
21.00	Capital DRG outlier payments	2.00	56, 978		0 56, 978	56, 978	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0407	0. 040	07 0. 0407		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	52, 073		0 52, 073	52, 073	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 388, 474		0 1, 388, 474	1, 388, 474	26.00
		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	80, 671	1	0 80, 671	80, 671	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30.01
31.00	HRR adjustment (see instructions)	70. 94	-28, 611		0 -28, 611	-28, 611	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
						(Amt. to Wkst. E, Pt.	
						A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

PART 1.00 Medic 2.00 Medic 3.00 PPS g 4.00 Outli 5.00 Enter 6.00 Line 7.00 Sum c 8.00 Trans 9.00 Anci I 10.00 Orgar 11.00 Total COMPU Reaso 12.00 Anci I 13.00 Orgar 14.00 Total Custo Total 5.00 Aggree 16.00 Amour had s Total 19.00 Excess instr 20.00 21.00 Lessé 22.00 Inter	OF REIMBURSEMENT SETTLEMENT 3 - MEDICAL AND OTHER HEALTH SERVICES al and other services (see instructions) al and other services reimbursed under OPPS (see instr ayments er payment (see instructions) the hospital specific payment to cost ratio (see inst 2 times line 5 f line 3 plus line 4 divided by line 6 itional corridor payment (see instructions) lary service other pass through costs from Wkst. D, Pt acquisitions cost (sum of lines 1 and 10) (see instructions) TATION OF LESSER OF COST OR CHARGES hable charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) r of cost or charges (line 11 minus line 20)	ructions) . IV, col. 13, line 200 line 69) or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	2016 Date/Time Pre 5/30/2017 11: PPS 1.00 8,388 24,515,419 15,079,133 474,885 0.000 0 0 0 0 0 0 0 0 0 0 0 0	29 am 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 11.00 12.00 13.00 14.00 14.00 15.00 16.00 17.00 18.00 19.00 19.00
1.00 Medic 2.00 Medic 2.00 Medic 3.00 PPS p 4.00 Outli 5.00 Enter 6.00 Line 7.00 Sum c 8.00 Trans 9.00 Anci I 10.00 Organ 11.00 Total COMPU Reaso 12.00 Anci I 13.00 Organ 14.00 Total Custo Aggree 16.00 Amour had s Troug 17.00 Excess 19.00 Excess instr 20.00 22.00 Inter	al and other services (see instructions) al and other services reimbursed under OPPS (see instr ayments er payment (see instructions) the hospital specific payment to cost ratio (see inst 2 times line 5 f line 3 plus line 4 divided by line 6 itional corridor payment (see instructions) lary service other pass through costs from Wkst. D, Pt acquisitions cost (sum of lines 1 and 10) (see instructions) TATION OF LESSER OF COST OR CHARGES able charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for ts that would have been reasonable cost (complete uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges over reasonable cost (complete uctions) s of customary charges over reasonable cost (complete uctions)	To 12/31/ Title XVIII Hospital Fuctions) Fructions)	2016 Date/Time Pre 5/30/2017 11: PPS 1.00 8,388 24,515,419 15,079,133 474,885 0.000 0 0 0 0 0 0 0 0 0 0 0 0	29 am 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
1.00 Medic 2.00 Medic 2.00 Medic 3.00 PPS p 4.00 Outli 5.00 Enter 6.00 Line 7.00 Sum c 8.00 Trans 9.00 Anci I 10.00 Organ 11.00 Total COMPU Reaso 12.00 Anci I 13.00 Organ 14.00 Total Custo Aggre 16.00 Amour had s Troug 17.00 Excess 19.00 Excess instr 20.00 Lesse 22.00	al and other services (see instructions) al and other services reimbursed under OPPS (see instr ayments er payment (see instructions) the hospital specific payment to cost ratio (see inst 2 times line 5 f line 3 plus line 4 divided by line 6 itional corridor payment (see instructions) lary service other pass through costs from Wkst. D, Pt acquisitions cost (sum of lines 1 and 10) (see instructions) TATION OF LESSER OF COST OR CHARGES able charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for ts that would have been reasonable cost (complete uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges over reasonable cost (complete uctions) s of customary charges over reasonable cost (complete uctions)	ructions) ructions) :ructions) :. IV, col. 13, line 200 line 69) or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	PPS 1.00 1.00 8,388 24,515,419 15,079,133 474,885 0.000 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
1.00 Medic 2.00 Medic 3.00 PPS p 4.00 Outli 5.00 Enter 6.00 Line 7.00 Sum c 8.00 Trans 9.00 Anci I 10.00 Organ 11.00 Total COMPU Reaso 12.00 Anci I 13.00 Total Custo Total Custo Total 19.00 Excessingth 19.00 Excessingth 21.00 Lesse 22.00 Inter	al and other services (see instructions) al and other services reimbursed under OPPS (see instr ayments er payment (see instructions) the hospital specific payment to cost ratio (see inst 2 times line 5 f line 3 plus line 4 divided by line 6 itional corridor payment (see instructions) lary service other pass through costs from Wkst. D, Pt acquisitions cost (sum of lines 1 and 10) (see instructions) TATION OF LESSER OF COST OR CHARGES able charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for ts that would have been reasonable cost (complete uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges over reasonable cost (complete uctions) s of customary charges over reasonable cost (complete uctions)	ructions) . IV, col. 13, line 200 line 69) or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	si s 0. 000000 20, 668 12, 280 0. 00000 0 0. 00 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
1.00 Medic 2.00 Medic 3.00 PPS p 4.00 Outli 5.00 Enter 6.00 Line 7.00 Sum c 8.00 Trans 9.00 Anci I 10.00 Organ 11.00 Total COMPU Reaso 12.00 Anci I 13.00 Total Custo Total Custo Total 19.00 Excessingth 19.00 Excessingth 21.00 Lesse 22.00 Inter	al and other services (see instructions) al and other services reimbursed under OPPS (see instr ayments er payment (see instructions) the hospital specific payment to cost ratio (see inst 2 times line 5 f line 3 plus line 4 divided by line 6 itional corridor payment (see instructions) lary service other pass through costs from Wkst. D, Pt acquisitions cost (sum of lines 1 and 10) (see instructions) TATION OF LESSER OF COST OR CHARGES able charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for ts that would have been reasonable cost (complete uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges over reasonable cost (complete uctions) s of customary charges over reasonable cost (complete uctions)	ructions) . IV, col. 13, line 200 line 69) or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	si s 0. 000000 20, 668 12, 280 0. 00000 0 0. 00 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
2.00 Medic 3.00 PPS p 4.00 Outl i 5.00 Enter 6.00 Li ne 7.00 Sum c 8.00 Trans 9.00 Anci I 10.00 Organ 11.00 Total COMPU Reaso 12.00 Anci I 13.00 Organ 14.00 Total Custo 15.00 Aggre 16.00 Amour had s 17.00 Ratic 18.00 Total 19.00 Excess i nstr 21.00 Lesse 22.00 Inter	al and other services reimbursed under OPPS (see instr ayments er payment (see instructions) the hospital specific payment to cost ratio (see inst 2 times line 5 f line 3 plus line 4 divided by line 6 itional corridor payment (see instructions) lary service other pass through costs from Wkst. D, Pt acquisitions cost (sum of lines 1 and 10) (see instructions) TATION OF LESSER OF COST OR CHARGES nable charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for so f customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	ructions) . IV, col. 13, line 200 line 69) or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	24, 515, 419 15, 079, 133 474, 885 0, 000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
3.00 PPS p 4.00 Outl i 5.00 Enter 6.00 Li ne 7.00 Sum c 8.00 Trans 9.00 Anci I 10.00 Orgar 11.00 Total COMPU Reaso 12.00 Anci I 13.00 Orgar 14.00 Total Custo 15.00 Aggre 16.00 Amour had s S 17.00 Ratic 18.00 Total 19.00 Excess instr 2.00 21.00 Lesse 22.00 Inter	ayments er payment (see instructions) the hospital specific payment to cost ratio (see inst 2 times line 5 f line 3 plus line 4 divided by line 6 itional corridor payment (see instructions) lary service other pass through costs from Wkst. D, Pt acquisitions cost (sum of lines 1 and 10) (see instructions) TATION OF LESSER OF COST OR CHARGES able charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	ructions) . IV, col. 13, line 200 line 69) or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	15, 079, 133 474, 885 0, 000 0, 00 0 0 0 0 0 0 0 0 0 8, 388 20, 668 0 20, 668 0 20, 668 3i s 0 0.00000 20, 668 12, 280 0	3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
4.00 Outli 5.00 Enter 6.00 Line 7.00 Sum of 8.00 Trans 9.00 Anci I 10.00 Orgar 11.00 Total COMPU Reaso 12.00 Anci I 13.00 Orgar 14.00 Total 0.00 Aggre 16.00 Aggre 16.00 Aggre 16.00 Ratio 18.00 Total 19.00 Excess instr 20.00 Excess 22.00 Inter	er payment (see instructions) the hospital specific payment to cost ratio (see inst 2 times line 5 f line 3 plus line 4 divided by line 6 itional corridor payment (see instructions) lary service other pass through costs from Wkst. D, Pt acquisitions cost (sum of lines 1 and 10) (see instructions) TATION OF LESSER OF COST OR CHARGES mable charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for the form the form the form patients liable for the form the form the form patients liable for the form the form patients liable for the form the form the form patients liable for the form the form the form patients liable form p	I IV, col. 13, line 200 line 69) or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	474, 885 0.000 0 0.00 0 0 0 0 8, 388 20, 668 0 20, 668 0 20, 668 0 20, 668 12, 280 0	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
5.00 Enter 6.00 Li ne 7.00 Sum c 8.00 Trans 9.00 Anci I 10.00 Orgar 11.00 Total COMPU Reaso 12.00 Anci I 13.00 Orgar 14.00 Total Custo 15.00 Aggre 16.00 Amour had s 17.00 Ratic 18.00 Total 19.00 Excess i nstr 20.00 Excess 22.00 Inter	the hospital specific payment to cost ratio (see inst 2 times line 5 f line 3 plus line 4 divided by line 6 itional corridor payment (see instructions) lary service other pass through costs from Wkst. D, Pt acquisitions cost (sum of lines 1 and 10) (see instructions) TATION OF LESSER OF COST OR CHARGES hable charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	I IV, col. 13, line 200 line 69) or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	si s asi s 0.00000000000000000000000000000000000	5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
6.00 Li ne 7.00 Sum o 8.00 Trans 9.00 Anci I 10.00 Organ 11.00 Total COMPU Reaso 12.00 Anci I 13.00 Organ 14.00 Total Custo 15.00 Aggre 16.00 Amour had s 17.00 Rati c 18.00 Total 19.00 Excess i nstr 20.00 Excess 22.00 Inter	2 times line 5 f line 3 plus line 4 divided by line 6 itional corridor payment (see instructions) lary service other pass through costs from Wkst. D, Pt acquisitions cost (sum of lines 1 and 10) (see instructions) TATION OF LESSER OF COST OR CHARGES hable charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	I IV, col. 13, line 200 line 69) or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	si s si s si s 0.00000 20, 668 0 20, 668 0 0.00000 20, 668 12, 280 0	6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
8.00 Trans 9.00 Anci I 10.00 Organ 11.00 Total COMPU Reaso 12.00 Anci I 13.00 Organ 14.00 Total Custo 15.00 Aggre 16.00 Amour had s 17.00 Ratic 18.00 Total 19.00 Excess instr 20.00 Excess 22.00 Inter	itional corridor payment (see instructions) lary service other pass through costs from Wkst. D, Pt acquisitions cost (sum of lines 1 and 10) (see instructions) TATION OF LESSER OF COST OR CHARGES hable charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	line 69) or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	0 0 8, 388 20, 668 0 20, 668 35i s 0 0.000000 20, 668 12, 280 0	8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
9.00 Anci I 10.00 Organ 11.00 Total COMPU Reaso 12.00 Anci I 13.00 Organ 14.00 Total Custo 15.00 Aggre 16.00 Amour had s 17.00 Ratic 18.00 Total 19.00 Excess i nstr 20.00 Excess i nstr 21.00 Lesse 22.00 Inter	<pre>lary service other pass through costs from Wkst. D, Pt acquisitions cost (sum of lines 1 and 10) (see instructions) TATION OF LESSER OF COST OR CHARGES able charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)</pre>	line 69) or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	0 0 8, 388 20, 668 0 20, 668 0 20, 668 3si s 0 0. 000000 20, 668 12, 280 0	9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
10.00 Orgar 11.00 Total COMPU Reaso 12.00 Anci I 13.00 Orgar 14.00 Total Custo Aggre 15.00 Aggre 16.00 Amour had s 17.00 17.00 Ratic 18.00 Total 19.00 Excess instr 20.00 21.00 Lesse 22.00 Inter	acquisitions cost (sum of lines 1 and 10) (see instructions) TATION OF LESSER OF COST OR CHARGES Table charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for ts that would have been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	line 69) or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	0 8, 388 20, 668 0 20, 668 si s 0 asi s 0 0. 000000 20, 668 12, 280 0	10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
11.00 Total COMPU Reaso 12.00 Anci I 13.00 Organ 14.00 Total 0 Total 0 Organ 14.00 Total 0 Gaso 15.00 Aggree 16.00 Amour had s 17.00 Ratic 18.00 Total 19.00 Excess instr 20.00 Excess 21.00 Lesse 22.00 Inter	cost (sum of lines 1 and 10) (see instructions) TATION OF LESSER OF COST OR CHARGES hable charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	8, 388 20, 668 0 20, 668 35i s 0 asi s 0 0. 000000 20, 668 12, 280 0	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
COMPU Reaso 12.00 Anci I 13.00 Organ 14.00 Total Custo 15.00 Aggre 16.00 Amour had s 17.00 Ratic 18.00 Total 19.00 Excess i nstr 20.00 Excess 22.00 Inter	TATION OF LESSER OF COST OR CHARGES hable charges lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for ts that would have been realized from patients liable for uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	20, 668 0 20, 668 si s 0 asi s 0. 000000 20, 668 12, 280 0	12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
12.00 Anci I 13.00 Organ 14.00 Total Custo 15.00 Aggre 16.00 Amour had s 17.00 Ratic 18.00 Total 19.00 Exces instr 20.00 Exces instr 21.00 Lesse 22.00 Inter	lary service charges acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable for uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	0 20, 668 si s 0 0. 000000 20, 668 12, 280 0	13.00 14.00 15.00 16.00 17.00 18.00 19.00
13.00 Organ 14.00 Total Custo Custo 15.00 Aggre 16.00 Amour had s S 17.00 Ratic 18.00 Total 19.00 Excession instr 20.00 21.00 Lesse 22.00 Inter	acquisition charges (from Wkst. D-4, Pt. III, col. 4, reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable e uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	0 20, 668 si s 0 0. 000000 20, 668 12, 280 0	13.00 14.00 15.00 16.00 17.00 18.00 19.00
14.00 Total Custo 15.00 Aggre 16.00 Amour had s 17.00 17.00 Ratic 18.00 Total 19.00 Excession instr 20.00 21.00 Lesse 22.00 Inter	reasonable charges (sum of lines 12 and 13) mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	or payment for services on a charge bas for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	20, 668 si s 0 asi s 0 0. 000000 20, 668 12, 280 0	14.00 15.00 16.00 17.00 18.00 19.00
Custo 15.00 Aggre 16.00 Amour had s had s 17.00 Ratic 18.00 Total 19.00 Excession 20.00 Excession 11.00 Lesses 22.00 Inter	mary charges gate amount actually collected from patients liable for ts that would have been realized from patients liable uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	si s 0 asi s 0 0. 000000 20, 668 12, 280 0	15.00 16.00 17.00 18.00 19.00
16.00 Amour had s 17.00 Ratic 18.00 Total 19.00 Exces instr 20.00 Exces instr 21.00 Lesse 22.00 Inter	ts that would have been realized from patients liable uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	for payment for services on a chargeba 3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	asi s 0 0. 000000 20, 668 12, 280 0	16.00 17.00 18.00 19.00
had s 17.00 Ratic 18.00 Total 19.00 Exces instr 20.00 Exces instr 21.00 Lesse 22.00 Inter	uch payment been made in accordance with 42 CFR §413.1 of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	3(e) only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	0. 000000 20, 668 12, 280 0	17.00 18.00 19.00
17.00 Ratic 18.00 Total 19.00 Exces instr 20.00 Exces instr 21.00 Lesse 22.00 Inter	of line 15 to line 16 (not to exceed 1.000000) customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	only if line 18 exceeds line 11) (see only if line 11 exceeds line 18) (see	20, 668 12, 280 0	18.00 19.00
18.00 Total 19.00 Excession 20.00 Excession 21.00 Lesse 22.00 Inter	customary charges (see instructions) s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	only if line 11 exceeds line 18) (see	20, 668 12, 280 0	18.00 19.00
19.00 Exces i nstr 20.00 Exces i nstr 21.00 Lesse 22.00 Inter	s of customary charges over reasonable cost (complete uctions) s of reasonable cost over customary charges (complete uctions)	only if line 11 exceeds line 18) (see	0	
20.00 Exces i nstr 21.00 Lesse 22.00 Inter	s of reasonable cost over customary charges (complete uctions)			20.00
i nstr 21.00 Lesse 22.00 Inter	uctions)			20.00
21.00 Lesse 22.00 Inter	,	see instructions)	0.077	
22.00 Inter			8, 388	21.00
22 00 0	ns and residents (see instructions)	,	0	1
	of physicians' services in a teaching hospital (see in	nstructions)	0	
	prospective payment (sum of lines 3, 4, 8 and 9) TATION OF REIMBURSEMENT SETTLEMENT		15, 554, 018	24.00
	tibles and coinsurance (for CAH, see instructions)		0	25.00
26.00 Deduc	tibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3, 099, 514	26.00
	tal [(lines 21 and 24 minus the sum of lines 25 and 26	b) plus the sum of lines 22 and 23] (se	ee 12, 462, 892	27.00
	uctions) t graduate medical education payments (from Wkst. E-4,	line 50)	0	28.00
	direct medical education costs (from Wkst. E-4, line 3		0	
	tal (sum of lines 27 through 29)		12, 462, 892	
	ry payer payments		2, 848	
	tal (line 30 minus line 31) ABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SER		12, 460, 044	32.00
	site rate ESRD (from Wkst. 1-5, line 11)		0	33.00
	able bad debts (see instructions)		187, 828	
	ted reimbursable bad debts (see instructions)		122, 088	
	able bad debts for dual eligible beneficiaries (see in	nstructions)	57, 828	
	tal (see instructions) CC reconciliation amount from PS&R		12, 582, 132 -250	
	ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		-230	
	er ACO demonstration payment adjustment (see instructi	ons)	0	
	al or full credits received from manufacturers for rep	laced devices (see instructions)	0	
	ERY OF ACCELERATED DEPRECIATION		0	
	tal (see instructions) stration adjustment (see instructions)		12, 582, 382 251, 648	
	im payments		12, 449, 029	
	tive settlement (for contractors use only)		0	
	ce due provider/program (see instructions)		-118, 295	
	sted amounts (nonallowable cost report items) in accor	dance with CMS Pub. 15-2, chapter 1,	0	44.00
<u>§115.</u> TO BE	COMPLETED BY CONTRACTOR			
	nal outlier amount (see instructions)		0	
	er reconciliation adjustment amount (see instructions	s)	0	
	ate used to calculate the Time Value of Money			92.00
	Value of Money (see instructions) (sum of lines 91 and 93)		0	93.00 94.00

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared
		Titlo	XVIII	Hospi tal	5/30/2017 11: PPS	29 am
		Inpatien			T B	
		mm/dd/yyyy	Amount		Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each		16, 126, 0	90 0	12, 203, 594 0	1.0 2.0 3.0
	payment. If none, write "NONE" or enter a zero. (1)					
. 01 . 02 . 03 . 04 . 05	Program to Provider ADJUSTMENTS TO PROVIDER	12/31/2016 07/08/2016	98, 3 54, 9		245, 435 0 0 0 0	3. 0 3. 0 3. 0 3. 0 3. 0
	Provider to Program			-	-	
50 51 52 53 54 99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines		153, 2 [,]	0 0 0 0 0 94	0 0 0 0 245, 435	3. 5 3. 5 3. 5 3. 5 3. 5
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		16, 279, 3	84	12, 449, 029	4.
	TO BE COMPLETED BY CONTRACTOR					_
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.
01	TENTATI VE TO PROVIDER			0	0	5.
02 03				0 0	0	5. 5.
50	Provider to Program TENTATIVE TO PROGRAM			0	0	F
50 51 52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0 0 0	0 0 0	5. 5. 5. 5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01 02 00	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		10, 14 16, 289, 5	0 33 Contractor	0 118, 295 12, 330, 734 NPR Date	6. 6. 7.
)	Number 1.00	(Mo/Day/Yr) 2.00	
	Name of Contractor	l)	1.00	2.00	8.

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0005	Peri od:	Worksheet E-3	
			From 01/01/2016 To 12/31/2016	Part VII Date/Time Pre 5/30/2017 11:	pared: 29 am
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpatient	
		LCES FOR TITLES V OR		2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV COMPUTATION OF NET COST OF COVERED SERVICES	TCES FOR TITLES V OR A	AIX SERVICES		-
1.00	Inpatient hospital/SNF/NF services		1, 457, 426		1.00
2.00	Medical and other services		.,,	0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1, 457, 426	0	
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments		1 457 404	0	
7.00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		1, 457, 426	0	7.00
	Reasonable Charges				1
8.00	Routi ne servi ce charges		849, 065		8.00
9.00	Ancillary service charges		2, 136, 495	0	9.00
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, 985, 560	0	12.00
13.00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for	convisor on a charge	0	0	13.00
13.00	basis	services on a charge	0	0	13.00
14.00	Amounts that would have been realized from patients liable for	payment for services	on 0	0	14.00
	a charge basis had such payment been made in accordance with 42			-	
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		2, 985, 560	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only	/ifline 16 exceeds	1, 528, 134	0	17.00
10.00	line 4) (see instructions)			0	10.00
18.00	Excess of reasonable cost over customary charges (complete only 16) (see instructions)	/ IF IT he 4 exceeds IT	ne u	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16		1, 457, 426	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c	completed for PPS provi	iders.		
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
25.00 26.00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	25.00 26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1, 457, 426	0	
	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, 457, 426	0	31.00
32.00	Deducti bl es		0	0	
33.00			0	0	00.00
35.00	Allowable bad debts (see instructions) Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	1, 457, 426	0	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	/	0	0	37.00
38.00	Subtotal (line 36 ± line 37)		1, 457, 426	0	•
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1, 457, 426	0	
41.00	Interim payments		1, 304, 749	0	
42.00	Balance due provider/program (line 40 minus line 41)		152, 677	0	
43.00	Protested amounts (nonallowable cost report items) in accordance	- WITH ONC DI 4E C	0	0	43.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	F	Period: From 01/01/2016 Fo 12/31/2016		pare 29 a
		General Fund	Specific Purpose Fund		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
00	Cash on hand in banks	5, 672, 854	(0 0	0	1.
00	Temporary investments	95, 263		0 0	0	2.
00	Notes receivable	0	0	0 0	0	3.
00	Accounts receivable	84, 850, 179	1	- -	0	
00	Other receivable	0	(-	0	
00	Allowances for uncollectible notes and accounts receivable	-53, 554, 457		- -	0	6
00 00	Inventory Prepaid expenses	2, 159, 737		-	0	7
00	Other current assets	39, 854, 574		- -	0	9
	Due from other funds	6, 122, 079		-	0	10
	Total current assets (sum of lines 1-10)	85, 200, 229		0 0	0	
	FIXED ASSETS	· · ·	•			1
. 00	Land	20, 928, 211	0	0 0	0	12
	Land improvements	0	0		0	
	Accumulated depreciation	0	(-	0	14
	Buildings	0	(-	0	15
	Accumulated depreciation Leasehold improvements	12 920 707		, i i i i i i i i i i i i i i i i i i i	0	16
	Accumul ated depreciation	12, 830, 797		-	0	18
	Fi xed equi pment	352, 993, 470		-	0	19
	Accumulated depreciation	-171, 029, 644		-	0	20
	Automobiles and trucks	0	(0	0	21
2.00	Accumulated depreciation	0	0	0 0	0	22
3.00	Major movable equipment	0	0	0 0	0	23
	Accumulated depreciation	0	0	-	0	24
	Minor equipment depreciable	0	(0	0	25
	Accumulated depreciation	0	(0	0	26
	HIT designated Assets Accumulated depreciation	0		-	0	27
	Mi nor equi pment-nondepreci abl e	0		-	0	
	Total fixed assets (sum of lines 12-29)	215, 722, 834			0	
	OTHER ASSETS			- <u>-</u>		
. 00	Investments	222, 575, 137	(0 0	0	31
	Deposits on Leases	0	0	0 0	0	32
	Due from owners/officers	0	C	- -	0	33
	Other assets	18, 275, 663	1	-	0	34
	Total other assets (sum of lines 31-34)	240, 850, 800			0	35
6.00	Total assets (sum of lines 11, 30, and 35)	541, 773, 863	(0 0	0	36
1 00	CURRENT LIABILITIES Accounts payable	8, 559, 085		0 0	0	37
	Salaries, wages, and fees payable	10, 936, 758	1		0	38
	Payrol I taxes payable	0			0	
	Notes and loans payable (short term)	0	0	0 0	0	40
	Deferred income	0	0	0 0	0	41
	Accelerated payments	0				42
	Due to other funds	1, 446, 386			0	
	Other current liabilities	43, 244, 815			0	
o. 00	Total current liabilities (sum of lines 37 thru 44)	64, 187, 044	(0 0	0	45
5.00	LONG TERM LIABILITIES Mortgage payable	0		0 0	0	46
	Notes payable	0			0	40
	Unsecured Loans	0		- -	0	
	Other long term liabilities	112, 845, 969		-	0	49
	Total long term liabilities (sum of lines 46 thru 49)	112, 845, 969		0 0	0	50
. 00	Total liabilities (sum of lines 45 and 50)	177, 033, 013	(0 0	0	51
	CAPI TAL ACCOUNTS		1			
	General fund balance	364, 740, 850			l	52
	Specific purpose fund		0)		53
	Donor created - endowment fund balance - restricted			0	l	54
	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55
	Plant fund balance - invested in plant			0	0	
	Plant fund balance - reserve for plant improvement,				0	
00	replacement, and expansion				0	"
		0/4 740 050			0	59
9.00	Total fund balances (sum of lines 52 thru 58)	364, 740, 850		0 0	. 0	1 35

Health Financial Systems	HENDRICKS REGIO	NAL HEALTH		In Lie	u of Form CMS-	2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet G-1 Date/Time Pre 5/30/2017 11:	pared:
	General	Fund	Special I	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.00.006.00.007.008.009.0010.00Total additions (sum of line 4-9)11.00Subtotal (line 3 plus line 10)12.00Deductions (debit adjustments) (specify)13.0014.0015.0017.00		348, 536, 968 16, 203, 882 364, 740, 850 0 364, 740, 850	0.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0,00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
<pre>18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)</pre>	Endowment	0 364, 740, 850 Pl ant	Fund	0		18.00 19.00
	Fund			_		
	6.00	7.00	8.00			1.00
 1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 6.00 7.00 8.00 9.00 	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17)	000	0 0 0 0 0 0		000		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)	O			0		19.00

IAIEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared
	Cost Center Description		I npati ent	Outpati ent	<u>5/30/2017 11:</u> Total	<u>29 am</u>
	cost center besch prion		1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
. 00	Hospi tal		27, 659, 52	21	27, 659, 521	1.0
. 00	SUBPROVIDER - IPF					2.0
. 00	SUBPROVIDER - IRF					3.0
. 00	SUBPROVIDER					4.0
. 00	Swing bed - SNF			0	0	
. 00 . 00	Swing bed - NF SKILLED NURSING FACILITY			0	0	6.0
. 00	NURSING FACILITY					8.0
. 00	OTHER LONG TERM CARE					9.0
D. 00	Total general inpatient care services (sum of lines 1-9)		27, 659, 52	21	27, 659, 521	
	Intensive Care Type Inpatient Hospital Services				,	
1.00	INTENSIVE CARE UNIT		5, 318, 30	53	5, 318, 363	111. (
2.00	CORONARY CARE UNIT					12.0
3.00	BURN INTENSIVE CARE UNIT					13. (
	SURGI CAL I NTENSI VE CARE UNI T					14.0
	OTHER SPECIAL CARE (SPECIFY)					15.
6.00	Total intensive care type inpatient hospital services (sum	oflines	5, 318, 30	53	5, 318, 363	16.0
7 00	11-15)	1()	22 077 0	- 4	22 077 004	17.
7.00 8.00	Total inpatient routine care services (sum of lines 10 and Ancillary services	10)	32, 977, 88 90, 661, 42		32, 977, 884 374, 447, 226	
	Outpatient services		14, 007, 55		118, 893, 136	
	RURAL HEALTH CLINIC		14,007,00	0 104,003,370	0 110, 093, 130	
1.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
	HOME HEALTH AGENCY			-	-	22.
3.00	AMBULANCE SERVICES					23.
4.00	СМНС					24.
5.00	AMBULATORY SURGICAL CENTER (D. P.)					25.
6.00	HOSPI CE					26.
7.00	PRIMARY CARE CLINIC			0 226, 137	226, 137	
	OCCUPATIONAL MEDICINE			0 1,009,660	1,009,660	
	SCHOOL AND TOWN CLINICS		10,000 (0 1, 462, 944	1, 462, 944	
7.03	PROFESSIONAL FEES		12, 088, 60		74, 083, 089	
7.04 8.00	LAB DISCOUNT Total patient revenues (sum of lines 17-27)(transfer column	2 to What	149, 735, 53	0 -589, 875 32 452, 774, 669	-589, 875 602, 510, 201	
5.00	G-3, line 1)	I S LU WKSL.	149, 735, 5	452, 774, 009	002, 510, 201	20.
	PART II - OPERATING EXPENSES					
9.00	Operating expenses (per Wkst. A, column 3, line 200)			256, 107, 383		29.0
0. OO	ADD (SPECIFY)			0		30.
1.00				0		31.
2.00				0		32.
3.00				0		33.
4.00				0		34.
5.00	Tatal additions (avm of lines 20.25)			0		35.
6.00 7.00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)			0		36. 37.
7.00 B.00						37.
9.00				0		39.
). 00). 00				0		40.
1.00				0		41.
	Total deductions (sum of lines 37-41)			0		42.
2.00	TOTAL DEDUCTIONS (SUIL OF TIMES 37-41)			01		

Heal th	Financial Systems	HENDRICKS REGIONAL	_ HEALTH	In Lieu	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	ł	Provider CCN: 15-0005	Peri od:	Worksheet G-3	
				From 01/01/2016 To 12/31/2016	Date/Time Pre	narod.
				10 12/31/2010	5/30/2017 11:	29 am
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Par	t I, column 3, line	28)		602, 510, 201	1.00
2.00	Less contractual allowances and discounts of	n patients' accounts	5		350, 079, 487	2.00
3.00	Net patient revenues (line 1 minus line 2)				252, 430, 714	3.00
4.00	Less total operating expenses (from Wkst. G	-2, Part II, line 43	3)		256, 107, 383	4.00
5.00	Net income from service to patients (line 3	minus line 4)			-3, 676, 669	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				12, 614, 860	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscelland	eous communication s	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gu	ests			15, 379	
					0	15.00
	· · · · · · · · · · · · · · · · · · ·		an patients		0	16.00
	Revenue from sale of drugs to other than pa				0	17.00
18.00					0	18.00
	Tuition (fees, sale of textbooks, uniforms,				0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a	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 INCOME				7, 250, 312	
25.00					19, 880, 551	25.00
	Total (line 5 plus line 25)				16, 203, 882	26.00
	OTHER EXPENSES (SPECIFY)				0	27.00
	Total other expenses (sum of line 27 and sul				0	28.00
29.00	Net income (or loss) for the period (line 2)	o minus line 28)			16, 203, 882	29.00

ALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016		
	Title XVIII	Hospi tal	5/30/2017 11: PPS	29 ai
			1.00	
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
00 Capital DRG other than outlier			1, 279, 423	
01 Model 4 BPCI Capital DRG other than outlier			0	1.
00 Capital DRG outlier payments			56, 978	
01 Model 4 BPCI Capital DRG outlier payments	be east reporting period (and inc	tructions)	0	
00 Total inpatient days divided by number of days in th 00 Number of interns & residents (see instructions)	ne cost reporting period (see ins	tructions)	50.08 0.00	
00 Indirect medical education percentage (see instructions)	i onc)		0.00	
00 Indirect medical education adjustment (multiply line		1 columns 1 and	0.00	
1.01) (see instructions)	e 5 by the sum of Thes T and T.O	r, corumns r anu	0	0.
00 Percentage of SSI recipient patient days to Medicard 30) (see instructions)	e Part A patient days (Worksheet	E, part A line	2. 29	7.
00 Percentage of Medicaid patient days to total days (see instructions)		17.40	8.
00 Sum of Lines 7 and 8			17.40	
.00 Allowable disproportionate share percentage (see in:	structions)		4.07	
. 00 Disproportionate share adjustment (see instructions)			52,073	
.00 Total prospective capital payments (see instructions			1, 388, 474	
	5)		1,000,171	12.
			1.00	
PART II – PAYMENT UNDER REASONABLE COST				
00 Program inpatient routine capital cost (see instruc	tions)		0	1.
00 Program inpatient ancillary capital cost (see instru			0	
00 Total inpatient program capital cost (line 1 plus li	ine 2)		0	
00 Capital cost payment factor (see instructions)			0	
00 Total inpatient program capital cost (line 3 x line	4)		0	5.
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00 Program inpatient capital costs (see instructions)			0	
00 Program inpatient capital costs for extraordinary c			0	
Net program inpatient capital costs (line 1 minus li	Ine 2)		0	
Applicable exception percentage (see instructions)	·		0.00	
Capital cost for comparison to payments (line 3 x l)			0	-
00 Percentage adjustment for extraordinary circumstance			0.00	
Adjustment to capital minimum payment level for ext	radiumary circumstances (Time 2	x i ne 6)	0	
00 Capital minimum payment level (line 5 plus line 7) 00 Current year capital payments (from Part I, line 12			0	-
.00 Current year comparison of capital minimum payment		Loss line 0)	0	
.00 Carryover of accumulated capital minimum payment le Worksheet L, Part III, line 14)			0	
.00 Net comparison of capital minimum payment level to	canital navments (line 10 plus li	ne 11)	0	12.
			0	
00 Current year exception payment (if line 12 is positi			0	
	vel over canital navment for the			
.00 Carryover of accumulated capital minimum payment le		rorrowing period	Ű	
.00 Carryover of accumulated capital minimum payment le (if line 12 is negative, enter the amount on this l	ine)	rorrowing perrou		
.00 Carryover of accumulated capital minimum payment le	ine) t (see instructions)	rorrowing period	0	15